NATIONAL QUALITY FORUM

Memo

TO: Consensus Standards Approval Committee (CSAC)

FR: Behavioral Health Project Team

RE: Behavioral Health 2016-2017

DA: June 21, 2017

CSAC ACTION REQUIRED: The CSAC will review recommendations from the Behavioral Health project at its June 21, 2017 meeting and vote whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, recommended measures, and themes identified from and responses to the public and member comments.

NQF Member voting on these recommended measures closed on June 19, 2017.

Accompanying this memo are the following documents:

1. **Behavioral Health Draft Report.** The draft report has been updated to reflect the changes made following Standing Committee discussion of public and member comments. The complete draft report and supplemental materials are available on the project page.
2. **Comment Table.** Staff has identified themes within the comments received. This table lists the 52 comments received during the post meeting comment period and the NQF/Standing Committee responses.

BACKGROUND

The multiphase project aims to endorse measures of accountability for improving the delivery of behavioral health services and achieving better behavioral health outcomes for the U.S. population. In this fourth phase of Behavioral Health work, the 27-member Behavioral Health Standing Committee evaluated seven newly submitted measures and six measures undergoing maintenance of endorsement against NQF's standard evaluation criteria. The Committee recommended nine measures for endorsement, did not recommend three measures, and deferred an endorsement decision on one measure. NQF's Behavioral Health portfolio includes 54 measures that address tobacco, alcohol, and substance use; depression, major depressive disorder (MDD), schizophrenia, and bipolar disorders; health screening and assessment for those with serious mental illness; attention deficit hyperactivity disorder (ADHD); safe and appropriate inpatient psychiatric care; and follow up after hospitalization.

DRAFT REPORT

The Behavioral Health Draft Report presents the results of the evaluation of 13 measures considered under the Consensus Development Process (CDP). Nine are recommended for endorsement and three were not recommended.

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The measures were evaluated against the 2015 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	6	7	13
Measures recommended for endorsement	5	4	9
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures not recommended for endorsement or trial use	0	3	3
Measures withdrawn from consideration	0	0	0
Reasons for not recommending	Importance- 0 Scientific Acceptability- 0 Overall- 0 Competing Measure- 0	Importance- 2 Scientific Acceptability- 1 Overall- 0 Competing Measure- 0	

CSAC ACTION REQUIRED

Pursuant to the CDP, the CSAC is asked to consider endorsement of nine candidate consensus measures.

Behavioral Health Measures Recommended for Endorsement:

- 0027: Medical Assistance with Smoking and Tobacco Use Cessation
  Overall Suitability for Endorsement: Y-22; N-0
- 0108: Follow-Up Care for Children Prescribed ADHD Medication
  Overall Suitability for Endorsement: Y-13; N-8
- 0576: Follow-Up After Hospitalization for Mental Illness
  Overall Suitability for Endorsement: Y-16; N-4
- 3132: Preventive Care & Screening: Screening for Clinical Depression and Follow-Up Plan (eMeasure)
  Overall Suitability for Endorsement: Y-23; N-0
- 3148: Preventive Care & Screening: Screening for Clinical Depression and Follow-Up Plan
  Overall Suitability for Endorsement: Y-23; N-0
- 3175: Continuity of Pharmacotherapy for Opioid Use Disorder
  Overall Suitability for Endorsement: Y-12; N-7
- 3205: Medication Continuation Following Inpatient Psychiatric Discharge
  Overall Suitability for Endorsement: Y-20; N-3
- 3185: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention

(eMeasure)
Overall Suitability for Endorsement: Y-24; N-0

- 3225: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
  Overall Suitability for Endorsement: Y-24; N-0

Behavioral Health Measures Not Recommended (See Appendix A for the Committee's votes and rationale)

- 3172: Continuity of Pharmacotherapy for Alcohol Use Disorder
- 3207: Medication Reconciliation on Admission
- 3229: Patient Panel Adult Smoking Prevalence

COMMENTS AND THEIR DISPOSITION

NQF received 52 comments from 13 organizations (including nine member organizations) and individuals pertaining to the general draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Behavioral Health project page under the Public and Member Comment section.

Comment Themes and Committee Responses

Comments about specific measure specifications and rationale were forwarded to the developers, who were invited to respond.

The Standing Committee reviewed all of the submitted comments (general and measure specific) and developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Reconsideration Request – 0108: Follow-Up Care for Children Prescribed ADHD Medication

During the in-person meeting, the Committee did not reach consensus on the subcriterion of evidence, mainly due to the lack of evidence for a follow-up visit within 30 days. Additionally, the Committee did not pass the measure on the subcriterion of validity, largely based on the lack of evidence for the specification of the initiation rate timeframe as well as the inability for providers to engage with patients in ways other than a face-to-face visit for the initial visit.

Committee Response: After reviewing the second round evidence review provided by the developer which showed that children on ADHD medications who received follow up visits within a few weeks to a year had improved clinical outcomes compared to children who did not and learning about their intention to allow videoconferencing and telephone visits to count towards a follow-up visit, the Committee decided to re-vote on this measure. As a result of a post-call voting survey, the Committee voted to recommend the measure for endorsement.

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Measure Specific Comments

0576: Follow-Up After Hospitalization for Mental Illness

Description: This measure received five comments, most of which were in support of the Committee's decision to recommend this measure as well as to emphasize the Committee's concerns and recommendations for this measure. Three of the comments focused on the Committee's recommendation to revise the measure to allow for telehealth to count as a visit towards the seven and 30-day follow-up criteria. Two commenters supported the recent decision by NQF's Measures Application Partnership to remove this measure from the Inpatient Psychiatric Facility Quality Reporting Program pending re-specification for the acute care setting. Two commenters raised concerns around the developers' decision to no longer credit organizations for provider visits conducted on the same day of discharge. They noted that given shortages with behavioral health practitioners, patients should take advantage of when appointments are available, even if they are on the same day as their discharge.

Committee Response: Thank you for your comments. We agree that measure revisions may be warranted in relation to telehealth and the definition of a mental health practitioner. The Committee discussed issues around same-day appointments at length during the in-person meeting and post-comment call. The Committee is concerned that the measure under consideration for endorsement allows for a same-day visit (post discharge) to count as a qualifying follow-up encounter, but that in the field, NCQA recently removed the same-day visit as a qualifying event. We realize that this is a timing issue – the developer is expected to update the specifications as part of its annual update. Ultimately, the Committee decided to maintain its recommendation for endorsement of the measure as it stood in its submission. That is, the Committee recommends endorsement for the measure that allows for a same-day visit to count as a follow-up visit in the initial phase. The Committee will review the removal of the same-day visit as part of the annual update to determine if this change affects the Committee's recommendation for endorsement. The Committee emphasizes that the measure as currently implemented in the field does not align exactly with the specifications of the measure as recommended for endorsement.

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Description: This measure received three comments, all of which expressed concerns with the Committee's decision to recommend the measure. All three commenters agreed that adherence to medication is important, particularly in the psychiatric population where psychotropic medication discontinuation can have a range of adverse effects. However, one commenter agreed that while hospitals should take steps to encourage and help patients obtain and take their medications as directed, assessing whether patients have their prescriptions filled within a certain time period does not necessarily constitute a hospital level measure. Another commenter stated that measuring a patient's access to a medication does nothing to measure whether a patient actually took the medication thus, the measure as it is currently specified measures whether a prescription has been filled, not whether it was taken.

Committee Response: The Committee did consider these issues during our in-person meeting, but concluded that hospitals have a role in properly educating patients on the importance of filling prescriptions. Additionally, hospital may be encouraged to increase the use of outpatient hospital pharmacies. The Committee agrees that the issues raised in these comments do not preclude our recommendation for endorsement. Further, NQF's recent work on attribution models noted that "as teams increasingly deliver care and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control."

NQF MEMBER VOTING RESULTS

The NQF Member Voting period closes on June 19, 2017 at 6:00pm. CSAC will be given an addendum with all voting results on June 20.

REMOVAL OF ENDORSEMENT

One measure previously endorsed by NQF has not been re-submitted and is withdrawn from maintenance of endorsement:

Measure	Measure Description	Reason for Removal of Endorsement
1364: Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	Percentage of patients aged 6 through 17 years with a diagnosis of major depressive disorder with documented evidence that they met the DSM-IV criteria [at least 5 elements with symptom duration of two weeks or longer, including 1) depressed mood (can be irritable mood in children and adolescents) or 2) loss of interest or pleasure] during the visit in which the new diagnosis or recurrent episode was identified	Retired by developer

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Appendix A – Measures Not Recommended for Endorsement

The table below lists the Committee's vote and rationale for measures not recommended for endorsement.

LEGEND: Y = Yes; N = No; H = High; M = Moderate; L = Low; I = Insufficient

Measure	Voting Results	Standing Committee Rationale
3172: Continuity of Pharmacotherapy for Alcohol Use Disorder	**Evidence** H-0; M-7; L-9; I-3 **Gap** N/A **Reliability** N/A **Validity** N/A **Feasibility** N/A **Usability and Use** N/A	The Committee concluded that the evidence for using medication alone for AUD is not strong, and therefore questioned the importance of measuring medication use in isolation from cognitive-behavioral therapies. The measure did not pass the evidence subcriterion and the Committee did not recommend this measure for endorsement.
3207: Medication Reconciliation on Admission	**Evidence** H-1; M-6; L-15; I-1 **Gap** N/A **Reliability** N/A **Validity** N/A **Feasibility** N/A **Usability and Use** N/A	The Committee expressed concern that the evidence was weak for the measure focus, noting that the systematic review cited only six of the 26 studies were rated as good quality, and the review did not distinguish when the reconciliation occurred. The Committee also noted that while national organizations may say medication reconciliation is important, they do not see clear evidence that specifically links each of the components of the measure with enhanced outcomes. The developer stated the measure is consistent with best practices of the Joint Commission, but the Committee noted these are not evidenced based recommendations. The measure did not pass the evidence subcriterion and the Committee did not recommend this measure for endorsement.
3229: Patient Panel	**Evidence**	The Committee noted high reliability in

Adult Smoking Prevalence	H-9; M-10; L-3; I-1 **Gap** H-13; M-9; L-0; I-1 **Reliability** H-3; M-10; L-10; I-0 **Validity** H-1; M-2; L-18; I-2 **Feasibility** N/A **Usability and Use** N/A	testing, but expressed concern for a provider's ability to "game" the measure. The measure excludes all patients who do not have a smoking status recorded; this resulted in 26.5 percent of patients being excluded during testing, which the Committee noted could impact the validity of the results. The Committee had other concerns including attributing failure of a patient to quit smoking to a provider who is actively working with a patient who has relapsed, as well as attributing failure to a provider who is seeing a patient for the first time. The Committee expressed their support for this type of measure, noting it was an important first step in moving towards outcomes; however, they suggested several considerations for the developer including reconfiguring the measure to be based on the percent change in smoking, combining the measure with a screening measure, and ensuring patients are attributed to providers who have seen them continuously. The measure did not pass the validity subcriterion and the Committee did not recommend this measure for endorsement.

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Appendix B – NQF Member Voting Results

NQF MEMBER VOTING RESULTS

The NQF Member Voting period closes on June 19, 2017 at 6:00pm. CSAC will be given an addendum with all voting results on June 20.

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Appendix C – Measure Evaluation Summary Tables

Measures Recommended

0027 Medical Assistance With Smoking and Tobacco Use Cessation

Submission | Specifications

Description: The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation:

Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year.

Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

Discussing Cessation Strategies: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Numerator Statement: Advising Smokers and Tobacco Users to Quit:

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider

Discussing Cessation Medications:

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications

Discussing Cessation Strategies:

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication

Denominator Statement: Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.

Exclusions: None

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Clinician Office/Clinic, Other

Type of Measure: Process

Data Source: Patient Reported Data

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence Exception: **Y-22; N-0**; 1b. Performance Gap: **H-11**; **M-11**; **L-0**; **I-0**

Rationale:

- In the previous submission, the developer provided evidence in the form of guidelines and recommendations from the USPSTF, ICSI, VA/DoD, and the U.S. Public Health Service related to the importance of tobacco-related prevention and treatment. For this submission, the

developer provided an updated guideline from the USPSTF (2015) on behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults (including pregnant women). The Committee agreed these updates were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and vote on evidence.

- The developer provided performance data at the health plan level (commercial, Medicare, Medicaid) for 2014-2016 for each of the three rates reported within this measure.
    - For 'advising smokers to quit,' mean scores in 2016 were 86 percent (Medicare), 75 percent (commercial), and 76 percent (Medicaid).
    - For 'discussing cessation medications,' the mean scores in 2016 were 48 percent (commercial) and 48 percent (Medicaid).
    - For 'discussing cessation strategies,' the mean scores in 2016 were 44 percent (commercial) and 43 percent (Medicaid).
- The developer provided literature about significant disparities in tobacco use among certain populations, but provided limited evidence on the disparities among smoking cessation efforts in these populations.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-5**; **M-15**; **L-2**; **I-0** 2b. Validity: **H-9**; **M-12**; **L-1**; **I-0**

<u>Rationale</u>:

- The Committee noted concerns raised in the last round of endorsement for this measure regarding recall bias. The developer expressed interest in looking into a future measure that triangulates data from prescriptions or claims for counseling, or quit lines in order to determine what services have actually been provided to patients who still smoke.
- The developer provided an updated assessment of measure score reliability using data from all the health plans that submitted HEDIS data to NCQA for this measure and had a valid rate in 2015-2016. Beta-binomial statistics for each rate in the measure were provided by type of health plan. The 2016 statistics for Medicaid and commercial plans ranged from 0.69 to 0.83 (which were similar to improved from the scores provided in the last submission). The beta-binomial statistic for the rate of 'advising smokers to quit' for Medicare was 0.95 in 2010; the testing in Medicare was not updated. These scores indicate sufficient signal strength to discriminate performance between accountable entities.
- In 2011, the developer reported systematic assessment of face validity and basic information about cognitive testing (of data elements) of the CAHPS survey instrument done in 2008. The face validity testing showed that NCQA's Committee on Performance Measurement recommended the measure for public reporting (10 supported, 1 opposed, 1 abstained).
- The Committee discussed concerns around the clarity of the questions in the measure and ensuring that patients are able to differentiate between each of the three questions. The developers explained that all questions undergo testing to help determine whether individuals are accurately interpreting the questions.
- For this submission, the developer provided new construct validity testing. This testing provided Pearson correlations ranging from 0.68 to 0.85. Scores of 0.37 or larger are considered to have a "large" correlation effect, indicating that the measure rates are significantly correlated with each other in the direction that was hypothesized.

- The Committee raised concerns related to behavioral health being a "carve out" for many states, and so behavioral health providers may be left out of this measure, since they would not be required to complete the CAHPS survey. The Committee also suggested having a stratification for behavioral health patients; the developer noted that the data captured in CAHPS could not be stratified in this way, but there could be a requirement for sampling in specific populations.

3. Feasibility: H-13; M-9; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The required data elements for this measure are collected from a patient-reported survey (CAHPS).
- The patient/family reported information may be obtained via electronic or paper sources.

4. Usability and Use: H-10; M-11; L-1; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used in several programs including the Medicaid Adult Core Set and the CMS Quality Rating System (QRS).
- The measure is also used for NCQA's accreditation of commercial, Medicaid, and Medicare Advantage plans. One Committee member noted that 49 states recognize NCQA health plan accreditation.

5. Related and Competing Measures

- This measure is related to several other measures:
  - 0028/3225/3185: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
  - 1654 (TOB-2): Tobacco Use Treatment Provided or Offered
  - 1656 (TOB-3): Tobacco Use Treatment Provided or Offered at Discharge
  - 2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
  - 2803: Tobacco Use and Help with Quitting Among Adolescents
- The Committee had a brief discussion about the portfolio of tobacco-related measures, and found that none of the measures were competing. They noted minor differences in definitions that may be considered for harmonization, but the Committee decided to table the discussion.

Standing Committee Recommendation for Endorsement: **Y-22**; **N-0**

6. Public and Member Comment:

- This measure received three comments. Two comments were in support of its continued endorsement and one provided feedback on expanding this measure for the adolescent population and users of e-cigarettes.
  - Developer response: Thank you very much for this feedback. NCQA's measure is based on the USPSTF recommendations for tobacco use screening and interventions. The USPSTF does not currently have a recommendation for screening or providing interventions to adolescents for tobacco cessation. In addition, the USPSTF found insufficient evidence to recommend electronic nicotine delivery systems for tobacco

	cessation in adults. NCQA will continue to monitor the guidelines and will consider updates to the measure as the evidence changes.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X	
8. Appeals	

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

Submission | Specifications

Description: The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge
- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

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

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

Denominator Statement: Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

Exclusions: Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

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 for non-mental health.

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

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Clinician Office/Clinic, Behavioral Health : Inpatient, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Claims (Only)

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **M-15**; **L-4**; **I-1**; 1b. Performance Gap: **H-8**; **M-12**; **L-0**; **I-0**

Rationale:

- For the previous submission, the developer provided National Institute for Health and Care Excellence (NICE) guidelines on the treatment and management of schizophrenia.
- For this submission, the developer provided several updated clinical guidelines for the care and management of schizophrenia (NICE and American Psychological Association [APA]),

bipolar disorder (APA), and major depressive disorder (APA). The developer stated that these clinical practice guidelines support follow-up after hospitalization. They also stated that evidence shows follow-up care reduces suicide attempts and readmissions and improves functioning.

- The Committee noted the variability in performance among plans, with mean scores for 2016 ranging from 33.8 percent (Medicaid) to 50.3 percent (Commercial) for the 7-day rate and from 52.4 percent (Medicare) to 69.7 percent (Commercial) for the 30-day rate.
- The Committee noted data cited by the developer that show statistically significant differences in the rates for follow-up after hospitalization for a mental disorder among various racial and ethnic groups.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-6**; **M-11**; **L-3**; **I-0**; 2b. Validity: **M-12**; **L-7**; **I-0**

<u>Rationale</u>:

- The Committee questioned the evidence for the 7-day and 30-day follow-up timeframes. The developer responded that these are consensus-based timeframes from their advisory panel. The developer also noted that studies are emerging that show that follow-up within these timeframes are contributing to reduced readmissions. One Committee member said that the 7-day and 30-day follow-up visits have become standard for managed behavioral health organizations.
- One Committee member suggested allowing telehealth visits to count toward follow-up. The developer noted that they are testing this and if approved, they will update the measure.
- One Committee member expressed concern about hospitals setting up same-day visits in their outpatient clinics in order to perform well on the measure. The developer stated they are looking at this issue, and may update the measure.
- Several Committee members expressed concern about limiting follow-up to a mental health practitioner only and suggested broadening the definition. The developer noted that their advisory panel advised this based on the seriousness of the illness (requiring hospitalization), and that they will keep pace with developments in how states define mental health providers (e.g., pediatricians getting more specialized training).
- One Committee member encouraged broadening the measure to include hospitalizations for drug and alcohol disorders.
- Several Committee members talked about potentially testing the measure at the facility (hospital) level in the future. The developer agreed this might help with care coordination.
- For reliability testing, the developer provided a signal-to-noise analysis for the measure score, which resulted in beta-binomial statistics all at 0.95 or above. These results were similar to the results calculated for the 2012 submission.
- For the 2012 submission, the developer stated face validity was assessed via NCQA's standardized process (the "HEDIS measure life cycle").
- The developer provided data on the ability to identify statistically meaningful differences by using 2016 HEDIS data to compare the differences between the 25th and 75th percentiles of performance on a measure.

3. Feasibility: H-6; M-12; L-2; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee noted that data are in electronic sources and no implementation challenges have been reported.
- One Committee member stated a concern for areas in which the behavioral health system is not integrated with the physical health system, noting that it can be a challenge to have those data systems interact in order to sufficiently gather the necessary data.

4. Usability and Use: H-6; M-10; L-3; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used in several CMS programs, including: Medicaid Child Core Set, Hospital Compare, the Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier (VBM), the Physician Feedback/Quality and Resource Use Reports (QRUR), and the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).
- The measure is also used for NCQA's accreditation of commercial, Medicaid, and Medicare plans.

5. Related and Competing Measures

- This measure relates to NQF #1937: Follow-Up After Hospitalization for Schizophrenia (7-day and 30-day). In 2012, the Committee recommended the developer incorporate NQF # 1937 as a subset or target population within NQF # 0576. At this current meeting, the Committee decided to table discussion of any updates.

Standing Committee Recommendation for Endorsement: **Y-16**; **N-4**

Rationale

- The Committee clarified that they were voting on the measure as it stands, and not considering potential updates as previously suggested (e.g., inclusion of telehealth, removal of same-day visit).

6. Public and Member Comment:

- This measure received five comments, most of which were in support of the Committee's decision to recommend this measure as well as to emphasize the Committee's concerns for this measure. Three of the comments focused on the Committee's recommendation to revise the measure to allow for telehealth to count as a visit towards the seven and 30-day follow-up criteria. Two of the comments supported the recent decision by NQF's Measures Application Partnership to remove this measure from the Inpatient Psychiatric Facility Quality Reporting Program pending re-specification for the acute care setting. Comments also raised concerns around the developer's decision to no longer credit organizations for provider visits conducted on the same day of discharge.
    - Developer response: We appreciate the challenge related to shortage of mental health providers. NCQA reviewed the same day visit topic with our Behavioral Health Measurement Advisory Panel which supported removing the same day visit. Our

panel agreed that an encounter on the date of discharge after hospitalization can be viewed as a quality improvement intervention designed to improve a patient's likelihood of receiving timely clinical follow-up care within 7 and 30-days, it should not be the only visit that patients have within a week of discharge, and does not reflect good quality of clinical care on its own; therefore it does not meet the intent of the measure .In addition, HEDIS auditors have also noticed that some organizations count case management or check list services on the same day toward the measure. Some of these services were being performed in locations such as the hospital cafeteria and thus were billed as an outpatient service. It is challenging to discern whether some services were provided before or after discharge. Because of these practical challenges, NCQA decided to remove the same-day visit to ensure the validity and comparability of the measure and to align with the measure intent. Regarding telehealth, we are proposing to add video conferencing to the measure for HEDIS 2018 and if approved by our governing Committee and Board of Directors in June 2017, will update the NQF endorsed version accordingly. o Committee response: The Committee expressed concern that the measure under consideration for endorsement allows for a same-day visit (post discharge) to count as a qualifying follow-up encounter, but that in the field, NCQA recently removed the same-day visit as a qualifying event. The Committee noted that this is a timing issue – the developer would be expected to update the specifications as part of its annual update, and the Committee would revisit the measure at that time. NCQA noted that they submitted the measure for endorsement at the end of 2016, but after that, their advisory panel recommended removing the same-day visit from the HEDIS version of the measure. Ultimately, the Committee decided to maintain its recommendation for endorsement of the measure as it stood in its submission, and will review the measure as part of its annual update to review the removal of the same-day visit. Committee members did encourage NCQA to align the measure in the field.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3132 Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Submission | Specifications

Description: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen **Numerator Statement**: Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen **Denominator Statement**: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period **Exclusions**: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder are excluded.

Patients with any of the following are excepted: patient reason(s), patient refuses to participate, or medical reason(s); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (for example: certain court appointed cases or cases of delirium).

Adjustment/Stratification: N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Health Record (Only)

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence Exception: **Y-23; N-0**; 1b. Performance Gap: **H-13**; **M-10**; **L-0**; **I-0**

<u>Rationale</u>:

- This measure is the new eMeasure version of measure #3148. The information provided for Evidence is identical to that submitted for #3148. Measure #3148 was discussed first and the rating for evidence was automatically assigned to this eMeasure without further discussion.
- The developer provided data on performance rates for EHR data showing a mean performance rate in CY2015 of 68.8 percent.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-9**; **M-13**; **L-1**; **I-0;** 2b. Validity: **M-18**; **L-4**; **I-1**

<u>Rationale</u>:

- The data elements are clearly defined and compliant with industry standards.
- The Committee noted that the measure score was assessed using EHR data from two different practices (one primary care and one pediatrics), and a beta binomial method was used to perform a signal-to-noise analysis. This analysis showed a mean reliability score of 0.984.
- One Committee member expressed a concern about the small sample. The developer cited a short timeframe to prepare for the Committee meeting, and given that participation was voluntary, they could not include more sites in this round of testing.
- The Committee noted that Bonnie testing on 22 test cases confirmed there was a test case for each pathway of logic, and that all the test cases performed as expected.
- The Committee noted that face validity testing with an expert panel showed that nine of 12 clinicians surveyed (75 percent) agreed or strongly agreed that the measure accurately reflects quality of care.

3. Feasibility: H-8; M-14; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee noted that data elements are routinely collected in electronic sources, and the

developer reported that the data elements required are in structured data fields. • One Committee member expressed concern about eMeasures in general, and asked if there was an ability to test whether the events actually occurred. The developer noted they did workflow analysis in their testing and looked for how the follow-up plan is documented in the EHR, which they said works better in some EHR systems than others. • The developer noted concern about identifying follow-up interventions or those in the denominator exceptions, but they concluded that these elements are unlikely to be used frequently enough to compromise feasibility.
4. Usability and Use: H-7; M-16; L-0; I-0 *(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)* Rationale: • The Committee noted the measure is widely used in various CMS programs and that the measure is similar to NQF #3148 and so did not require additional discussion.
5. Related and Competing Measures • This measure relates to NQF #3148: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. NQF #3132 is the eMeasure version of NQF #3148 and has been harmonized to the extent possible, thus the Committee did not discuss harmonization.
Standing Committee Recommendation for Endorsement: **Y-23**; **N-0**
6. Public and Member Comment: • This measure received two comments. Both supported the Committee's decision to recommend this measure but one noted that it should only be applied at the clinician level, not at the health plan level.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Submission | Specifications
Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. **Numerator Statement**: Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen **Denominator Statement**: All patients aged 12 years and older **Exclusions**: Not Eligible – A patient is not eligible if one or more of the following conditions are documented: •Patient refuses to participate •Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

•Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

•Patient has an active diagnosis of Depression

•Patient has a diagnosed Bipolar Disorder

Adjustment/Stratification: N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), Registry

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence, 1b. Performance Gap)

1a. Evidence Exception: **Y-23; N-0**; 1b. Performance Gap: **H-17**; **M-6**; **L-0**; **I-0**

<u>Rationale</u>:

- In the last review, the developer cited several studies and reviews related to screening for depression in both children and adults (USPSTF 2009, ICSI 2011, ICSI 2012).
- The developer provided USPSTF and ICSI guidelines (2016). The Committee agreed these updated guidelines were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and vote on evidence.
- The Committee noted data showing a mean performance rate in CY2015 of 36.5 percent for claims and 28.9 percent for registry (provider). The developer also provided literature indicating lower rates of screening and treatment in minority adults.
- The Committee noted that PQRS data show performance rates have been going down (from 82.6 percent in 2011 to 52.4 percent in 2014). However, the developer noted more providers are reporting on this measure as it is required for ACOs. Committee members agreed this is typical in that measures are often reported initially by high performers, and then performance rates go down as the pool of reporting providers broadens.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-8**; **M-14**; **L-1**; **I-0** 2b. Validity: **M-18**; **L-3**; **I-2**

<u>Rationale</u>:

- In the previous review, the developer provided data on the inter-rater reliability testing of the data elements on a random sample of 275 Medicare claims, resulting in 89.7 percent agreement for the numerator, 100 percent agreement for the denominator, and 66.5 percent agreement for exclusions.
- The Committee noted good results in updated reliability testing – using a signal-to-noise analysis at the score level, the developer reported a mean reliability statistic of 0.99 for both claims and registry.
- Committee members expressed concerns about particular exclusions. One expressed concern about excluding people who refuse screening, noting that people who are depressed might be more inclined to refuse to engage in such activity. Committee members expressed concern

about other exclusions including the emergent nature of a visit, noting that the emergent visit might be the result of a risk-taking behavior related to depression and about excluding individuals with bipolar disorder, because the assumption that they're in treatment may not be true. One Committee member expressed concern about emergency room physicians being evaluated on this measure, but the developer clarified that the evaluation and management codes for emergency medicine are excluded from this measure.

- The developer noted that exclusions do not occur frequently. (For Medicare claims, 3.6 percent of eligible encounters were excluded and for registry data, 4.9 percent of eligible encounters were excluded.) The developer further noted that "active diagnosis of depression" was the most common exclusion.
- One Committee member suggested adding an exclusion for "adjustment disorder with depressed mood" in order to avoid overly aggressive treatment. The developer clarified that the "follow-up plan" does not require being seen by a psychiatrist or psychologist or starting medication, but rather could include referral to pastoral counselor or even just to have a return visit in 2 weeks, as long as it is documented.
- The Committee expressed concern about the frequency of screening, asking if the screening should occur at each visit. The developer noted that the clinician could screen more frequently if there were indications that it was needed.
- The Committee noted that face validity testing showed that nine of 12 clinicians surveyed (75 percent) agreed or strongly agreed that the measure accurately reflects quality of care.

3. Feasibility: H-12; M-9; L-1; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The Committee noted that data elements are routinely collected in electronic sources and there have been no implementation challenges noted. The developer emphasized that for this claims/registry measure, they use HCPCS codes for reporting.
- One Committee member expressed concern with the difficulty of documenting the follow-up plan.

4. Usability and Use: H-3; M-17; L-2; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used in several CMS programs, including: Medicaid Adult Core Set, the Medicare Shared Savings Program (MSSP), the Electronic Health Record Incentive Program, the Physician Value-Based Payment Modifier (VBM), the Physician Feedback/Quality and Resource Use Reports (QRUR), and Physician Compare.
- As noted earlier, the Committee restated the decreasing performance that is likely due to the increased number of individuals reporting on the measure. The developer agreed, noting that the declining numbers as more people are reporting show the true gap and opportunity for improvement.
- The Committee expressed a desire to learn more about impact on outcomes and comparison across plans. The developer noted that they only have access to CMS Medicare claims. The developer further noted that they are using the measure to identify the under-diagnosis of

depression and encourage more screening.

- One Committee member asked about harmonizing this measure with the PHQ-9 depression measure. The developer noted they have discussed this with their expert work group, but that this measure is not prescriptive about which screening tool should be used.

5. Related and Competing Measures

- This measure relates to NQF #3132: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. NQF #3132 is the eMeasure version of NQF #3148 and has been harmonized to the extent possible, thus the Committee did not discuss harmonization.

Standing Committee Recommendation for Endorsement: **Y-23**; **N-0**

6. Public and Member Comment:

- This measure received three comments. One comment notes that it was considered for inclusion in the Core Measure Set, but ultimately rejected, primarily because consumer members desired a more robust, outcome-focused measure. A lack of trends in performance data indicates there may be issues with data collection in actual practice, and we share the concerns regarding exclusions as noted by the committee. In addition, the measure does not clearly define frequency, nor does it indicate if a screen is required at all encounters. For example, screening for depression may not be appropriate in cases where a patient is being seen by a primary care physician for the sole purpose of an acute condition, such as an URI.
    - Developer response: We thank you for your feedback and comment. Although this is a process measure, evidence shows that screening patients for depression and providing appropriate follow up care to patients who screen positive leads to better patient outcomes. In relation to your comment, we offer the following information:

      1.Trends in performance data

      •Analysis of claims and registry data did reveal a decrease in the average performance rate (from 82.6% in 2011 to 52.4% in 2014). However, the pool of total eligible professionals or clinicians reporting this measure to the Physician Quality Reporting System (PQRS) increased substantially from 1,700 to 61,000. Given the sharp increase in the pool of reporting eligible professionals or clinicians, we anticipated instability in performance. These data demonstrate that providers are beginning to report this measure and that there is still significant room for improvement. Therefore, it is difficult to assess trends over time as the eligible professionals or clinicians who recently began voluntarily reporting the measure may have lower performance rates than those who have been reporting it for a longer period of time.

      2.Exclusion criteria

      •Expert work groups review exclusion criteria annually and have accounted for certain situations in which it is appropriate not to screen and follow up with patients for depression, such as when patients are already diagnosed with depression or when patients are in emergent situations. We will review the Committee's comments with the expert work group when it re-convenes.

      3.Frequency of Screening

      •We agree that specifications could provide more specific guidance to define the frequency of screening. Because this measure is patient-based rather than encounter-

based, the measure requires depression screening once per measurement period but not at all encounters. We will consider clarifying the frequency of screening in the specification in a future update.

- The second comment noted that it should only be applied at the clinician level, not at the health plan level.

7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

8. Appeals

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Submission | Specifications

Description: Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

Numerator Statement: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

Denominator Statement: Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

Exclusions: There are no denominator exclusions.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Population : Regional and State

Setting of Care: Clinician Office/Clinic, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Claims (Other), Pharmacy

Measure Steward: RAND Corporation

STANDING COMMITTEE MEETING 03/01/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H: 3; M-10**; **L-0; I-5;** 1b. Performance Gap: **H-5**; **M-11**; **L-1**; **I-1**

Rationale:

- The developer provided guidelines on the management of substance use disorders (VA/DoD 2015). In addition, they cited evidence showing the increased mortality associated with interruption of medication, with highest risks being in the first few weeks after stopping the medication.
- One Committee member noted an article not included in this submission from the *New England Journal of Medicine* in March 2016 on vivitrol.
- The developer also provided evidence on reasoning for choice of 6-month continuation (based on FDA trial lengths) and 7-day gap (drug effectiveness and mortality risk following interruption of medication). The developer noted there is no empirical evidence on the best length of time overall for patients to stay on these medications, and suggests this as a needed area of research.

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- The Committee noted the gaps in performance, with mean performance in 2014-2015 of 27.7 percent, (10th percentile at 16.2 percent and 90th percentile at 40.9 percent).

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-0**; **M-15**; **L-2**; **I-2;** 2b. Validity: **M-14**; **L-2**; **I-3**

<u>Rationale</u>:

- The Committee had extensive discussions about how the measure was specified – in particular, they expressed concern about the measure capturing individuals who are appropriately discontinuing their medication, as the measure cannot tell which patients have been on medication for years. The Committee asked why the measure was not specified to only look at those who had just initiated treatment. The developer acknowledged this could lead to some measurement error, but they expected this to only be a small number. The developer said they made the choice to err on the side of sensitivity over specificity in order to be more generalizable and look at a cross-section of patients, given that the performance gap is so large. The developer also noted that the measure has a rolling 2-year timeframe. The developer also noted that it can be difficult to identify those who have been on medications long term in commercial insurance because individuals can change plans over time.
- One Committee member expressed concern that the measure could encourage providers to keep patients on their medications unnecessarily.
- The Committee also raised issues about the measure not including counseling in conjunction with medication. The developer cited issues with defining counseling, and the ability to capture all types of counseling (e.g., community-based support groups). The Committee suggested in the future the measure might be expanded to set a minimum standard for the occurrence of any type of counseling.
- The Committee asked why the measure had only been tested in the commercial insurance pool. The developer noted timeline constraints to submit the measure for consideration, but stated they intend to do testing in both the Medicare and Medicaid populations.
- The developer provided a signal-to-noise analysis showing reliability rates of 0.977 at the state level and 0.891 at the health plan level.
- The Committee noted the face validity testing of the measure score resulted in eight of 10 experts in agreement that the measure can be used to distinguish good quality from poor quality.
- The Committee had several suggestions for improvements to the measures specifications in the future including:
    - Expansion of the patient pool (e.g., Medicare, Medicaid).

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o Stratification of the data for patients who have just initiated medication and those who have been on medication for a longer time. o Addition of a counseling component.
3. Feasibility: H-8; M-10; L-1; I-0 *(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)* Rationale: • The Committee noted that the data are readily available in electronic form and no issues have been reported in testing.
4. Use and Usability: H-1; M-11; L-5; I-2 *(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)* Rationale: • The Committee strongly recommended that the measure not be used in pay-for-performance programs initially.
5. Related and Competing Measures • This measure relates to NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). NQF #0004 was discussed with the Committee in October 2016, and discussions around harmonization have been deferred until after an update is available. • This measure relates to NQF #1664: SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge, a facility-level measure for the hospital setting. There are minor differences that may be considered for harmonization, but the Committee decided to table discussion.
Standing Committee Recommendation for Endorsement: **Y-12**; **N-7** • The Committee clarified that they were voting on the measure as it stands, and not considering potential updates as previously suggested (e.g., stratification of new users, addition of counseling).
6. Public and Member Comment: • This measure received three comments. One comment supported the endorsement of the measure and two comments raised concerns around the endorsement of the measure at the health plan level and failure to distinguish between dangerous non-therapeutic MAT-discontinuation and appropriate, planned Opioid Substitution Treatment (OST) tapers (e.g., discontinuation of Vivitrol, naltrexone for extended-release injectable suspension). • The developer of this measure also provided additional information and testing data based on Medicaid claims from national databases in response to the Committee's request for this information during the in-person meeting.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X

NATIONAL QUALITY FORUM

Memo

3175 Continuity of Pharmacotherapy for Opioid Use Disorder
8. Appeals

3205 Medication Continuation Following Inpatient Psychiatric Discharge
Submission | Specifications
Description: This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years. **Numerator Statement**: The numerator for this measure includes: 1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge 2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge 3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge **Denominator Statement**: The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder. **Exclusions**: The denominator for this measure excludes discharged patients who: 1. Received Electroconvulsive Therapy (ECT) during the inpatient stay or follow-up period. 2. Received Transcranial Magnetic Stimulation (TMS) during the inpatient stay or follow-up period. 3. Were pregnant during the inpatient stay. 4. Had a secondary diagnosis of delirium. 5. Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia. **Adjustment/Stratification**: N/A **Level of Analysis:** Facility **Setting of Care:** Behavioral Health : Inpatient **Type of Measure**: Process **Data Source**: Claims (Only) **Measure Steward**: Centers for Medicare & Medicaid Services, Contracting Officer's Representative (COR)
STANDING COMMITTEE MEETING 02/28/2017 **1. Importance to Measure and Report: The measure meets the Importance criteria** (1a. Evidence: 1b. Performance Gap, 1c. High Priority) 1a. Evidence: **M-21**; **L-2; I-0;** 1b. Performance Gap: **H-7**; **M-16**; **L-0**; **I-0** Rationale:

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- The developer provided evidence for medication continuation based on treatment guidelines for major depressive disorder (APA 2010, VA/DoD 2016), schizophrenia (APA 2010), and bipolar disorder (APA 2002, VA/DoD 2010).
- The Committee agreed there is evidence that lack of adherence to medication leads to relapse and negative outcomes. They also noted that claims data related to medication adherence are directly correlated to outcomes.
- The Committee noted that the overall distribution of performance score seemed somewhat high with a performance rate of 66.7 percent in the tenth percentile, and a rate of 88.3 percent in the 90th percentile. The developer agreed with a hypothesis that the patient population likely did not have access issues (e.g., all have full prescription drug coverage). The Committee also notes that this measure may not correlate with the lower performance rates of a measure of post-discharge follow-up because that measure only looks at follow-up with a behavioral health provider, while geriatric patients may more typically follow up with a primary care physician.
- The Committee also noted the developer's findings that black patients have significantly worse rates of mediation continuation than the reference group; specific data were not provided.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-6**; **M-17**; **L-0**; **I-0;** 2b. Validity: **H-2**; **M-18**; **L-3**; **I-0**

<u>Rationale</u>:

- The developers performed a signal-to-noise analysis and found that a provider needs to have at least 75 discharges in order to obtain an overall reliability score of at least 0.7 (the minimum acceptable reliability value). The developer noted that 1,200 of about 1,700 of the facilities had at least 75 discharges. They further noted that they use a 2-year measurement period to increase the number of facilities eligible to report.
- One Committee member expressed concern about the number of patients who do not show their prescription cards due to the extremely low cost of generic drugs, and so may not be captured.
- Committee members raised questions related to the fact that the measure only looks at prescriptions being filled, and not if the medication is being taken correctly (or at all). The developer noted that most studies use a proxy for adherence (filling of the prescription), so most of the outcomes data related to adverse events are related to filling of the prescription and not a patient-reported measure of attestation about actually taking the medication.
- The Committee also questioned how the measure would work for individuals who already had a supply of medication at home. The developer said they did an analysis of patients in the

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cohort and found that for the overwhelming majority of patients, their last prescription fill prior to an inpatient hospitalization was for a 30 day supply, so those individuals would still likely be captured. • For validity testing, the developer performed a Spearman's rank correlation showing that the proposed measure correlates as expected with existing endorsed measures. In particular, the developer noted a large correlation effect (0.43) with a measure of follow-up after hospitalization (30-day).
3. Feasibility: H-14; M-9; L-0; I-0 *(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)* Rationale: • The Committee noted that the required data elements are routinely collected, and there have been no reports of implementation challenges.
4. Use and Usability: H-5; M-15; L-3; I-0 *(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)* Rationale: • Several Committee members raised concerns about the hospital being held responsible for patients' filling prescriptions, particularly for hospitals such as public hospitals with transient populations. The developer stated that they see this measure as the first step in continuity of care, and they are not considering the facility responsible for long-term follow up. Other Committee members noted that it may drive hospitals to use outpatient pharmacies and also to ensure they are educating the patients on the importance of taking the medication. • The Committee also recommended the developer to try to expand the measure denominator to include Medicare Advantage and/or other patients.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-20**; **N-3**
6. Public and Member Comment: • This measure received seven comments. Three comments expressed concerns with the Committee's decision to recommend the measure. All three commenters agreed that adherence to medication is important, particularly in the psychiatric population where psychotropic medication discontinuation can have a range of adverse effects. However, one commenter agreed that while hospitals should take steps to encourage and help patients obtain and take their medications as directed, assessing whether patients have their

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prescriptions filled within a certain time period does not necessarily constitute a hospital level measure. Another commenter stated that measuring a patient's access to a medication does nothing to measure whether a patient actually took the medication thus, the measure as it is currently specified measures whether a prescription has been filled, not whether it was taken. o Developer response: We thank you for your comments on the measure. The measure does not require the inpatient treatment team to monitor patients' medication adherence following discharge. There is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge processes, can help to increase medication continuation rates. In response to the question about the Committee summary, inpatient pharmacies do not generally dispense prescriptions for ambulatory use. We envision the measure may promote innovative approaches to coordinating care post discharge. The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs. Interventions to improve medication continuation should be tailored to meet each patient's needs and circumstances. This measure gives facilities the flexibility to determine which interventions are most appropriate for their patient populations. For more information on the measure specifications, supporting literature, and measure results, refer to the measure methodology report at the following link by opening the "Inpatient Psychiatric Facility Medication Continuation Measure" zip file: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/measure-methodology.html o Committee response: The Committee did consider these issues during our in-person meeting, but concluded that hospitals have a role in properly educating patients on the importance of filling prescriptions. Additionally, hospital may be encouraged to increase the use of outpatient hospital pharmacies. The Committee agrees that the issues raised in these comments do not preclude our recommendation for endorsement. Further, NQF's recent work on attribution models noted that "as teams increasingly deliver care and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control."
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3185 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Submission | Specifications

NATIONAL QUALITY FORUM

Memo

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user

Numerator Statement: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Denominator Statement: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Adjustment/Stratification: N/A

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Setting of Care: Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Electronic Health Record (Only)

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence, 1b. Performance Gap)

1a. Evidence Exception: **Y-24; N-0**; 1b. Performance Gap: **H-8**; **M-16**; **L-0**; **I-0**

Rationale:

- This measure is the new eMeasure version of NQF #3225. The information provided for Evidence is identical to that submitted for #3225. Measure 3225 was discussed first and the rating for evidence was automatically assigned to this eMeasure without further discussion.
- The developer provided data showing the average PQRS EHR performance rate for 2015 as 76.38 percent, with a range of 27.84 percent (1st decile) to 100 percent (10th decile)
- As for Measure 3225, the developer cited literature showing that rates of tobacco screening and intervention varied by patients' race, age, and insurance status.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-5**; **M-19**; **L-0**; **I-0** 2b. Validity: **M-19**; **L-5**; **I-0**

Rationale:

- The data elements are clearly defined and compliant with industry standards.
- One Committee member suggested that dental offices be included as a setting of care.
- One Committee member suggested making the denominator less restrictive by removing the requirement for "at least two visits," noting that the patients who are seen less frequently may be in more need of assistance.
- A Committee member also suggested changing the measure so that the provider must report separate rates for screening and treatment, with the stipulation that the provider is required to report on both rates. The developer noted they have modeled this and CMS is reviewing this possibility.
- The Committee again discussed the exclusion for "medical reasons" (as was discussed in an earlier discussion of Measure #3225), with the developer again noting this is a rare occurrence (0.4 percent). The Committee discussed the need for caution in creating a situation in which the measure can be "gamed," especially as more individuals report on the measure.

- The developer reported that the reliability of the measure score was assessed using 2015 data reported via the EHR option to the PQRS program. A beta binomial method was used to perform a signal-to-noise analysis. This analysis showed a reliability statistic of 0.81 at the minimum number of events and a statistic of 0.99 at the average number of events.
- The developer reported that Bonnie testing on 40 test cases confirmed there was a test case for each pathway of logic, and that all the test cases performed as expected.
- The developer reported that face validity testing with an expert panel showed that six of 10 clinicians surveyed (60 percent) agreed or strongly agreed that the measure can accurately distinguish good and poor quality.

3. Feasibility: H-7; M-17; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

Rationale:

- The data can be obtained through EHRs.
- The Committee noted that the feasibility assessment showed that only 17 of the 26 elements were currently feasible. The developer explained that some providers cannot use certain codes (e.g., an internal medicine provider may not be able to use behavioral health codes). In addition, some EHRs cannot capture some of the exclusions in structured fields, and the developer noted that most providers will use free text for documentation.

4. Usability and Use: H-10; M-14; L-0; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- This measure is currently used in several CMS programs, including: Medicare Shared Savings Program (MSSP); Physician Value-Based Payment Modifier (VBM) and Physician Feedback/Quality and Resource Use Reports (QRUR).
- The Committee stressed the importance and need for screening and intervention in mental health and substance use disorder populations.

5. Related and Competing Measures

- No competing measures noted.
- Related Measures include:
  - 0027: Medical Assistance With Smoking and Tobacco Use Cessation
  - 1651: TOB-1 - Tobacco Use Screening
  - 1654: TOB-2 - Tobacco Use Treatment Provided or Offered
  - 1656: TOB-3- Tobacco Use Treatment Provided or Offered at Discharge
  - 2600 : Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
  - 2803 : Tobacco Use and Help with Quitting Among Adolescents
  - 3225: Tobacco Use: Screening and Cessation Intervention
- The Committee had a brief discussion about the portfolio of tobacco-related measures, and found that none of the measures were competing. They noted minor differences in definitions that may be considered for harmonization, but the Committee decided to table the discussion.

NATIONAL QUALITY FORUM

Memo

Standing Committee Recommendation for Endorsement: **Y-24**; **N-0**
6. Public and Member Comment: • This measure received three comments supporting endorsement of the measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3225 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Submission | Specifications
Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user **Numerator Statement**: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user **Denominator Statement**: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period **Exclusions**: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason) **Adjustment/Stratification**: N/A **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual **Setting of Care:** Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient **Type of Measure**: Process **Data Source**: Claims (Only), Claims (Other), Registry **Measure Steward**: PCPI Foundation
STANDING COMMITTEE MEETING 02/28/2017 **1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>** (1a. Evidence, 1b. Performance Gap) 1a. Evidence Exception: **Y-24; N-0**; 1b. Performance Gap: **H-6**; **M-14**; **L-2**; **I-1** <u>Rationale</u>: • In 2012, the developer provided guidelines from the U.S. Public Health Service and the USPSTF that recommend clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. • For this submission, the developer provided updated statements from the USPSTF (2015), noting high quality, quantity, and consistency of the evidence base. • The Committee agreed the updates in the evidence were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and vote on evidence. • The developer reported an average performance rate in 2014 of 88.9 percent, with 21.7 percent of eligible professionals reporting on the measure. For claims, the fourth through tenth percentiles were all performing at 100 percent. For the registry, the eighth through tenth percentiles were performing at 100 percent. • The Committee discussed the high rates of performance. Some Committee members noted that high performers may be choosing this measure to report on and the developer stated that the literature suggests the performance is likely lower in the broader provider population.

- The developer cited literature showing that rates of tobacco screening and intervention varied by patients' race, age, and insurance status.
- Committee members noted a desire to see gaps specifically for patients with mental health and substance use disorders.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **H-11**; **M-12**; **L-0**; **I-0** 2b. Validity: **M-20**; **L-2**; **I-1**

<u>Rationale</u>:

- One Committee member questioned the 24-month period for screening and intervention. The developer explained that the interval was based on feedback from expert workgroups; they noted that screening and intervention can certainly be done more often than this interval – the measure only works to ensure it is done at least once in this time period.
- Other Committee members raised issues about how the offer for cessation interventions is documented, and the developer confirmed that this often relies on attestation from the provider. Committee members noted that there may be challenges in documenting interventions that are captured in other places (e.g., workplace wellness programs).
- One Committee member questioned exclusions for "medical reasons" (e.g., limited life). The developer said this was suggested as appropriate by expert workgroups and also deemed appropriate by palliative care groups. They noted that these types of exclusions occur infrequently.
- Several Committee members discussed the need to expand this measure (and other tobacco measures) to include other forms of nicotine delivery (e.g., electronic cigarettes). They also recognized that this would add to the burden of documentation and data collection.
- The Committee also suggested expanding this measure to cover adolescents, and also discussed the possibility of linking this measure to actual decreases in rates of tobacco use. Another suggestion was to develop a stratification for the rates for patients with mental health and substance use disorders.
- The developer reported that the reliability of the measure score was re-assessed for this submission using a beta-binomial method to perform a signal-to-noise analysis. The developer used two testing samples – one using 2015 data reported via the registry option to the PQRS program and one using the claims option. For the registry option, this analysis showed a reliability statistic of 0.78 at the minimum number of events and a statistic of 0.99 at the average number of events. For the claims option, this analysis showed a reliability statistic of 0.71 at the minimum number of events and a statistic of 0.97 at the average number of events.
- The developer provided updated face validity testing which showed that six of ten clinicians (60 percent) surveyed agreed or strongly agreed that the measure can accurately distinguish good and poor quality. During the meeting, the developer noted that since the submission, they had received more feedback from their experts (for a total of 29 responses), resulting in an increase of the validity testing score to 76 percent.

3. Feasibility: H-12; M-11; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c.Susceptibility to inaccuracies/ unintended consequences identified 3d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Committee agreed that the measure is feasible to implement, as the data can be obtained through claims registry and/or patient records.

4. Usability and Use: H-12; M-10; L-2; I-0

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

Rationale:

- The measure is currently used in several CMS programs including Physician Quality Reporting System (PQRS), Physician Compare, and the Medicare Shared Savings Program (MSSP).

5. Related and Competing Measures

- This measure is related to several other measures:
  - 0027: Medical Assistance With Smoking and Tobacco Use Cessation
  - 1651: TOB-1 - Tobacco Use Screening
  - 1654: TOB-2 - Tobacco Use Treatment Provided or Offered
  - 1656: TOB-3- Tobacco Use Treatment Provided or Offered at Discharge
  - 2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
  - 2803: Tobacco Use and Help with Quitting Among Adolescents
  - 3185: Tobacco Use: Screening and Cessation Intervention (eMeasure)
- The Committee had a brief discussion about the portfolio of tobacco-related measures, and found that none of the measures were competing. They noted minor differences in definitions that may be considered for harmonization, but the Committee decided to table further discussions.

Standing Committee Recommendation for Endorsement: **Y-24**; **N-0**

6. Public and Member Comment:

- This measure received four comments mostly in support of the Committee's decision to endorse the measure. Two comments provided feedback on expanding this measure for the adolescent population and users of e-cigarettes.
  - Developer response: Thank you for your comment. The PCPI's measure development is a rigorous, evidence-based and multi-disciplinary process that has been refined and standardized over the past seventeen years of activity. Ensuring that performance measures are evidence-based and relevant to clinical practice remains integral to the process, with an emphasis on measures that reflect the most rigorous clinical evidence, particularly as included in clinical practice guidelines, and address areas most in need of improvement. In 2015, the USPSTF published an update to its 2009 recommendation on counseling and interventions to prevent tobacco use and tobacco-related disease in adults, including pregnant women. The USPSTF reviewed the current evidence for electronic nicotine delivery systems (ENDS) and concluded that it is insufficient to recommend ENDS for tobacco cessation in adults, including pregnant women. Additionally, ENDS are not currently classified as tobacco in the recent evidence review to support the update of the USPSTF recommendation given that the devices do not burn or use tobacco leaves. In light of the current lack of recommendations included in clinical practice guidelines, most notably the USPSTF, regarding ENDS, the measure does not currently capture e-cigarette usage as either

	tobacco use or a cessation aid and we feel that further evidence is required before we can include ENDS in the measure. The PCPI conducts an annual maintenance review of this and all measures that we steward during which clinical evidence and implementation feedback are reviewed with a Technical Expert Panel. Any new or emerging guideline recommendations regarding ENDS will most certainly be a focal point for upcoming and future reviews and subsequent modifications considered with the input of the TEP. Additionally, as it relates to expanding the measure to include adolescents, the PCPI recognizes that a current NQF endorsed measure, NQF #2803, is focused on assessing clinical level performance on tobacco cessation counseling among adolescents. We have traditionally included the identification of existing performance measures as an essential element in our measure development and maintenance process. These measures are reviewed to determine topic relevance, avoid duplicative efforts and achieve harmonization. With that said, we do see value in parsimony and recognize the seeming arbitrary limitation of the measure by excluding the adolescent population. We plan to review the issue with the aforementioned TEP and will determine if expanding the measure's patient population is appropriate.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X	
8. Appeals	

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)

Submission | Specifications

Description: Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

Numerator Statement: Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

Denominator Statement: Children 6-12 years of age newly prescribed ADHD medication.

Exclusions: Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

NATIONAL QUALITY FORUM

Memo

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)

1a. Evidence: **H-1**; **M-8**; **L-7; I-4;** 1b. Performance Gap: **H-6**; **M-9**; **L-2**; **I-1**
UPDATED Votes 1a. Evidence: H-3; M-11; L-4; I-3; 1b. Performance Gap: H-6; M-11; L-3; I-1
Rationale:

- In 2014, the developer cited AAP clinical practice guidelines and AACAP practice parameters for the treatment of ADHD in children and adolescents. For this current submission, the developer stated "Numerous (>100) studies related to the care for patients with ADHD have been published since the publication of this guideline, none of which contradict the need for appropriate follow-up once treatment with medication begins."
- One Committee member noted that while the initial 30-day timeframe is supported by AAP guidelines, there is no literature to support that timeframe and that the AAP acknowledges it is based on an agreement among individuals that the timeframe is appropriate. The Committee member further noted a 2017 study of this measure which showed that the poor performers (for the 30-day rate) actually had lower use of EDs and lower hospitalizations, because compliant parents (who came in for follow-up) were willing to bring them in to the ED more often. Additionally, the Committee member stated the study showed that expanding the timeframe resulted in a 20 percent increase in compliance.
- One Committee member emphasized that the focus of the measure is largely supported by clinical practice guidelines and not strong evidence. They also noted that the AACAP guidelines do not suggest a specific timeframe for follow-up.
- One Committee member asked about studies on how consumers felt about having to come back in (related to burden).
- One Committee member asked about the extensiveness of the literature review since the field has been changing. The developer said their review did not rise to the level of a systematic review, but instead was a review for any evidence saying the measure was outdated, no longer effective, or causing harm.
- One Committee member raised concern about an overestimation of adherence, because many children do not get to the maintenance phase.
- Committee members also noted that the use of ADHD medications has gone up exponentially, so follow-up is very important conceptually.
- The Committee did not reach consensus on the evidence subcriterion.
- The Committee noted that the 10th percentile of performers has a performance rate of 29 percent for both Medicaid and Commercial plans, and the 90th percentile has a 50 percent performance rate for Commercial plans and 56 percent for Medicaid, representing a big gap in performance.
- Committee members also noted very little change in performance over the years.
- The developer conducted a second-round evidence review and cited additional studies showing that children on ADHD medications who received follow-up visits within a few weeks

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
to a year had improved clinical outcomes as compared to children who did not have follow-up visits. • The Committee discussed their continued concerns for the specification for a 30-day follow-up visit, including whether another similar timeframe might be just as reasonable. NCQA noted that they went back to the American Academy of Pediatrics (AAP), and AAP has maintained their support of this timeframe as it is based on the consensus of a panel. • During the post-comment call, the Committee discussed the new information submitted. Voting was conducted on a post-call voting survey, and the Committee voted to recommend the measure.
2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-7**; **M-8**; **L-5**; **I-0;** 2b. Validity: **H-2**; **M-5**; **L-11**; **I-2** **UPDATED Votes 2a. Reliability: H-5; M-11; L-4; I-1; 2b. Validity: H-0; M-13; L-4; I-4** <u>Rationale</u>: • The developer provided an update of reliability testing of the measure score using a signal-to-noise analysis. The initiation phase demonstrated beta-binomial statistics of 0.90 (Commercial) and 0.98 (Medicaid) for the initiation phase, and statistics of 0.75 (Commercial) and 0.95 (Medicaid) for the continuation phase. • Validity testing included face validity testing with panels of experts. One Committee member raised concern about the low number of providers on the panel who were physicians or prescribers of medication, as well as the lack of a pediatrician on the initial panel. • One Committee member raised concern about the construct validity testing, stating that they did not agree that contact with a primary care provider was a comparable measure. • In a continuation of earlier discussions about the timeframe for follow-up, the Committee expressed significant concern about the requirement for a face-to-face encounter for the first visit. The Committee noted that providers are being encouraged to use alternative ways to engage with patients (e.g., telehealth, including video conferencing, apps, and other modalities), especially as a way to save costs for patients with high-deductible plans. The developer responded that they are evaluating the use of telehealth in general across all of their measures, and that there is a recommendation currently out for comment to use video-conferencing in this particular measure. The developer also noted that telehealth is acceptable for one of the other two visits. • The Committee voted to pass the measure on the validity subcriterion.
3. Feasibility: H-8; M-12; L-0; I-0 *(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented*

NATIONAL QUALITY FORUM

Memo

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
(eMeasure feasibility assessment of data elements and logic)
4. Use and Usability: H-6; M-9; L-5; I-1 *(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)*
5. Related and Competing Measures: N/A
Standing Committee Recommendation for Endorsement: Y-13; N-8
6. Public and Member Comment: • This measure received one comment from the developer requesting that the Committee reconsider the validity criteria based on the new information that they provided. Based on the Committee's recommendation, NCQA conducted a second-round evidence review and cited additional randomized control studies showing that children on ADHD medications who received follow up visits (providing medication management and monitoring services) within a few weeks to a year had improved clinical outcomes compared to children who did not have follow-up visits. Due to this additional information, the Committee decided to revote on this measure. • During the post-comment call, the Committee discussed the new information submitted. During voting conducted on a post-call voting survey, the Committee voted to recommend the measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

Measures Not Recommended

3172 Continuity of Pharmacotherapy for Alcohol Use Disorder
Submission
Description: Percentage of adults 18-64 years of age with pharmacotherapy for alcohol use disorder (AUD) who have at least 180 days of treatment and a Proportion of Days Covered (PDC) of at least 0.8 **Numerator Statement**: Individuals in the denominator who have at least 180 days of treatment and a PDC of at least 0.8 for AUD medications **Denominator Statement**: Individuals 18-64 years of age who had a diagnosis of AUD and at least one claim for an AUD medication **Exclusions**: There are no denominator exclusions. **Adjustment/Stratification**: N/A **Level of Analysis:** Health Plan, Population : Regional and State **Setting of Care:** Clinician Office/Clinic, Behavioral Health : Outpatient **Type of Measure**: Process **Data Source**: Claims (Other), Pharmacy **Measure Steward**: RAND Corporation

NATIONAL QUALITY FORUM

Memo

3172 Continuity of Pharmacotherapy for Alcohol Use Disorder

STANDING COMMITTEE MEETING 03/01/2017

1. Importance to Measure and Report: Did not meet the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-0**; **M-7**; **L-9; I-3;** 1b. Performance Gap: **N/A**

Rationale:

- The developer provided recommendations from the VA/DoD 2015 guideline on the management of substance use disorders regarding specific medications to offer for AUD.
- The Committee expressed concern about the evidence for the 180-day timeframe for continuation of medication. The developer noted the timeframe was based on FDA trial lengths.
- The Committee regarded the evidence on the individual medications to be of varied strength and quality, stating that some of the individual medications had little evidence to support the timeframe of the measure or even the efficacy of the medication itself. Committee members stated that often guidelines will suggest the use of medications for when everything else has failed.
- The Committee expressed concern that the medications are used to reduce the number of days of alcohol use, but do not necessarily help patients to stop using alcohol altogether. The Committee also noted that while the medications may lead to decreased alcohol use, relapses are not specifically associated with discontinuation of the medication.
- The Committee expressed concern that some of the medications are not approved by the FDA for alcohol use disorder. The developer stated that guidelines often support the off-label use of older medications, and that there will likely not be studies that would be required to go through the FDA process to get such approvals. The Committee also noted that some of the medications have other uses (e.g., gabapentin for neuropathy), and so patients using these medications for other reasons who appropriately stop taking those medications would be captured in this measure.
- The Committee also expressed concern that the evidence for using medication alone for alcohol use disorder is not strong (as it is for opioid use disorder). The Committee noted that cognitive-behavioral therapies can be equally effective, and they questioned the importance to measure medication use in isolation for alcohol use disorder. The developer noted that this measure does not question the choice to go on medication or not, but to say that if someone is prescribed a medication, there should be an effort to try to ensure adherence.

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A** 2b. Validity: **N/A**

3. Feasibility: N/A

NATIONAL QUALITY FORUM

Memo

3172 Continuity of Pharmacotherapy for Alcohol Use Disorder
(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)
4. Use and Usability: N/A *(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)*
5. Related and Competing Measures: N/A
Standing Committee Recommendation for Endorsement: **N/A**
6. Public and Member Comment: • No comments were received on this measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3207 Medication Reconciliation on Admission

Submission
Description: The average completeness of the medication reconciliation process within 48 hours of admission to an inpatient facility. **Numerator Statement**: This measure does not have a traditional numerator. The numerator is a facility-level score of the completeness of the medication reconciliation process within 48 hours of admission. This score is calculated by averaging the scores of the three components of the medication reconciliation process. The components include: 1) Comprehensive prior to admission (PTA) medication information gathering and documentation 2) Completeness of critical PTA medication information 3) Reconciliation action for each PTA medication **Denominator Statement**: The denominator for the composite measure includes admissions to an inpatient facility from home or a non-acute setting with a length of stay greater than or equal to 48 hours. **Exclusions**: This measure does not have any denominator exclusions. **Adjustment/Stratification**: N/A **Level of Analysis:** Facility **Setting of Care:** Behavioral Health : Inpatient **Type of Measure**: Composite **Data Source**: Other, Paper Records **Measure Steward**: Centers for Medicare & Medicaid Services, Contracting Officer's Representative (COR)
STANDING COMMITTEE MEETING 02/28/2017 **1. Importance to Measure and Report: Did not meet the Importance criteria** (1a. Evidence: 1b. Performance Gap, 1c. High Priority)

NATIONAL QUALITY FORUM

Memo

1a. Evidence: **H-1**; **M-6**; **L-15; I-1;** 1b. Performance Gap: **N/A**

Rationale:

- The developer provided evidence in the form of a 2012 systematic review of hospital-based medication reconciliation practices and individual related studies new since the systematic review. The developer also noted The Joint Commission National Patient Safety Goals for hospitals which includes a goal to "maintain and communicate accurate patient medical information." This goal specifically includes aspects related to medication information.
- The Committee expressed concern that the evidence was weak for this measure focus, noting that in the 2012 systematic review, only 6 of the 26 studies were rated as good quality. Further, the review did not discriminate whether the reconciliation occurred at admission, transfer between units, or at discharge. The developer stated that studying medication errors and measuring preventable adverse drug events can be challenging.
- The Committee also noted that while national organizations may say medication reconciliation is important, they do not see clear evidence that specifically links each of the components of the measure with enhanced outcomes. The developer stated the measure is consistent with The Joint Commission's National Patient Safety Goals, but the Committee noted these are not evidenced based recommendations. Further, Committee members noted that studies of the medication reconciliation process are usually conducted in acute care facilities, and not in inpatient psychiatric facilities.
- Committee members recommended providing more evidence about how each of the components will lead to improvements

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **N/A**. Validity: **N/A**

3. Feasibility: N/A

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

4. Use and Usability: N/A

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

5. Related and Competing Measures: N/A

Standing Committee Recommendation for Endorsement: **N/A**

6. Public and Member Comment:

- This measure received four comments, all of which agreed with the Committee's decision not to recommend the measure. Two commenters agreed that it is important to know a patient's medication history however; they argue that the structure and complexity of the measure make it unacceptably burdensome. Another commenter shared the Committee's concerns that the evidence for the measure focus was weak and that adequate links were not demonstrated between the three components of the proposed measure and improved outcomes. The developer for this measure provided a memo for the Committee's consideration that includes background on the measure, the feedback that was received during the in-person meeting, and their responses to that feedback.

o Developer response: Thank you for your comments on the measure. We plan to incorporate feedback from the NQF Behavioral Health Standing Committee, the Technical Expert Panel, and other key stakeholders who have provided public comments when we re-specify the measure. To address the concerns related to the complexity of the measure calculation, burden, and evidence for each component, we will restructure the measure to have a single score rather than a composite score and reduce the number of data elements to align with existing measures that evaluate the medication reconciliation process in other settings.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals

3229 Patient Panel Adult Smoking Prevalence

Submission

Description: Percentage of adults (age 18 years or older) who are tobacco smokers at time of most recent encounter during the measurement period.

Numerator Statement: Patients age 18 years and older who had a qualifying encounter with a provider during the measurement period AND were indicated as smokers as of the most recent qualifying encounter during the measurement period.

Denominator Statement: Patients age 18 years and older who had a qualifying encounter with a provider during the measurement period AND were screened for smoking within 24 months prior to the measurement period end date AND screening occurred during or prior to the patient's mo

Exclusions: Patients were excluded if they were <18 years old. Additionally, they were excluded from being screened for smoking status if they had limited life expectancy, had a medical reason, or had smoking status missing (details in exclusion analysis Section 2b3).

Adjustment/Stratification: N/A

Level of Analysis: Clinician : Individual

Setting of Care: Clinician Office/Clinic, Other, Behavioral Health : Outpatient

Type of Measure: Outcome

Data Source: Electronic Health Record (Only)

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-9**; **M-10**; **L-3; I-1;** 1b. Performance Gap: **H-13**; **M-9**; **L-0**; **I-1**

Rationale:

- The Committee recognized the measure focus has a strong evidence base in the form of clinical practice guidelines, USPSTF recommendations, and a systematic review showing the overall evidence to be of high quality, quantity, and consistency. The Committee also found evidence that there are interventions that can impact the desired outcome (e.g., association between advice to quit and smokers actually quitting).

NATIONAL QUALITY FORUM

Memo

3229 Patient Panel Adult Smoking Prevalence

- The Committee noted variation in provider-level prevalence rates, ranging from 0.0 percent to 69.2 percent, and a mean prevalence of 13.2 percent. (Lower values are better in that they reflect a lower prevalence of smoking.)

2. Scientific Acceptability of Measure Properties: Did not meet the Scientific Acceptability criteria
(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)
2a. Reliability: **H-3**; **M-10**; **L-10**; **I-0;** 2b. Validity: **H-1**; **M-2**; **L-18**; **I-2**
Rationale:

- The developer demonstrated high reliability in testing (average reliability 0.899) when tested among providers who reported smoking status for at least 10 patients and at least 50 percent of all their patients.
- The Committee was concerned about the potential for providers to "game" the system; the measure excludes all patients who do not have a smoking status recorded. The Committee noted that providers might score well on the measure by not reporting smoking status for their smokers. The Committee further noted that 26.5 percent of patients were excluded in testing due to missing smoking status, and expressed concern for how this affected the validity of the measure, since the missing data could skew the results. The developers noted that this would cause the provider to score poorly on other measures related to screening, and the Committee suggested the measures might be combined to avoid such "gaming."
- The Committee also expressed concern that providers would be punished for their patients relapses in spite of their efforts to encourage their patients to quit. They also raised issues about a patient's smoking status being attributed to the most recent physician, even though the patient may have recently changed physicians.
- Several Committee members suggested the measure be reconfigured as a measure of percent change in smoking status, and the developer agreed this could be a direction to go in the future.
- The Committee expressed their support for this type of measure, noting it was an important first step toward a population-based outcome measure for smoking, but that more work was needed on the specifications to ensure validity.

3. Feasibility: N/A
(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

4. Use and Usability: N/A
(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

NATIONAL QUALITY FORUM

Memo

3229 Patient Panel Adult Smoking Prevalence
5. Related and Competing Measures: N/A
Standing Committee Recommendation for Endorsement: **N/A**
6. Public and Member Comment: • One comment was received on this measure in support of the Committee's decision not to recommend the measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X
8. Appeals