TO: Consensus Standards Approval Committee (CSAC)

FR: Sarah Sampsel and Poonam Bal

RE: Behavioral Health Phase 3 Member Voting Results

DA: February 10, 2015

The CSAC will review recommendations from the Behavioral Health Phase 3 project at its February 10, 2015 conference call.

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

Voting for Behavioral Health Phase 3 measures closes at 6pm on February 6th. Voting results will follow this memo as an addendum when available.

Accompanying this memo are the following documents:

1. **Behavioral Health Phase 3 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 58 comments received and the NQF/Standing Committee responses.

CSAC ACTION REQUIRED
Pursuant to the CDP, the CSAC may consider approval of 17 candidate consensus standards.

Behavioral Health Phase 3 Measures Recommended for Endorsement:

- 0710 Depression Remission at Twelve Months
- 0711 Depression Remission at Six Months
- 0712 Depression Utilization of the PHQ-9 Tool
- 1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
- 0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- 2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
- 2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- 2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
- 2602 Controlling High Blood Pressure for People with Serious Mental Illness
- 2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
- 2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
- 2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

- 2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
- 2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
- 2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
- 2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

Behavioral Health Phase 3 Approved for Trial Use

- 2597 Substance Use Screening and Intervention Composite

Behavioral Health Phase 3 Measures Not Recommended

- 0722 Pediatric Symptom Checklist (PSC)

BACKGROUND

In the United States, it is estimated that approximately 26.4 percent of the population suffers from a diagnosable mental disorder. These disorders – which can include serious mental illnesses, substance use disorders, and depression – are associated with poor health outcomes, increased costs, and premature death. Although general behavioral health disorders are widespread, the burden of serious mental illness is concentrated in about six percent of the population. In addition, many people suffer from more than one mental disorder at any given time; nearly half of those suffering from one mental illness meet the criteria for at least two more. By 2020, behavioral health disorders are expected to surpass all physical diseases as the leading cause of disability worldwide.

In 2012, NQF endorsed 10 behavioral health measures in the areas of tobacco and alcohol use, medication adherence, diabetes health screening and assessment, and hospitalization follow-up. A subsequent phase of work recommended 20 measures for endorsement in the areas of: tobacco and alcohol use, depression screening, medication adherence, and hospital-based inpatient psychiatric services. These recommendations were put forth for public comment in September, 2013; the project was completed by March of 2014. In this current and third phase of the behavioral health work, the 24 Standing Committee members recommended 16 out of 18 measures for endorsement, deferred 1 measure and approved 1 measure for trial use. The comment period for these measures was open from November 10, 2014 to December 12, 2014.

DRAFT REPORT

The Behavioral Health Phase 3 Draft Report presents the results of the evaluation of 18 measures considered under the CDP. 16 are recommended for endorsement as voluntary consensus standards suitable for accountability and quality improvement, one was approved for trial use and one was not recommended. The measures were evaluated against the 2013 version of the measure evaluation criteria.

	MAINTENANCE	NEW	TOTAL
Measures considered	6	13	19
Withdrawn from consideration	0	1	1

Recommended	5	11	16
Measures Approved for Trial	0	1	1
Not recommended	1	0	1
Reasons not Recommended	Importance- 0 Scientific Acceptability- 1 Overall- 0 Competing Measure- 0	Importance- 0 Scientific Acceptability- 0 Overall- 0 Competing Measure- 0	

COMMENTS AND THEIR DISPOSITION

NQF received 58 comments from 12 organizations (including two 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 measure specifications were forwarded to the developers, who were invited to respond.

At its review of all comments, the Standing Committee had the benefit of developer responses. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Theme 1 **-** Stratifying Subpopulations in Current Diabetes Measures

Two commenters expressed concerns that the subpopulation of patients with Serious Mental Illness (SMI) is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the Committee to recommend that the subpopulation measures be stratified into the current measures before endorsement.

Committee Response: During their deliberations, the Committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.

Theme 2 **-** Reconsider 0722: Pediatric Symptom Checklist (PSC)

One commenter encouraged the committee to allow the measure developer to refine and resubmit this measure. NQF staff asked the Committee of their interest in reconsidering their previous recommendation based on conversations with the measure developer about intent to resubmit. The developer acknowledges the need for significant revisions and would like to work with NQF staff for

technical assistance. The developer was unable to provide a timeline for resubmission. The Committee was advised of the outcomes of their decision: If the measure is not recommended, the measure will lose endorsement and will not be re-evaluated until another Behavioral Health or related project is slated to begin. If the measure is deferred, the developer will be able to retain endorsement until a new project is slated to start. The measure previously received endorsement in 2013.

Committee Response: The Committee stands by their decision to not recommend this measure and encourages the developer to resubmit when suggested changes have been made.

REMOVE ENDORSEMENT OF MEASURES

17 measures previously endorsed by NQF have not been re-submitted, were withdrawn from maintenance of endorsement, or not recommended for continued endorsement. The measures list can be found in Appendix B.

Appendix A-Measure Evaluation Summary Tables

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

0710 Depression Remission at Twelve Months
Submission
Description: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator. Numerator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five. Denominator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine. Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded. Adjustment/Stratification: Level of Analysis: Facility, Clinician : Group/Practice Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient Type of Measure: PRO Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Measure Steward: MN Community Measurement
STANDING COMMITTEE MEETING - October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: Y-22; N-0; 1b. Performance Gap: H-23; M-0; L-0; I-0; 1c. Impact: H-22; M-1; L-0; I-0 Rationale: • The Committee noted this measure is nearly identical to measure #0711; the only difference is that the measures are examining the same patient at two different points in time (six months and twelve months). • The Committee also noted that performance on the measure has not changed much over time. The developer acknowledged it has been difficult to see movement in the overall statewide average in Minnesota, which is currently at 6.9 percent, with higher performing clinics at the 20 percent mark. • The Committee agreed that depression is an important area to measure. One member expressed that this might be the only true population-based outcome measure for mental health and substance use disorder which is used widely and publically reported. • Some members questioned the necessity of two separate measures, wondering if it is enough to just measure progress at six months, particularly given the fact that the data didn't show much movement from measuring at six months to twelve. Other Committee members maintained the state of the evidence able to answer whether twelve months is also needed, noting that there are indications that a patient with severe depression might have to go through a number of drugs and treatment and wouldn't necessarily be remitted within six months.

0710 Depression Remission at Twelve Months

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-21; M-1; L-0; I-0 2b. Validity: H-19; M-3; L-0; I-0

Rationale:

- Committee members questioned the timing around monitoring patients within the measure. The developer clarified that both a diagnosis and an elevated PHQ-9 score is needed to start the clock ticking on these measures.
- A member noted this measure could be skewed towards the more severe patients since a diagnosis could theoretically occur months after the initial PHQ-9 screening tool.

3. Feasibility: H-16; M-6; 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 Committee agreed that the measure, while not necessarily simple to report, is feasible.

4. Use and Usability: H-19; M-4; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The developer described the public reporting approach for this measure. For the consumer-facing website, the measure results are typically stratified by specialists versus primary care providers.
- The Committee determined that the use and usability of this measure is high.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure NQF # 0711: Depression Remission at 6 Months. The Committee discussed related measures on its January 8, 2015 post-comment call

- Description: *Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.*
- The Committee was unable to discuss related and competing measures during the in-person meeting and will have the opportunity to do so during the post-meeting follow-up call.
- The Committee agreed the measures do not need to be harmonized at this time.

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

6. Public and Member Comment

- Three commenters were generally in support of this measure, however, had a few concerns.
- One of these commenter felt the two depression remission measures should be combined. The standing committee discussed the harmonization of the two depression remission measures and agreed with the developer there was a need for two measures.
- Another commenter expressed concern with the utilization of the PHQ-9 tool. The developer's response was: We appreciate the general support of this measure as one that addresses an important gap in performance measurement. Follow-up for this patient population is a clinically important component in the successful treatment of depression. Depression is an isolating condition and patients are often the least capable of reaching out and making that connection on their own. As such, patients with missing PHQ-9 assessments in follow-up remain in the

0710 Depression Remission at Twelve Months
denominator and are not counted in the numerator, resulting in a numerator "miss." This approach to managing missing data further promotes ongoing contact between the patient and provider.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

0711 Depression Remission at Six Months
Submission
Description: Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator. Numerator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five. Denominator Statement: Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine. Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded. Adjustment/Stratification: Level of Analysis: Facility, Clinician : Group/Practice Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient Type of Measure: PRO Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Measure Steward: MN Community Measurement
STANDING COMMITTEE MEETING - October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: Y-22; N-0; 1b. Performance Gap: H-21; M-1; L-0; I-0; 1c. Impact: H-21; M-1; L-0; I-0 Rationale: • The Committee noted that this measure is nearly identical to measure #0710; the only difference is that the measures are examining the same patient at two different points in time (six months and twelve months). • The Committee also noted that performance on the measure has not changed much over time. The developer acknowledged it has been difficult to see movement in the overall statewide average in Minnesota which is currently at 5.6 percent, with higher performing clinics at the 20 percent mark. Even so, for both of the measures, the number of denominator cases has increased fourfold in the last four years.

0711 Depression Remission at Six Months

- The Committee agreed that depression is an important area to measure. One member expressed that this might be the only true population-based outcome measure for mental health and substance use disorder which is used widely and publically reported.

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-19; M-0; L-0; I-0 2b. Validity: H-18; M-4; L-0; I-0

Rationale:

- The Committee asked for clarification as to whether completion of the PHQ-9 "starts the clock" for the measure. The developer explained that an elevated PHQ-9, and a confirming diagnosis is needed to start the clock ticking for each patient. Therefore, every patient has a different index date.
- A member noted that this measure could potentially be skewed towards the more severe patients since a diagnosis could theoretically occur months after the initial PHQ-9 screening tool.

3. Feasibility: H-16; M-7; 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 Committee agreed that the measure, while not necessarily simple to report, is highly feasible.

4. Use and Usability: H-17; M-5; L-1; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The developer described the public reporting approach for this measure. For the consumer-facing website, the measure results are typically stratified by specialists versus primary care providers.
- The Committee determined that the use and usability of this measure is high.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure NQF # 0710: Depression Remission at 12 Months. The Committee discussed related measures on its January 8, 2015 post-comment call

- Description: *Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.*
- The Committee agreed the measures do not need to be harmonized at this time.

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

6. Public and Member Comment

- Three commenters were generally in support of this measure, however, had a few concerns.
- One of these commenter felt the two depression remission measures should be combined. The Standing Committee discussed the harmonization of the two depression remission measures and agreed with the developer there was a need for two measures.
- Another commenter expressed concern with the utilization of the PHQ-9 tool. The developer's response was: We appreciate the general support of this measure as one that addresses an important gap in performance measurement. Follow-up for this patient population is a clinically important component in the successful treatment of depression. Depression is an isolating condition and patients are often the least capable of reaching out and making that connection on

0711 Depression Remission at Six Months
their own. As such, patients with missing PHQ-9 assessments in follow-up remain in the denominator and are not counted in the numerator, resulting in a numerator "miss." This approach to managing missing data further promotes ongoing contact between the patient and provider.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

0712 Depression Utilization of the PHQ-9 Tool
Submission
Description: Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. Numerator Statement: Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period. Denominator Statement: Adult patients age 18 and older with the diagnosis of major depression or dysthymia. Exclusions: Patients who die, are a permanent resident of a nursing home or are enrolled in hospice are excluded from this measure. Additionally, patients who have a diagnosis (in any position) of bipolar or personality disorder are excluded. Adjustment/Stratification: Level of Analysis: Facility, Clinician : Group/Practice Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient Type of Measure: Process Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records Measure Steward: MN Community Measurement
STANDING COMMITTEE MEETING- October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: Y-21; N-1; 1b. Performance Gap: H-20; M-3; L-0; I-0; 1c. Impact: H-19; M-3; L-0; I-0 Rationale: • This measure is a paired process measure that seeks to promote frequent use of the PHQ-9 and supports the two additional MN Community Measurement outcome measures submitted (#0710 and #0711). This measure, unlike the outcome measures, examines the entire population that has depression or dysthymia, regardless of the PHQ-9 score. • The Committee noted that there is significant variability among the clinics that report this measure. • There was general agreement that depression and dysthymia are common illnesses occurring in nine percent of the population and there is a significant gap in care: patients are frequently untreated, undertreated, or treated inappropriately.
2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

0712 Depression Utilization of the PHQ-9 Tool

2a. Reliability: H-19; M-4; L-0; I-0 2b. Validity: H-19; M-3; L-0; I-0

Rationale:

- The Committee agreed reliability testing for the measure itself as well as the PHQ-9 tool both demonstrated strong results.
- The Committee questioned the exclusions within the measure, and the developer confirmed that the measure excludes bipolar disorder and other personality disorders. The developer explained that it instructs its practices that if it is not appropriate to give a PHQ-9 to someone due to dementia or cognitive disorders, they shouldn't use the tool.
- The Committee questioned the risk adjustment model in the measure. The developer explained that the model includes the severity of a patient's depression, insurance product as a proxy for socioeconomic status, and age. The measure does not currently collect data on alcohol use or cognitive impairment, so those factors are not included in the model.
- One member questioned whether the tool had been translated into other languages and tested in those languages. The developer explained that the PHQ-9 is available in over 70 languages but was not certain whether those versions had been tested.
- The Committee questioned why the measure specifies that the PHQ-9 tool be administered at least once during a four month measurement period. The developer explained that the purpose of this measure is to support the outcome measures (#0710 and #0711), which look longitudinally at a patient over time. This measure is intended to encourage frequent administration of the PHQ-9.
- The Committee asked for clarification as to whether completion of the PHQ-9 "starts the clock" for the two outcome measures that this measure supports. The developer explained that an elevated PHQ-9, and a confirming diagnosis is needed to start the clock ticking for each patient. Therefore, every patient has a different index date.

3. Feasibility: H-18; M-4; 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 Committee agreed that the measure is highly feasible, even in systems where the PHQ-9 is not routinely recorded.

4. Use and Usability: H-20; M-2; L-0; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure has been collected in the state of Minnesota as part of a suite of measures. It is also included in the CMS Meaningful Use Program.
- The Committee agreed this is a strong measure for quality improvement on both an individual and system basis.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure NQF # 2620: Multidimensional Mental Health Screening Assessment. The Committee discussed related measures on its January 8, 2015 post-comment call

- Description: *This is a process measure indicating the percent of patients who have had this assessment completed in a period of time. Specifically, adult patients age 18 and older in an ambulatory care practice setting who have a Multidimensional Mental Health Screening Assessment administered at least once during the twelve month measurement period (e.g., once during the calendar year) when staff-assisted care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. "Staff-assisted care supports" refers to clinical staff that assist the primary care clinician by providing*

0712 Depression Utilization of the PHQ-9 Tool
some direct care and/or coordination, case management, or mental health treatment. A Multidimensional Mental Health Screening Assessment is defined as a validated screening tool that screens for the presence or risk of having the more common psychiatric conditions, which for this measure include major depression, bipolar disorder, post-traumatic stress disorder (PTSD), one or more anxiety disorders (specifically, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and/or social phobia), and substance abuse. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-22; N-0
6. Public and Member Comment • Two commenters were generally in support of this measure.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Submission
Description: Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk Numerator Statement: Patient visits with an assessment for suicide risk Denominator Statement: All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder Exclusions: None Adjustment/Stratification: Level of Analysis: Clinician : Individual Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient Type of Measure: Process Data Source: Electronic Clinical Data : Electronic Health Record Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
STANDING COMMITTEE MEETING- October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: H-18; M-7; L-0; I-0; IE-0; 1b. Performance Gap: H-18; M-6; L-1; I-0; 1c. Impact: H-21; M-4; L-0; I-0 Rationale: • The Committee agreed there is a gap in performance and that the measure will have a high impact but questioned the age range specified in the measure (ages 6-17), asking whether it is appropriate to include children as young as six given that children cannot conceptualize death until approximately age eight. The developer explained that they included children as young as six in the measure based on the Academy of Child and Adolescent clinical guidelines and a 2013 cohort study by Rohde, et al. that showed in their cohort, five percent had their first incidence of MDD between the ages of five and twelve.

1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
• Committee members also questioned the linkage between screening and improved outcomes. The developer noted a 2010 study examining screening rates and impact on detection of suicidal ideation and referral rates. The results were that increased screening resulted in increased detection and referral rates. • The Committee accepted the developer's explanation and agreed the measure is important to measure and report.
2. Scientific Acceptability of Measure Properties: Consensus Not Reached (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: H-3; M-12; L-3; I-6 2b. Validity: H-1; M-13; L-4; I-6 Rationale:, • The Committee expressed concern about the reliability of the measure, citing the variability in the ways in which suicide assessments are conducted and documented. Members also commented that specifying one particular tool, such as the Columbia Severity Suicide Rating Scale (CSSRS), should be considered. The developer noted that the CSSRS is included in the measure but not required, in order to allow more flexibility in the use of the measure and reduce burden. • It was noted by Committee members that only 101 patients were sampled across very different practices. Committee members were also concerned that in primary care settings the frequency of MDD might be very low, and questioned whether the measure would be meaningful in those settings. The developer explained the sample size was determined using the Donner Eliasziw kappa sample size calculation as a method of determining a baseline number of charts to abstract per measure, and determined the sample size is statistically significant. The developer also noted the measure is important for mental health providers who will have a larger sample size. • Committee members recommended that, in the future, the measure be characterized as a screening measure. • Ultimately, the Committee did not reach consensus on the validity of the measure. The Committee encouraged the submission of comments during the member and public commenting period. The Committee did not feel that either the public comment nor the developer response warranted further consideration or re-vote on the consensus not reached criteria (Scientific Acceptability) of the measure.
3. Feasibility: H-2; M-13; L-5; I-4 (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 agreed the measure is feasible, however, had expressed concerns about the variability in the ways in which suicide assessments are conducted and documented, and noted this could impact the feasibility of the measure, particularly if there is not systematic collection of suicide risk assessments in Electronic Health Records. • The Committee recommended that the measure should be expanded in future to include comorbid conditions and persistent depression, in order to align with new DSM-V criteria in future iterations.
4. Use and Usability: H-4; M-10; L-5; I-5 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The Committee noted that the measure is in use; performance data are not yet available.
5. Related and Competing Measures • No related or competing measures noted.

1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

Standing Committee Recommendation for Endorsement: Y-15; N-9

6. Public and Member Comment

- Two commenters were generally in support of this measure. One commenter expressed concerns regarding the validity of the measure. The developer responded to these concerns with the following statement: The PCPI appreciates the concerns raised regarding validity for this measure. To address this concern, we will revise the numerator definition to provide clarity around the intent of the measure. The revised definition (pending review of clinical content expert) is as follows: "The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate: 1. Risk (eg, age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (eg, religious belief, concern not to hurt family) that may influence the desire to attempt suicide; 2. Current severity of suicidality; 3. Most severe point of suicidality in episode and lifetime.

  Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used." We hope that the by delineating minimum criteria to be included in a risk assessment and providing an example of a tool that would meet the measure, there will be less variability in how these assessments are performed and captured.
- While the Committee appreciated the responsiveness of the developer to comments, it did not feel that either the public comment or the developer response warranted further consideration or re-vote on the consensus not reached criteria (Scientific Acceptability) of the measure. The issues raised by the Committee were regarding validity and the extent to which suicide assessments would improve outcomes and neither of these issues were addressed. Thus, the Committee recommended staying with their in-person vote and letting the measure continue through the NQF process.

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

8. Board of Directors Vote: Yes/No

9. Appeals

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

Submission

Description: The 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: This measure assesses the receipt of follow-up visits for children prescribed ADHD medication.

Two rates are reported.

1. INITIATION PHASE: The percentage of children between 6 and 12 years of age who were newly prescribed ADHD medication who had one follow-up visit with a prescribing practitioner within 30 days.

2. CONTINUATION AND MAINTENANCE PHASE: The percentage of children between 6 and 12 years of age newly prescribed ADHD medication and remained on the medication for at least 210 days, who had, in addition to the visit in the Initiative Phase, at least two follow-up visits with a practitioner in the 9 months subsequent to the Initiation Phase.

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

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Exclusions: Children with a diagnosis of narcolepsy
Adjustment/Stratification:
Level of Analysis: Health Plan, Integrated Delivery System
Setting of Care: Ambulatory Care : Clinician Office/Clinic
Type of Measure: Process
Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy
Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-7; M-9; L-5; I-0; IE-0; 1b. Performance Gap: H-9; M-11; L-0; I-0; 1c. Impact: H-12; M-7; L-3; I-0

Rationale:

- The Committee expressed concerns that the measure excludes individuals who are non-compliant within the 30-day initiation phase and noted these individuals might need follow-up care the most. The developer explained the measure addresses just one aspect of ADHD care, follow-up visits with providers, and the measure's focus is on monitoring potential side effects and responses to medication.
- Committee members also questioned the evidence supporting the 30-day timeframe and its linkage to improved outcomes. Many committee members referenced office co-pays and lapses in medication usage during the summer as possible barriers to meeting the 30-day requirement as well. The developer explained that American Academy of Pediatrics (AAP) and American Academy of Child and Adolescent Psychiatry (AACAP) clinical guidelines were used to support the 30-day follow-up period. For this health plan measure, 15-, 30-, 45- day follow-up periods were considered, but it was found that the 30-day follow up period worked best in balancing when it was most possible to get children seen, and allowing the claims system to process the claim.
- While the Committee noted the adherence rate has changed very little over the years, they agreed a performance gap persists (only 38-39 percent of children between 6 and 12 years of age who were newly prescribed ADHD medication who had one follow-up visit with a prescribing practitioner within 30 days and 43-45 percent of children between 6 and 12 years of age newly prescribed ADHD medication and remained on the medication for at least 210 days, who had, in addition to the visit in the Initiative Phase, at least two follow-up visits with a practitioner in the 9 months subsequent to the Initiation Phase).
- The Committee agreed the measure addresses a high priority, as attention-deficit hyperactivity disorder (ADHD) is one of the most prevalent behavioral health diseases in children. A National Survey of Children's Health study found that, in 2007, about 9.5% of children 4 to 17 years of age, or about 5.4 million, had a history of ADHD (CDC 2010). Of those 5.4 million children with a history of ADHD, 78% had a current diagnosis of ADHD at the time of the survey (CDC 2010) and 66.3% of those children were taking medication for the disorder (CDC 2010).

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-1; M-14; L-4; I-3 2b. Validity: H-2; M-14; L-4; I-3

Rationale:

- The Committee found the signal-to-noise reliability testing results using the beta binomial method to be strong with most of the reliability results being above .7. The Committee expressed concerns regarding the various forms of follow-up, potential summer medication lapses and the unaccounted-for dropout rates; however, the Committee concluded that the benefits of following-up care

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outweighed the consequences of potential extra screenings.

- Construct validity was calculated from HEDIS data that included 357 Commercial health plans for the Initiation Phase and 234 Commercial health plans for the Continuation and Maintenance Phase, and the Committee agreed the results were sufficient. Face validity was assessed with four panels of experts from diverse backgrounds, and the Committee found this assessment to be sufficient.

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)

Rationale:

- The Committee agreed that the data are routinely generated through care delivery and captured in electronic sources.

4. Use and Usability: H-4; M-13; L-6; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The Committee agreed the measure is sufficiently usable. The developer describes at least four current accountability uses of the measure including public reporting of health plan data.
- Some members remained concerned about follow-up frequency, the linkage of follow up care to improved outcomes, and about children who are more complex and potentially less adherent who could fall out of the measure. Members also noted the limitations of claims data versus richer data sources that could allow developers to better address these issues.
- The Committee ultimately agreed the benefit of performing follow-up outweighs potential unintended consequences, or burdens of measurement related to requiring follow-ups to be performed more frequently than the evidence provided suggested.

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: Y-17; N-6

6. Public and Member Comment

- Two commenters were in support of the measure. One commenter felt the 30-day follow-up timeframe was too prescriptive and would not allow for the clinical judgment of the physician when determining the frequency of follow-up care. The developer responded with the following: The AACAP clinical guidelines recommend early and ongoing monitoring for potential side effects and response to treatment when a child is on ADHD medication. NCQA's Behavioral Health Measurement Advisory Panel considered the timeframe for the measure to be reasonable and consistent with the principles of the guidelines. We agree that treating clinicians should determine the frequency of follow-up care for each patient. However, the measure establishes minimum necessary expectations for monitoring and follow-up care.
- During their deliberations, the Committee acknowledged that the evidence supporting the 30-day timeframe and its linkage to improved outcomes was indirect, however, agreed with the developer that the 30-day follow up period worked best in balancing when it was most possible to get children seen, and allowing the claims system to process the claim. In addition, the committee raised the issue of capturing provider/patient/parent interactions that may fulfill the intent of the measure, but are not captured in claims. The Committee was specifically concerned with interactions that take place telephonically, via email, or via a patient portal and are emerging as standard practice across the country. The developer acknowledged the difficulty in capturing such interactions, but indicated internal discussions on how to incorporate into measurement were

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already occurring. The Committee requested annual reports on progress being made by the developer in the measure adapting to advancing technology.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
Submission
Description: The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI). Numerator Statement: Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user. Denominator Statement: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. Exclusions: Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set). Adjustment/Stratification: Level of Analysis: Health Plan Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records Measure Steward: National Committee for Quality Assurance
STANDING COMMITTEE MEETING - October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: H-7; M-11; L-1; I-1; IE-1; 1b. Performance Gap: H-17; M-3; L-1; I-0; 1c. Impact: H-18; M-3; L-0; I-0 Rationale: • Committee members expressed concerns about the measure's link to proven outcomes. Specific threats to improved outcomes included the fact that many people with SMI do not regularly visit their primary care physician and the fact that the evidence suggests that screening and brief intervention is more effective for alcohol use in a population that has mild to moderate substance use, which may not apply to the majority of the SMI population. The Committee ultimately agreed sufficient evident is presented to support the measure • It was noted that there is a performance gap in the area of alcohol screening for people with SMI as

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well as significant disparities in care as noted by the developer. There was some disagreement however that health plans should be held accountable for ensuring that patients actually receive follow-up care when many are recalcitrant to treatment. Committee members noted the significant variation among the states regarding the payment of substance use treatment. In some states such as Arkansas, Medicaid does not pay for alcohol treatment. Consequently, there is no incentive to screen and provide follow-up care. • The developer explained, and Committee members agreed, the field should move beyond the argument that providers and health plans shouldn't ultimately be responsible for the actions of the patient. The developer stressed that this measure encourages the health plan to be responsible for ensuring the coordination and integration of care across multiple settings.
2. Scientific Acceptability of Measure Properties: Consensus Not Reached (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: H-0; M-12; L-8; I-1 2b. Validity: H-2; M-10; L-6; I-3 Rationale: • The Committee expressed concern that the measure was not tested in commercial health plans but rather in a variety of Medicaid and Medicare plans. An additional area of concern was the allowance of "self-help services" such as Alcoholics Anonymous to count as a follow-up event within the measure. The developer explained that the measure development panel felt strongly that there is a clear need to capture and measure efforts to connect people to peer support and peer-led interventions. • The developer also confirmed a well-documented phone call counts as follow-up care, noting that the contact doesn't have to come from the physician but could also come from a nurse or care manager. As long as the follow-up contact is documented in the EMR, it can be abstracted, even if it was not done by a billable provider. • The Committee asked whether there are specific diagnostic codes that are required to be counted in the measure. The developer explained that the measure only requires a positive screen, not a diagnosis. • The Committee ultimately did not reach consensus on the reliability or validity of this measure.
3. Feasibility: H-1; M-11; L-8; I-1 (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 generally agreed that the data is routinely generated through care delivery and captured in electronic sources and the measure is moderately feasible.
4. Use and Usability: H-2; M-12; L-5; I-2 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The Committee expressed some concern about the ability of the health plan to influence outcomes for this measure.
5. Related and Competing Measures This measure was identified by NQF staff as relating to measures NQF # 2600: Tobacco Use Screening & Follow-Up for People with SMI and NQF # 2597 Substance Use Screening & Intervention Composite. The Committee discussed related measures on its January 8, 2015 post-comment call

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
• Description NQF# 2597: *Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results*. • Description NQF# 2600: *The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported.* *Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user.* *Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user*. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-13; N-8
6. Public and Member Comment • Two commenters expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
Submission
Description: The percentage of patients 18 years and older with a serious mental illness or alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user. Two rates are reported.

2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence

Rate 1: The percentage of patients 18 years and older with a diagnosis of serious mental illness who received a screening for tobacco use and follow-up for those identified as a current tobacco user.

Rate 2: The percentage of adults 18 years and older with a diagnosis of alcohol or other drug dependence who received a screening for tobacco use and follow-up for those identified as a current tobacco user.

Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028). This measure is currently stewarded by the AMA-PCPI and used in the Physician Quality Reporting System.

Numerator Statement: Rate 1: Screening for tobacco use in patients with serious mental illness during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.

Rate 2: Screening for tobacco use in patients with alcohol or other drug dependence during the measurement year or year prior to the measurement year and received follow-up care if identified as a current tobacco user.

Denominator Statement: Rate 1: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.

Rate 2: All patients 18 years of age or older as of December 31 of the measurement year with any diagnosis of alcohol or other drug dependence during the measurement year.

Exclusions: Not applicable.

Adjustment/Stratification:

Level of Analysis: Health Plan

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

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-18; M-2; L-1; I-0; IE-0; 1b. Performance Gap: H-18; M-1; L-0; I-2; 1c. Impact: H-16; M-4; L-1; I-0

Rationale:

- The Committee agreed that there is an existing measurement gap for population health and for preventive screening and monitoring of chronic conditions in the seriously mentally ill (SMI) population. The developer highlighted that stakeholders rated this measure as a high priority during focus groups.
- The Committee agreed that there is significant evidence supporting the link between tobacco use and poor health outcomes for the target population. Data submitted by the developer suggests that from 2009 – 2011, 36.1 percent of individuals with mental illness smoke verses only 21.4 percent of the general population.
- The Committee highlighted that evidence indicates pharmacotherapy for alcohol is the most effective when it also includes counseling, and noted the measure as currently specified allows for either pharmacotherapy or counseling—but does not require both. The developer explained that the measure is structured this way due to the short measurement timeframe.
- The Committee also raised concerns that adding additional medication is not always the best treatment approach, specifically for the SMI population. The developer explained that this measure

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assesses both the SMI and the AOD population and allowing medication or counseling to meet the measure numerator allows providers to have more flexibility when using the measure. • The Committee accepted the developer's explanations and agreed the measure is important to measure and report.
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-14; L-1; I-0 2b. Validity: H-5; M-14; L-3; I-0 <u>Rationale</u>: • The Committee noted that the measure has strong inter-rater reliability. • The Committee raised concerns about the high rates of missing records, noting that the data submitted by the developer suggests that only a third of patients have behavioral health records available. • A Committee member suggested that the pediatric population should be included in the patient population instead of limiting the measure to those over 18 years of age. • The Committee also challenged the limitation of this health plan level measure to include only outpatient settings, noting that much care is now delivered in acute care settings. The Committee suggested that in future, that this measure should also monitor inpatient services. It was noted that there is a measurement gap in assessing the services provided in inpatient settings. The developer agreed that there is a gap in this area, noting however that health plans do not usually track individuals who received a screening for tobacco use and follow-up services in inpatient settings.
3. Feasibility: H-7; 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) <u>Rationale</u>: • The Committee expressed no concerns regarding the feasibility of this measure.
4. Use and Usability: H-6; M-14; L-1; I-0 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) <u>Rationale</u>: • The Committee agreed this measure is widely used in routine care.
5. Related and Competing Measures This measure was identified by NQF staff as relating to measures NQF # 2597 Substance Use Screening & Intervention Composite and NQF # 2599: Alcohol Screening and Follow-up for People with Serious Mental Illness. The Committee discussed related measures on its January 8, 2015 post-comment call • *<u>Description NQF# 2597:</u>* Percentage of patients aged 18 years and older who were screened at least once within the last 24 months for tobacco use, unhealthy alcohol use, nonmedical prescription drug use, and illicit drug use AND who received an intervention for all positive screening results. • *<u>Description NQF# 2599:</u>* The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-19; N-2
6. Public and Member Comment

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• One commenter was in support of this measure. • One commenter expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures. The developer responded with the following statement: Thanks for the comment. There are major differences in both the numerator and denominator between this measure and the existing AMA-PCPI (NQF#0028) measure. The denominator of this measure focuses on SMI population and the numerator requires two counseling services, as compared with one counseling service for the general population in measure #0028. Our expert panels and stakeholders encouraged us to strengthen the numerator to meet the need of this vulnerable population. Because of these major differences, stratifying the provider level measure will not meet the intent of this new measure. All measures for the SMI population can be reported using a single sample of people with SMI, which helps increase the efficiency of data collection. • Another commenter expressed concerns regarding the potential burden of the measure, however, was more concerned that the measure required chart review. The developer responded with: We appreciate the comment. We would note that claims codes for tobacco cessation counseling are available mitigating the burden related to chart review. We recognize the expanding use of tele-health. It is a cross-cutting issue that impacts other NQF endorsed measures. NCQA is evaluating this issue and will consider tele-health for the measures when the evidence supports inclusion and welcome specific references from the literature. While this is a process measure, the USPSTF B grade recommendation supports tobacco screening and cessation services, which leads to better outcomes.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
Submission
Description: The percentage of patients 18 years and older with a serious mental illness who received a screening for body mass index and follow-up for those people who were identified as obese (a body mass index greater than or equal to 30 kg/m2). Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (Preventive Care & Screening: Body Mass Index: Screening and Follow-Up NQF #0421). It is currently stewarded by CMS and used in the Physician Quality Reporting System. Numerator Statement: Patients 18 years and older with calculated body mass index documented during the measurement year or year prior to the measurement year and follow-up care is provided if a person's body

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mass index is greater than or equal to 30 kg/m2. Denominator Statement: All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year. Exclusions: Active diagnosis of pregnancy during the measurement year or the year prior to the measurement year. Adjustment/Stratification: Level of Analysis: Health Plan Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records Measure Steward: National Committee for Quality Assurance
STANDING COMMITTEE MEETING - October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: H-14; M-8; L-1; I-0; IE-0; 1b. Performance Gap: H-19; M-4; L-0; I-0; 1c. Impact: H-17; M-4; L-1; I-1 Rationale: • The Committee agreed that the quality of evidence to support the focus of the measure is sufficient. A small number of good studies were presented which indicate improved outcomes, although the effects were small. It was also noted that there is a disparity as to those with SMI are screened for BMI: during testing, the results showed there is not much BMI screening documented in behavioral health medical records. The Committee agreed that this is a high priority health condition in the general population and is most likely an even greater priority in the SMI population. • The Committee requested clarification regarding the denominator, asking why, for schizophrenia and bipolar, the measure requires one inpatient visit or two outpatient visits, while for major depression only one inpatient visit is required. The developer explained that this denominator is consistent for all the measures. Literature and an expert advisory panel were used to determine how best to define the SMI population, particularly those with depression, which can fall along a spectrum of mild to moderate and/or episodic to disabling. To ensure the best approach the developer followed the model found in the literature of using schizophrenia and bipolar wherever it exists as an inpatient diagnosis, or two outpatient events to confirm the diagnosis was not in error. For major depression, one inpatient event is used, as hospitalization would indicate that the depression is at a higher level of severity. This avoids sweeping those with milder depression into the denominator. • The Committee asked for clarification regarding what counts as a follow-up in the measure. The developer noted the measure is modeled after an existing, endorsed HEDIS measure and includes a variety of activities that count as follow-up based on United States Preventive Services Task Force (USPSTF) recommendations. • Committee members suggested including in the measure the additional intervention of changing an individual's medications to help address weight management issues. The developer explained that in the next update of the measure, an additional USPSTF-recommended medication will be included in the measure. The developer also noted that including the option of changing medications was considered, however accurate tracking of and understanding of why medications is a challenge to determine from pharmacy claims data. As a result the measure includes the counseling option, and as long as the provider documents that weight management has been addressed, that would count toward the measure.

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- Committee members agreed there are differences in this population as compared to the general population and thus interventions may need to be different. It was noted that this measure differs from the general population measure in that the number of follow up events is increased from a single event for the general population, to two events within three months for the SMI population. Another difference is that in the original physician level measure a referral to nutrition counseling is adequate to meet the measure. In this health plan measure both the referral and a nutrition counseling event must be noted in the medical record to meet the measure.

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-10; M-9; L-4; I-0 2b. Validity: H-10; M-8; L-3; I-2
Rationale:

- In general, the Committee found the measure to have precise and clear specifications and testing results that indicate the measure is highly reliable. The Committee agreed the testing results, expert panel comments and public comments support the validity of the measure as well.
- The Committee asked about the general population HEDIS score for the BMI measure. The developer indicated the HEDIS results had been compared, and there is disparity in the results. However, it's important to note that they are different measures. The SMI-focused measure results are much lower, but establish a higher bar. The general population HEDIS measure is just the screening component. There was a 10 percentage point difference in the rates.
- The Committee questioned whether the measure would be implemented in commercial plans. It was clarified that this was a question about implementation and not scientific acceptability. Upon endorsement, the use of a measure is open for various applications. The measure has been tested in public sector plans: a Medicaid plan, a special needs plan (SNP), and a dual-eligible SNP.

3. Feasibility: H-9; M-7; L-6; I-1
(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:

- There were no overarching concerns about feasibility, however it was acknowledged that measures based on medical record extraction impose a greater burden on users.

4. Use and Usability: H-5; M-13; L-4; I-4
(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)
Rationale:

- The measure is in use for the general population and the Committee agreed this measure is usable.

5. Related and Competing Measures
This measure was identified by NQF staff as relating to measure NQF measure #0421 Preventive Care & Screening: Body Mass Index: Screening and Follow-Up. The Committee discussed related measures on its January 8, 2015 post-comment call This proposed health plan measure is adapted from the existing provider-level measure for the general population.

- The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population.

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- The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized.
- Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues.
- The Committee agreed the measures do not need to be harmonized at this time.

Standing Committee Recommendation for Endorsement: Y-20; N-3

6. Public and Member Comment

- Two commenters were generally in support of this measure.
- One commenter expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability.
- Another commenter also recommended stratification stating health plans will have to collect data for this measure separately from the ABA measure which will be burdensome and resource intensive. The developer responded with: We appreciate the comment. We would like to make a distinction between the new measure and NCQA's ABA measure and CMS's measure - Preventive Care & Screening: Body Mass Index: Screening and Follow-Up (NQF #0421) from which our new measure is adapted. This new measure is different from the existing measures in terms of denominator and numerator. The denominator of this measure focuses exclusively on the SMI population and the numerator requires two counseling services, as compared with one counseling service for the general population in the CMS measure and no follow-up care in NCQA's BMI assessment measure. Our expert panels and stakeholders encouraged us to strengthen the numerator to meet the need of this vulnerable population. Because of these major differences, stratifying the existing measures will not meet the intent of this new measure. All measures for the SMI population can be reported using a single sample of people with SMI and this helps increase the efficiency of data collection. Claims codes on BMI counseling can be used in the measure as well as chart review.
- During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.

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

8. Board of Directors Vote: Yes/No

9. Appeals

2602 Controlling High Blood Pressure for People with Serious Mental Illness

Submission

Description: The percentage of patients 18-85 years of age with serious mental illness who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled during the measurement year.

Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0018: Controlling High Blood Pressure). It was originally endorsed in 2009 and is owned and stewarded by NCQA. The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guideline. NCQA will submit the revised specification for Controlling High Blood Pressure NQF #0018 in the 4th quarter 2014 during NQF's scheduled measure update period. This measure uses the new specification to be consistent with the current guideline.

Numerator Statement: Patients whose most recent blood pressure (BP) is adequately controlled during the measurement year (after the diagnosis of hypertension) based on the following criteria:

-Patients 18-59 years of age as of December 31 of the measurement year whose BP was <140/90 mm Hg.

-Patients 60-85 years of age as of December 31 of the measurement year and flagged with a diagnosis of diabetes whose BP was <140/90 mm Hg.

-Patients 60-85 years of age as of December 31 of the measurement year and flagged as not having a diagnosis of diabetes whose BP was <150/90 mm Hg.

Denominator Statement: All patients 18-85 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND a diagnosis of hypertension on or before June 30th of the measurement year.

Exclusions: All patients who meet one or more of the following criteria should be excluded from the measure:

- Evidence of end-stage renal disease (ESRD) or kidney transplant
- A diagnosis of pregnancy

Adjustment/Stratification:

Level of Analysis: Health Plan

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

Type of Measure: Outcome

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-15; M-7; L-1; I-0; IE-0; 1b. Performance Gap: H-16; M-6; L-1; I-0; 1c. Impact: H-18; M-5; L-0; I-0

Rationale:

- The Committee agreed the measure is important due to discrepancies between the SMI population and the general population with regard to measuring and controlling blood pressure. The Committee agreed the measure would have a high impact given the significant morbidity and mortality related to hypertension.
- The most common reason criteria were not met is because members had no visits with a provider during the measurement year.

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

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

2a. Reliability: H-9; M-7; L-6; I-4 2b. Validity: H-9; M-8; L-4; I-2

Rationale:

- The measure specifications reflect the new specifications that NCQA published for 2015 and are aligned with updated clinical guidelines. This measure assesses different blood pressure expectations depending on age and is focused on those with serious mental illness. The numerator is the same as the general population measure.
- The Committee requested clarification regarding the exclusion of pregnant women from the denominator. The developer explained that health plans are confirming the diagnosis in the medical record in the first six months of the year and assessing if the last blood pressure of the year is meeting the threshold. Including those who are pregnant in the denominator would make the measure too complex to implement.
- The Committee questioned the exclusion of ED visits in the specifications. The developer explained that while because of concerns about "white coat hypertension" or hypertension that might be picked up only during an ED visit, ED visits are excluded as they may not indicate true diagnosis of hypertension.
- The Committee agreed the measure has precise and clear specifications and testing results indicate the measure is highly reliable. Committee members expressed concerns about whether or not health plans reliably access the data needed due to fragmentation of care.
- The Committee agreed the validity testing presented is sufficient.

3. Feasibility: H-7; M-9; L-5; 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:

- There were no overarching concerns about feasibility; however, it was acknowledged that medical record based measures do pose a greater burden to health plans due to chart abstraction.
- Additional concerns were raised about the overall fragmentation of care and behavioral health carve-outs specifically were discussed.
- The committee noted that some aspects of the measure can be captured electronically, but not all are well maintained in an electronic sources.

4. Use and Usability: H-6; M-11; L-6; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is in use for the general population and the Committee agreed this measure is usable.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure NQF measure #0018: Controlling High Blood Pressure, as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call

- The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population.
- The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized.

2602 Controlling High Blood Pressure for People with Serious Mental Illness
• Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-18; N-5
6. Public and Member Comment • One commenter was generally in support of this measure. • Two commenters expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with:. We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures. • Another commenter questioned the developer's hypertension measurement strategy. The developer's response was: Thanks for the comment. The clinical guidelines recommend the treatment goal to be <140/90. The guidelines specifically mentioned that for individuals whose BP is >=140/90, the treatment goal should be <140/90.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
Submission
Description: The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had hemoglobin A1c (HbA1c) testing during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing). This measure is endorsed by NQF and is stewarded by NCQA. Numerator Statement: Patients who had Hemoglobin A1c (HbA1c) testing during the measurement year. Denominator Statement: Patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2) during

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the measurement year or year before.

Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure:

-Patients with a diagnosis of polycystic ovaries.

-Patients with gestational or steroid-induced diabetes.

Adjustment/Stratification:

Level of Analysis: Health Plan

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

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-19; M-4; L-0; I-0; IE-0; 1b. Performance Gap: H-21; M-2; L-0; I-0; 1c. Impact: H-19; M-4; L-0; I-0

Rationale:

- The Committee agreed that the quality of evidence to support the focus of the measure is high. It was also noted that there is a substantial gap in performance and there is a disparity in testing HvA1c for those with SMI. The Committee agreed that this is a high priority in the SMI population, where diabetes is shown to be more prevalent.
- The Committee requested clarification regarding the denominator, asking why, for schizophrenia and bipolar, the measure requires one inpatient visit or two outpatient visits, while for major depression only one inpatient visit is required. The developer explained that this denominator is consistent for all the measures. Literature and an expert advisory panel were used to determine how best to define the SMI population, particularly those with depression, which can fall along a spectrum of mild to moderate and/or episodic to disabling. To ensure the best approach the developer followed the model found in the literature of using schizophrenia and bipolar wherever it exists as an inpatient diagnosis, or two outpatient events to confirm the diagnosis was not in error. For major depression, one inpatient event is used, as hospitalization would indicate that the depression is at a higher level of severity. This avoids sweeping those with milder depression into the denominator.

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-16; M-5; L-2; I-0 2b. Validity: H-14; M-5; L-3; I-0

Rationale:

- The Committee agreed the measure is clearly and precisely specified and the testing results demonstrate the measure is highly reliable. The Committee noted that the measure was tested across three different plans: a Medicaid plan for non-disabled adults, a Special Needs Plan for dual-eligible members (Medicare and Medicaid) and a Medicaid plan for disabled adults; and there was substantial variability in performance. It was noted that at the workgroup level there was some was concern about the small sample size used in the testing, however the group determined that the testing data suggested that the measure could detect meaningful differences in performance across the plans.
- Committee members raised concerns that because data needed to report the measure can be siloed,

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health plans may not reliably have access to all needed data. The developer explained that they own most of the data needed to report the measure. • The Committee agreed the validity testing presented is sufficient.
3. Feasibility: H-10; M-9; L-4; 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: • There were no overarching concerns about feasibility; however, it was acknowledged that medical record based measures do pose a greater burden to health plans due to chart abstraction. • Additional concerns were raised about the overall fragmentation of care and behavioral health carve-outs specifically were discussed. • The committee noted that some aspects of the measure can be captured electronically, but not all are well maintained in electronic sources.
4. Use and Usability: H-13; M-6; L-4; I-0 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The measure is in use for the general population and the Committee agreed this measure is usable.
5. Related and Competing Measures This measure was identified by NQF staff as relating to measure NQF measure #0057: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing, as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call • The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. • The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized. • Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-21; N-2
6. Public and Member Comment • Two commenters were generally in support of this measure. • Two commenters expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate

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measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
Submission
Description: The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who received a nephropathy screening test or had evidence of nephropathy during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0062: Comprehensive Diabetes Care: Medical Attention for Nephropathy). It is endorsed by NQF and is stewarded by NCQA. Numerator Statement: Patients who received a nephropathy screening test or had evidence of nephropathy during the measurement year. Denominator Statement: All patients 18-75 years as of December 31st of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diagnosis of diabetes (type 1 and type 2) during the measurement year or the year before. Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria may be excluded from the measure: -Patients with a diagnosis of polycystic ovaries. -Patients with gestational or steroid-induced diabetes. Adjustment/Stratification: Level of Analysis: Health Plan Setting of Care: Ambulatory Care : Clinician Office/Clinic Type of Measure: Process Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy Measure Steward: National Committee for Quality Assurance
STANDING COMMITTEE MEETING - October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria** (1a. Evidence, 1b. Performance Gap, 1c. High Impact) 1a. Evidence: H-15; M-5; L-0; I-0; IE-0; 1b. Performance Gap: H-19; M-2; L-0; I-0; 1c. Impact: H-16; M-6; L-0; I-

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Rationale:

- The Committee agreed that the quality of evidence presented to support the focus of the measure is high, and that there is a disparity as to how diabetics with SMI are screened for this major complication of diabetes. It was noted that the evidence for treatment options to prevent nephropathy onset and delay the progression of nephropathy is the strongest, with the most RCTs. While the evidence supporting screenings for nephropathy is weaker in comparison, the Committee was satisfied that there is a strong link between regular nephropathy screenings and improved outcomes, given the opportunity for early detection of diabetic nephropathy and early treatment to delay progression of the disease.
- The Committee also noted that managing the quality of care that is provided to this population is important given the prevalence of diabetes among individuals with SMI, and given that nephropathy is a high risk, high cost complication in both financial and human terms.

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-14; M-5; L-3; I-0 2b. Validity: H-11; M-7; L-4; I-0

Rationale:

- The Committee agreed the measure is clearly and precisely specified and the testing results demonstrate the measure is highly reliable. The Committee noted that the measure was tested across three different plans: a Medicaid plan for non-disabled adults, a Special Needs Plan for dual-eligible members (Medicare and Medicaid) and a Medicaid plan for disabled adults; and there was substantial variability in performance. It was noted that at the workgroup level there was some was concern about the small sample size used in the testing, however the group determined that the testing data suggested that the measure could detect meaningful differences in performance across the plans.
- Committee members raised concerns that because data needed to report the measure can be siloed, health plans may not reliably have access to all needed data. The developer explained that they own most of the data needed to report the measure.
- The Committee agreed that the face validity testing is sufficient; however some members questioned how well the set of measures have performed in the general population over time. The developer explained that the over time, not much improvement has been seen in performance by Medicaid plans, but more improvement has been seen in other plans, where the measure is used in a variety of pay for performance programs.

3. Feasibility: H-12; M-8; 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:

- It was noted that medical record-based measures pose a greater burden to health plans due to the need for chart abstraction, however the Committee agreed the measure is feasible.
- The Committee also discussed the overall fragmentation of care and the potential for missing data given possible behavioral health carve-outs at the state level, and raised concerns about the ability of plans to identify full populations with partial data. The developer noted that testing of the measures indicates that health plans do have the data necessary to report the measure, and that the intent of this set of measures is to move beyond the limitations of claims data and bridge data silos.
- Committee members noted that some aspects of the measure can be captured electronically, but not all are well maintained in electronic sources.

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4. Use and Usability: H-10; M-9; L-3; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is in use for the general population and the Committee agreed this measure is usable.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure NQF measure #0062 Comprehensive Diabetes Care: Medical Attention for Nephropathy, as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call

- The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population.
- The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized.
- Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues.
- The Committee agreed the measures do not need to be harmonized at this time.

Standing Committee Recommendation for Endorsement: Y-21; N-1

6. Public and Member Comment

- One commenter was generally in support of this measure.
- Two commenters expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability.
- During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.

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

8. Board of Directors Vote: Yes/No

9. Appeals

2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
Submission
Description: The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge. Four rates are reported: - The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge. - The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge. Numerator Statement: The numerator for each denominator population consists of two rates: Mental Health - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge Alcohol or Other Drug Dependence - Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge - Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge Denominator Statement: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year. Exclusions: The following are exclusions from the denominator: -If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alchohol or other drug dependence within the 30-day follow-up peri Adjustment/Stratification: Level of Analysis: Health Plan, Population : State Setting of Care: Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Outpatient Type of Measure: Process Data Source: Administrative claims Measure Steward: National Committee for Quality Assurrance
STANDING COMMITTEE MEETING - October 1-2, 2014 1. Importance to Measure and Report: **The measure meets the Importance criteria**

2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence

(1a. Evidence, 1b. Performance Gap, 1c. High Impact)
1a. Evidence: H-9; M-9; L-4; I-0; IE-0; 1b. Performance Gap: H-17; M-5; L-0; I-0; 1c. Impact: H-14; M-6; L-1; I-1
Rationale:

- The Committee noted that the measure is a good diagnostic of the health care system's ability to plan and meet the needs of complex patients.
- A Committee member expressed that this measure is important from a consumer protection advocacy perspective because it has the potential to combat against over-hospitalized which is a high priority for consumers.

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-15; M-5; L-0; I-2 2b. Validity: H-3; M-9; L-8; I-1
Rationale:

- The Committee questioned the exclusion of individuals with an alcohol use disorder who have been transferred to sub-acute residential treatment from the numerator given that in many cases the most appropriate referral for those individuals is to a sub-acute residential detox program in the community.
- Committee Members also questioned why the measure is specified to only include individuals with a primary diagnosis of mental health or alcohol or other drug dependence since trauma injuries are usually the primary diagnosis in emergency departments and behavioral health conditions are usually the secondary and the tertiary diagnosis. The Committee also raised concerns about people with secondary and tertiary mental health and substance use diagnosis being excluded because they felt that these people also need referrals for the outpatient service.
- The Committee questioned the inclusion of targeted case management in the measure numerator, acknowledging that targeted case management is a linkage service but is not considered a treatment service by Medicaid. The Committee also questioned whether telemedicine counted as visit in the measure specifications. The developer explained that mobile unit services are currently included in the measure codes and that they are currently working on incorporating codes recently created by CMS for telemedicine.
- The Committee raised concerns about linkages to services in rural settings and questioned the feasibility of people being able to access outpatient services.
- The Committee also questioned the measurement timeframe, stating that seven days was not a long enough time to achieve quality improvement, but also cautioning that thirty days was too long a timeframe since patients have the potential of being readmitted prior to receiving services. The developer explained that the measurement timeframe is based on an existing hospitalization measure and that the timeframe also gives health plans more leeway to meet the requirements of the measure.
- The Committee asked if psychiatric emergency services were considered an emergency department visit and the developer explained that the measure utilizes coding specifications from HEDIS to define what an emergency department visit is and that if psychiatric emergency services utilize these codes they will be captured by the measure since they will show up in claims data.
- The Committee questioned the type of reliability testing the developer used. The developer explained that because this is a claims-based measure, they used a signal to noise reliability metric to test for reliability. NQF explained that this form of testing is a standard approach used for the majority of the

2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
claims-based measures NQF has received.
3. Feasibility: H-5; M-13; L-2; I-1 (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 raised concerns that the measure only captured primary care diagnosis of alcohol and drug dependence since emergency departments are not financially reimbursed for any resulting conditions that are related to alcohol.
4. Use and Usability: H-5; M-8; L-5; I-3 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The measure is in use for the general population and the Committee agreed this measure is usable.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: Y-16; N-6
6. Public and Member Comment • Two commenters were generally in support of this measure. One of these commenters also expressed concerns that the rates included in the numerator make this measure too complicated to implement. The commenter responded by stating: Thanks for the comments. This measure is adapted from an existing NCQA measure (Follow-up After Hospitalization for Mental Illness NQF #0576) which also has a 7-day and 30-day rates. This new measure uses administrative claims data and organizations can feasibly implement the measure. The intent of the measure is that patients who are sick enough to have an emergency department visit for mental health or alcohol or other drug dependence should receive follow-up care in 7 days after discharge. If not within 7 days, then they should at least get follow-up care in 30 days after discharge. Our expert panels and stakeholder groups considered that both the 7-day and 30-day rates are necessary and feasible for implementation. • Another commenter had concerns regarding the measure's specifications. The developer's response was: We appreciate the comment and recognize the challenge that health plans may not always know within 7 days that their health plan member was in the ED. However, our expert panel and stakeholders including health plans supported this measure based on the importance of timely follow-up care for this population. Stakeholders considered that a measure like this will encourage improved information sharing between EDs and health plans and help drive quality improvement efforts. This measure is claims-based and does not differentiate whether a discharge is planned or unplanned (leave before discharge). The intent of the measure is for anyone who had an ED visit to get follow-up care regardless of whether the discharge was planned. At its core the measure assesses the plan's ability to coordinate care in a patient-centered and timely manner.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)

Submission

Description: The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading during the measurement year is <140/90 mm Hg.

Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0061: Comprehensive Diabetes Care: Blood Pressure Control <140/90 mm Hg) which is endorsed by NQF and is stewarded by NCQA.

Numerator Statement: Patients whose most recent BP reading is less than 140/90 mm Hg during the measurement year.

This intermediate outcome is a result of blood pressure control (<140/90 mm Hg). Blood pressure control reduce the risk of cardiovascular diseases. There is no need for risk adjustment for this intermediate outcome measure.

Denominator Statement: All patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2) during the measurement year or year prior to the measurement year.

Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria may be excluded from the measure:

-Patients with a diagnosis of polycystic ovaries.

-Patients with gestational or steroid-induced diabetes.

Adjustment/Stratification:

Level of Analysis: Health Plan

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

Type of Measure: Outcome

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-15; M-5; L-3; I-0; IE-0; 1b. Performance Gap: H-16; M-6; L-1; I-0; 1c. Impact: H-13; M-5; L-5; I-0

Rationale:

- The Committee agreed that there is sufficient evidence to support the focus of the measure, that there is a gap in performance and that the measure addresses a high priority.
- Committee members expressed concern however, that this measure potentially overlaps with another measure in this set that is focused on management of hypertension within the SMI population. The developer noted that for this health plan level measure, the intent is to ensure that blood pressure is managed, whether an individual has a primary diagnosis of hypertension, or has diabetes with a comorbidity or potential comorbidity of hypertension. It was noted that unfortunately individuals with differing primary diagnoses might be managed differently when it comes to blood pressure control. The developer also clarified that the timing of measurement differs between the two measures, reflecting the different foci of the measures: for the diabetes measure blood pressure readings must continually monitored whether or not there is a diagnosis of hypertension, while for the hypertension measure, individuals who fall below the specified reading will fall out of the denominator.

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
• The Committee accepted the developer's explanation and agreed the measure meets the Importance criteria.
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-13; M-8; L-2; I-0 2b. Validity: H-8; M-12; L-3; I-0 <u>Rationale</u>: • The Committee agreed the measure is clearly and precisely specified and the testing results demonstrate the measure is highly reliable. The Committee noted that the measure was tested across three different plans: a Medicaid plan for non-disabled adults, a Special Needs Plan for dual-eligible members (Medicare and Medicaid) and a Medicaid plan for disabled adults; and there was substantial variability in performance. It was noted that at the workgroup level there was some was concern about the small sample size used in the testing, however the group determined that the testing data suggested that the measure could detect meaningful differences in performance across the plans. • Committee members raised concerns that because data needed to report the measure can be siloed, health plans may not reliably have access to all needed data. The developer explained that they own most of the data needed to report the measure. • The Committee agreed that the face validity testing is sufficient; however some members questioned how well the set of measures have performed in the general population over time. The developer explained that the over time, not much improvement has been seen in performance by Medicaid plans, but more improvement has been seen in other plans, where the measure is used in a variety of pay for performance programs.
3. Feasibility: H-7; M-13; L-3; 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>: • It was noted that medical record-based measures pose a greater burden to health plans due to the need for chart abstraction, however the Committee agreed the measure is feasible. • The Committee also discussed the overall fragmentation of care and the potential for missing data given possible behavioral health carve-outs at the state level, and raised concerns about the ability of plans to identify full populations with partial data. The developer noted that testing of the measures indicates that health plans do have the data necessary to report the measure, and that the intent of this set of measures is to move beyond the limitations of claims data and bridge data silos.
4. Use and Usability: H-7; M-11; L-5; I-0 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) <u>Rationale</u>: • The measure is in use for the general population and the Committee agreed this measure is usable.
5. Related and Competing Measures This measure was identified by NQF staff as relating to measure NQF measure #0061 Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call • The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population.

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
• The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized. • Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-17; N-6
6. Public and Member Comment • Two commenters were generally in support of this measure. • One commenter expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Submission
Description: The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is >9.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control >9.0%). This measure is endorsed by NQF and is stewarded by NCQA. Numerator Statement: Patients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year.

2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

The intermediate outcome is an out of range result of an HbA1c test, indicating poor control of diabetes. Poor control puts the individual at risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator Statement: Patients 18-75 years of age as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diabetes (type 1 and type 2) during the measurement year or the year before.

Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure:

-Patients with a diagnosis of polycystic ovaries.

-Patients with gestational or steroid-induced diabetes.

Adjustment/Stratification:

Level of Analysis: Health Plan

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

Type of Measure: Outcome

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-19; M-4; L-0; I-0; IE-0; 1b. Performance Gap: H-18; M-5; L-0; I-0; 1c. Impact: H-16; M-6; L-0; I-0

Rationale:

- The Committee agreed that there is sufficient evidence to support the focus of this measure. The evidence presented demonstrated that diabetics with SMI are tested less often and even when they are monitored, their diabetes is more often poorly controlled compared to diabetics without SMI. Only 47.3 percent of diabetics with SMI were tested for HbA1c levels and of those who were tested, 62.8 percent fell into the poor control range with HbA1c levels greater than 9 percent. This is compared to 55.5 percent of diabetics without SMI in the poor control range in Medicaid plans, and 28.2 percent in Medicare plans.
- The Committee agreed that managing the quality of diabetes care that is provided to this population is important noting the prevalence and impact of the disease, but some members expressed concern about the potential for harms if HbA1c levels consistently fall too low. The developer noted that there is substantial evidence that HbA1c levels should always be less than 9 percent, but noted that they do report a measure for quality improvement purposes that assesses HbA1c levels that are less than 7 percent, which addresses the hypoglycemia concern. That measure has not been brought forward for NQF endorsement.
- The Committee accepted the developer's explanation and agreed the measure is important to measure and report.

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-13; M-8; L-2; I-0 2b. Validity: H-10; M-10; L-3; I-0

2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

Rationale:

- The Committee agreed the measure is clearly and precisely specified and the testing results demonstrate the measure is highly reliable. The Committee noted that the measure was tested across three different plans: a Medicaid plan for non-disabled adults, a Special Needs Plan for dual-eligible members (Medicare and Medicaid) and a Medicaid plan for disabled adults; and there was substantial variability in performance. It was noted that at the workgroup level there was some was concern about the small sample size used in the testing, however the group determined that the testing data suggested that the measure could detect meaningful differences in performance across the plans.
- Committee members raised concerns that because data needed to report the measure can be siloed, health plans may not reliably have access to all needed data. The developer explained that they own most of the data needed to report the measure.
- The Committee agreed that the face validity testing is sufficient; however some members questioned how well the set of measures have performed in the general population over time. The developer explained that the over time, not much improvement has been seen in performance by Medicaid plans, but more improvement has been seen in other plans, where the measure is used in a variety of pay for performance programs.

3. Feasibility: H-10; M-10; L-3; 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:

- It was noted that medical record-based measures pose a greater burden to health plans due to the need for chart abstraction, however the Committee agreed the measure is feasible.
- The Committee also discussed the overall fragmentation of care and the potential for missing data given possible behavioral health carve-outs at the state level, and raised concerns about the ability of plans to identify full populations with partial data. The developer noted that testing of the measures indicates that health plans do have the data necessary to report the measure, and that the intent of this set of measures is to move beyond the limitations of claims data and bridge data silos.

4. Use and Usability: H-11; M-7; L-4; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is in use for the general population and the Committee agreed this measure is usable.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure NQF measure #0059 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%), as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call

- The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population.
- The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized.
- Building on the existing measure is intended to help to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care

2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
issues. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-21; N-1
6. Public and Member Comment • Two commenters were generally in support of this measure. • Two commenters expressed concerns that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. You are correct, the small numbers issue and the disparities in care for the SMI population necessitate a separate blood pressure measure for the SMI population with diabetes. Having a separate measure of poor HbA1c control for the SMI population with diabetes sheds needed light on observed disparities and encourages improvement in care for this vulnerable population. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
Submission
Description: The percentage of patients 18-75 years of age with a serious mental and diabetes (type 1 and type 2) whose most recent HbA1c level during the measurement year is <8.0%. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0575: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control <8.0). This measure is endorsed by NQF and is currently stewarded by NCQA. Numerator Statement: Patients whose most recent HbA1c level was less than 8.0% during the measurement year. The outcome is an out of range result of an HbA1c test, indicating good control of diabetes. Good control

2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)

reduces the risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.

Denominator Statement: Patients 18-75 years as of December 31st of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diagnosis of diabetes (type 1 and type 2) during the measurement year or the year before.

Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria are excluded from the measure:

Patients with a diagnosis of polycystic ovaries.

Patients with gestational or steroid-induced diabetes.

Adjustment/Stratification:

Level of Analysis: Health Plan

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

Type of Measure: Outcome

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-19; M-3; L-0; I-0; IE-0; 1b. Performance Gap: H-18; M-5; L-0; I-0; 1c. Impact: H-17; M-5; L-0; I-0

Rationale:

- The Committee agreed that there is sufficient evidence to support the focus of the measure, that there is a large disparity as to how diabetics with SMI are managed when it comes to maintaining good control of diabetes compared to those without SMI: field tests showed that 32.8 percent of diabetics with SMI met the recommended HbA1c level of 8 percent for 2012, compared to 46.5 percent of those without SMI in Medicaid plans, and 63.6 percent in Medicare plans.
- The Committee also agreed that managing the quality of diabetes care that is provided to this population is a high priority given the prevalence and impact of the disease.

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-15; M-6; L-2; I-0 2b. Validity: H-10; M-8; L-4; I-0

Rationale:

- The Committee agreed the measure is clearly and precisely specified and the testing results demonstrate the measure is highly reliable. The Committee noted that the measure was tested across three different plans: a Medicaid plan for non-disabled adults, a Special Needs Plan for dual-eligible members (Medicare and Medicaid) and a Medicaid plan for disabled adults; and there was substantial variability in performance. It was noted that at the workgroup level there was some was concern about the small sample size used in the testing, however the group determined that the testing data suggested that the measure could detect meaningful differences in performance across the plans.
- Committee members raised concerns that because data needed to report the measure can be siloed, health plans may not reliably have access to all needed data. The developer explained that they own

2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
most of the data needed to report the measure. • The Committee agreed that the face validity testing is sufficient; however some members questioned how well the set of measures have performed in the general population over time. The developer explained that the over time, not much improvement has been seen in performance by Medicaid plans, but more improvement has been seen in other plans, where the measure is used in a variety of pay for performance programs.
3. Feasibility: H-11; M-8; L-4; 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: • It was noted that medical record-based measures pose a greater burden to health plans due to the need for chart abstraction, however the Committee agreed the measure is feasible. • The Committee also discussed the overall fragmentation of care and the potential for missing data given possible behavioral health carve-outs at the state level, and raised concerns about the ability of plans to identify full populations with partial data. The developer noted that testing of the measures indicates that health plans do have the data necessary to report the measure, and that the intent of this set of measures is to move beyond the limitations of claims data and bridge data silos.
4. Use and Usability: H-11; M-6; L-5; I-0 (Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement) Rationale: • The measure is in use for the general population and the Committee agreed this measure is usable.
5. Related and Competing Measures This measure was identified by NQF staff as relating to measure NQF measure #0575 Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call • The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. • The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized. • Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. • The Committee agreed the measures do not need to be harmonized at this time.
Standing Committee Recommendation for Endorsement: Y-20; N-2
6. Public and Member Comment • Two commenters were generally in support of this measure. • Three commenters expressed concerns regarding data collection burden. • One of these commenters stated that the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have

2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. You are correct, the small numbers issue and the disparities in care for the SMI population necessitate a separate blood pressure measure for the SMI population with diabetes. Having a separate measure of poor HbA1c control for the SMI population with diabetes sheds needed light on observed disparities and encourages improvement in care for this vulnerable population. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures. • Two of these commenters further expressed concerns that the CPT Category II code used for this measure is not specified enough to denote numerator compliance, so other sources must be used making this measure burdensome to collect. The developer responded with: The measure specification indicates that CPT II codes on HbA1c Level 7.0–9.0 included in the Value Set do not satisfy numerator criteria and organizations are required to use other sources (laboratory data, hybrid reporting method) to identify the actual value and determine if the HbA1c result was <8%.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
Submission
Description: The percentage of patients 18-75 years of age with a serious mental illness and diabetes (type 1 and type 2) who had an eye exam during the measurement year. Note: This measure is adapted from an existing health plan measure used in a variety of reporting programs for the general population (NQF #0055: Comprehensive Diabetes Care: Eye Exam). This measure is endorsed by NQF and is stewarded by NCQA. Numerator Statement: Patients who received an eye exam during the measurement year. Denominator Statement: All patients 18-75 years as of December 31 of the measurement year with at least one acute inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year AND diagnosis of diabetes (type 1 and type 2) during the measurement year or the year before. Exclusions: Patients who do not have a diagnosis of diabetes and meet one of the following criteria may be excluded from the measure: - Patients with a diagnosis of polycystic ovaries. - Patients with gestational or steroid-induced diabetes. Adjustment/Stratification:

2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

Level of Analysis: Health Plan

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

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy

Measure Steward: National Committee of Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

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

1a. Evidence: H-19; M-3; L-0; I-0; IE-0; 1b. Performance Gap: H-18; M-4; L-0; I-0; 1c. Impact: H-15; M-7; L-0; I-0

Rationale:

- The Committee agreed there is sufficient evidence to support the focus of the measure though the evidence is somewhat limited.
- The Committee noted that there is a significant opportunity for improved performance, as field test results show that only 13.2 percent of those with SMI and diabetes had received an eye exam for 2012, compared to an average rate (among people with diabetes) of 53.2 percent in Medicaid plans, and 65.7 percent in Medicare plans.
- The Committee noted that this gap in performance may be driven in large part by the need for referrals for specialty care exams, which can constitute a barrier for those with SMI.

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-14; M-7; L-1; I-0 2b. Validity: H-12; M-7; L-4; I-0

Rationale:

- Upon clarification that the eye exam must be conducted by an eye care professional, the Committee agreed the measure is clearly and precisely specified.
- The Committee also agreed the testing results demonstrate the measure is highly reliable. The Committee noted that the measure was tested across three different plans: a Medicaid plan for non-disabled adults, a Special Needs Plan for dual-eligible members (Medicare and Medicaid) and a Medicaid plan for disabled adults; and there was substantial variability in performance. It was noted that at the workgroup level there was some was concern about the small sample size used in the testing, however the group determined that the testing data suggested that the measure could detect meaningful differences in performance across the plans.
- Committee members raised concerns that because data needed to report the measure can be siloed, health plans may not reliably have access to all needed data. The developer explained that they own most of the data needed to report the measure.
- The Committee agreed that the face validity testing is sufficient; however some members questioned how well the set of measures have performed in the general population over time. The developer explained that the over time, not much improvement has been seen in performance by Medicaid plans, but more improvement has been seen in other plans, where the measure is used in a variety of pay for performance programs.

3. Feasibility: H-8; M-11; L-3; 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:

2609 Diabetes Care for People with Serious Mental Illness: Eye Exam

- It was noted that medical record-based measures pose a greater burden to health plans due to the need for chart abstraction, however the Committee agreed the measure is feasible.
- The Committee also discussed the overall fragmentation of care and the potential for missing data given possible behavioral health carve-outs at the state level, and raised concerns about the ability of plans to identify full populations with partial data. The developer noted that testing of the measures indicates that health plans do have the data necessary to report the measure, and that the intent of this set of measures is to move beyond the limitations of claims data and bridge data silos.

4. Use and Usability: H-9; M-10; L-3; I-0

(Meaningful, understandable, and useful to the intended audiences for 4a. Public Reporting/Accountability and 4b. Quality Improvement)

Rationale:

- The measure is in use for the general population and the Committee agreed this measure is usable.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measure # 0055 Comprehensive Diabetes Care: Eye Exam (retinal) Performed, as it is adapted from this existing general population measure. The Committee discussed related measures on its January 8, 2015 post-comment call

- The developer has explained that this measure is focused on the high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population.
- The numerator of this measure is consistent with the measure used for the general population while the denominator has been adapted to focus on individuals with serious mental illness. The specifications are harmonized.
- Building on this existing measure is intended to help reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues.
- The Committee agreed the measures do not need to be harmonized at this time.

Standing Committee Recommendation for Endorsement: Y-20; N-3

6. Public and Member Comment

- One commenter was generally in support of this measure.
- Two commenters expressed concerns about the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement. The developer responded with: We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of poor HbA1c control adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability. You are correct, the small numbers issue and the disparities in care for the SMI population necessitate a separate blood pressure measure for the SMI population with diabetes. Having a separate measure of poor HbA1c control for the SMI population with diabetes sheds needed light on observed disparities and encourages improvement in care for this vulnerable population.

2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
• The developer further responded with: You are correct, the small numbers issue and the disparities in care for the SMI population necessitate a separate blood pressure measure for the SMI population with diabetes. Having a separate measure of eye screening for diabetic retinal eye disease for the SMI population with diabetes sheds needed light on observed disparities and encourages improvement in care for this vulnerable population. This measure does not require a vision benefit and optometrists are included in the measure as an eligible provider. We would note for the general population that the top 10% of health plans achieve an average rate of 73.5% indicating feasibility of this measurement approach. • During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible, however, not necessarily stratify the measures.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

Appendix B-Table of Withdrawn Measures

Measure	Description	Reason for removal of endorsement
0003 : Bipolar Disorder: Assessment for diabetes	Percentage of patients treated for bipolar disorder who are assessed for diabetes within 16 weeks after initiating treatment with an atypical antipsychotic agent.	Measure Withdrawn by Developer
0106 : Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents	Percentage of patients, aged 4-18 years, newly diagnosed with attention deficit hyperactivity disorder (ADHD) whose medical record contains documentation of DSM-V criteria.	Measure Withdrawn by Developer
0107 : Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents	Percentage of patients, aged 6-18 years old, treated with psychostimulant medication for the diagnosis of attention deficit hyperactivity disorder (ADHD) whose medical record contains documentation of follow-up visits at least twice a year that include height, weight, a discussion of medication, a discussion of school progress and a care plan.	Measure Withdrawn by Developer
0109 : Bipolar Disorder and Major Depression: Assessment for Manic or hypomanic behaviors	Percentage of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors.	Measure Withdrawn by Developer
0110 : Bipolar Disorder and Major Depression:	Percentage of patients with depression or bipolar disorder	Measure Withdrawn by Developer

Measure	Description	Reason for removal of endorsement
Appraisal for alcohol or chemical substance use	with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use	
0111 : Bipolar Disorder: Appraisal for risk of suicide	Percentage of patients with bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide.	Measure Withdrawn by Developer
0112 : Bipolar Disorder: Level-of-function evaluation	Percentage of patients treated for bipolar disorder with evidence of level-of-function evaluation at the time of the initial assessment and again within 12 weeks of initiating treatment	Measure Withdrawn by Developer
0580 : Bipolar antimanic agent	This measure identifies the percentage of patients with newly diagnosed bipolar disorder who have received at least 1 prescription for a mood-stabilizing agent during the measurement year.	Measure Withdrawn by Developer
0595 : Lithium Annual Lithium Test in ambulatory setting	This measure identifies the percentage of patients taking lithium who have had at least one lithium level test after the earliest observed lithium prescription during the measurement year.	Measure Withdrawn by Developer
0596 : Lithium Annual Thyroid Test in ambulatory setting	This measure identifies the percentage of patients taking lithium who have had at least one thyroid function test after the earliest observed lithium prescription during the	Measure Withdrawn by Developer

Measure	Description	Reason for removal of endorsement
	measurement year.	
0609 : Lithium Annual Creatinine Test in ambulatory setting	This measure identifies the percentage of patients taking lithium who have had at least one creatinine test after the earliest observed lithium prescription during the measurement year.	Measure Withdrawn by Developer
0690 : Percent of Residents Who Have Depressive Symptoms (Long-Stay)	This measure is based on data from MDS 3.0 assessments of nursing home residents. Either a resident interview measure or a staff assessment measure will be reported. The preferred version is the resident interview measure. The resident interview measure will be used unless either there are three or more missing sub-items needed for calculation or the resident is rarely or never understood, in which cases the staff assessment measure will be calculated and used. These measures use those questions in MDS 3.0 that comprise the Patient Health Questionnaire (PHQ-9) depression instrument. The PHQ-9 is based on the diagnostic criteria for a major depressive disorder in the DSM-IV.	Measure Withdrawn by Developer
1394 : Depression Screening By 13 years of age	The percentage of adolescents 13 years of age who had a screening for depression using a standardized tool.	Measure Withdrawn by Developer

Measure	Description	Reason for removal of endorsement
1401 : Maternal Depression Screening	The percentage of children 6 months of age who had documentation of a maternal depression screening for the mother.	Measure Withdrawn by Developer
1406 : Risky Behavior Assessment or Counseling by Age 13 Years	The percentage of children with documentation of a risk assessment or counseling for risky behaviors by 13 years of age. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, Risk Assessment or Counseling for Sexual Activity.	Measure Withdrawn by Developer
1507 : Risky Behavior Assessment or Counseling by Age 18 Years	The percentage of adolescents with documentation of assessment or counseling for risky behavior by the age of 18 years. Four rates are reported: Risk Assessment or Counseling for Alcohol Use, Risk Assessment or Counseling for Tobacco Use, Risk Assessment or Counseling for Other Substance Use, and Risk Assessment or Counseling for Sexual Activity.	Measure Withdrawn by Developer
1515 : Depression Screening By 18 Years of Age	The percentage of adolescents 18 years of age who had a screening for depression using a standardized tool.	Measure Withdrawn by Developer