Behavioral Health Endorsement Maintenance 2014: Phase 3

DRAFT REPORT FOR VOTING

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Contents

Behavioral Health Phase 3

DRAFT REPORT

Executive Summary

This is the third in a series of three reports describing NQF's 2013-2015 measure evaluation projects for Behavioral Health measures. The background and description of the project and overview of NQF's Patient and Family Centered Care Portfolio are available on NQF's project web page. The multi-phase project is aimed at endorsing measures of accountability for improving the delivery of behavioral health services and achieving better behavioral health outcomes for the U.S. population. Phase 3, detailed in this report, examines measures of tobacco use, alcohol and substance use, psychosocial functioning, ADHD, depression, and health screening and assessment for people with serious mental illness (SMI). On October 1-2, 2014, the Behavioral Health Standing Committee evaluated 13 new measure and six existing measures undergoing maintenance review. Sixteen of these measures were recommended for endorsement by the Committee, one was approved for trial use, one was not recommended, and one was deferred.

Recommended:

- #0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
- #0710 Depression Remission at Twelve Months (MN Community Measurement)
- #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
- #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
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- #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

Approved for Trial Use:

- #2597 Substance Use Screening and Intervention Composite

Not Recommended:

- #0722 Pediatric Symptom Checklist (PSC)

Deferred:

- #2620 Multidimensional Mental Health Screening Assessment

Introduction

In the United States, it is estimated that approximately 26.4 percent of the population suffers from a diagnosable mental disorder.[1] These disorders – which can include serious mental illnesses, substance use disorders, and depression – are associated with poor health outcomes, increased costs, and premature death.[2] Although general behavioral health disorders are widespread, the burden of serious mental illness is concentrated in about six percent of the population.[3] 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.[4] By 2020, behavioral health disorders are expected to surpass all physical diseases as the leading cause of disability worldwide.[5]

In 2005, an estimated $113 billion was spent on mental health treatment in the United States. $22 billion of that amount was spent on substance use treatment alone, making substance use one of the most costly (and treatable) illnesses in the nation.[6] It is estimated that nearly 23 million Americans needed treatment for substance use in 2010.[7] Financial estimates for behavioral health disorders inflate substantially when wider social costs are factored in such as criminal, welfare, juvenile, and future earnings potential.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is currently advancing the *National Framework for Quality Improvement in Behavioral Health Care* (NBHQF).[8] In the framework, SAMHSA notes that efforts to successfully implement the portions of the Affordable Care Act (ACA) relevant to Behavioral Health will require a better understanding of the current status and needs of the behavioral health population and delivery system, as well as an increased ability to adequately assess and monitor these populations over time. Of course, meaningful mental health performance measurement is a key driver to transform the healthcare system and advance both of these goals.

National Quality Strategy

The National Quality Strategy (NQS) serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, State, and national) to improve the quality of health care in the U.S.[9]The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities, focusing on six priorities to achieve those aims: *Safety, Person and Family*

[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.
[2] Kilbourne, A., Keyser, D., & Pincus, H. (2010). Challenges and opportunities in measuring the quality of mental health care. *Canadian Journal of Psychiatry*, *55*(9), 549-557.
[3] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.
[4] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.
[5] Department of Health and Human Services, Department of Mental Health and Substance Abuse. (2011). Leading change: a plan for SAMPHSA'S roles and actions 2011-2014 (1104692). Washington, DC
[6] Mark, T. (2011). Changes in U.S. spending on mental health and substance abuse treatment. Health Affairs, 28(6).
[7] Substance Abuse and Mental Health Services Administration (SAMHSA). (2011). Results from the 2010 National Survey on Drug Use and Health: National findings. (Center for Behavioral Health Statistics and Quality, NSDUH Series H-41, DHHS Publication No. SMA 11-4658). Rockville, MD: SAMHSA.
[8] National Behavioral Health Quality Framework, SAMHSA. http://www.samhsa.gov/data/national-behavioral-health-quality-framework
[9] U.S. Department of Health and Human Services. National Strategy for Quality Improvement in Health Care. 2014.

Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and *Affordable Care*.[10]

Improvement efforts related to behavioral health conditions include patient reported experience of behavioral health care, screening, assessment, treatment and follow-up for tobacco, alcohol and substance use; treatment, monitoring and medication adherence for those with depression, major depressive disorder (MDD), schizophrenia, bipolar disorders and attention deficit hyperactivity disorder (ADHD); health screening and assessment for those with serious mental illness; safe and appropriate inpatient psychiatric care, and follow-up after hospitalizations. These efforts are consistent with the NQS triple aim and align with all six of the NQS priorities.

Behavioral Health Measure Evaluation: Refining the Evaluation Process

Changes to the Consensus Development Process (CDP)—transitioning to Standing Committees and Trial eMeasure Approval—have been incorporated into the ongoing maintenance activities for the Behavioral Health portfolio. These changes are described below.

Standing Steering Committee

In an effort to remain responsive to its stakeholders' needs, NQF is constantly working to improve the CDP. Volunteer, multi-stakeholder steering committees are the central component to the endorsement process, and the success of the CDP projects is due in large part to the participation of its Steering Committee members. In the past, NQF initiated the Steering Committee nominations process and seated new project-specific committees only when funding for a particular project had been secured. Seating new committees with each project not only lengthened the project timeline, but also resulted in a loss of continuity and consistency because committee membership changed—often quite substantially—over time.

To address these issues in the CDP, NQF is beginning to transition to the use of Standing Steering Committees for various topic areas. These Standing Committees will oversee the various measure portfolios; this oversight function will include evaluating both newly-submitted and previously-endorsed measures against NQF's measure evaluation criteria, identifying gaps in the measurement portfolio, providing feedback on how the portfolio should evolve, and serving on any ad hoc or expedited projects in their designated topic areas.

The Behavioral Health Standing Committee currently includes 25 members (see Appendix D). Each member has been randomly appointed to serve an initial two- or three- year term, after which he/she may serve a subsequent 3-year term if desired.

[10] Health Services Advisory Group. National Impact Assessment of Medicare Quality Measures. Centers for Medicare and Medicaid Services; 2014.

Trial eMeasure Approval

NQF has developed and is piloting in this project an optional path of trial measure approval for eMeasures. This path is intended for eMeasures that meet technical eligibility requirements and are ready for implementation, but cannot yet be adequately tested to meet NQF endorsement criteria. For such eMeasures, NQF is piloting use of the multi-stakeholder consensus process to evaluate and approve eMeasures that address important areas for performance measurement and quality improvement, even though they may not have the requisite testing needed for NQF endorsement.

Trial measure approval by a Committee indicates eMeasures are ready for testing purposes only, and is not endorsement of the measure for accountability applications. Approved measures are judged by the Committee to meet the other NQF criteria of importance to measure and report, scientific acceptability, feasibility, and usability and planned use, and are evaluated relative to any related and competing measures. Measure developers are expected to provide full field testing for approved measures and submit them for full endorsement within 3 years after approval. The trial measure designation automatically expires three years after initial Committee approval if the measure is not submitted for full endorsement prior to that time.

The Behavioral Health Standing Committee has approved one composite eMeasure for this optional pathway; the measure is discussed in the Measure Evaluation section of this report. Additional information regarding the trial measure approval pathway is available on the NQF webpage.

NQF Portfolio of Performance Measures for Behavioral Health Conditions

The Behavioral Health portfolio of measures is organized according to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Behavioral Health Quality Framework (NBHQF).[11] The NBHQF is aligned with the National Quality Strategy and sets forth broad aims and six initial priorities and goals:

1. Promote the most effective prevention, treatment and recovery practices for BH disorders
2. Assure behavioral health care is person and family centered
3. Encourage effective coordination within behavioral health care, and between behavioral health care and other health care and social support services
4. Assist communities to utilize best practices to enable healthy living
5. Make behavioral health care safer by reducing harm caused in the delivery of care
6. Foster affordable high quality behavioral health care for individuals, families, employers and governments by developing and advancing new delivery models

Currently, NQF's portfolio of Behavioral Health measures includes measures that address tobacco, alcohol and substance use, depression, major depressive disorder (MDD), schizophrenia, bipolar disorders, health screening and assessment for those with serious mental illness, attention deficit hyperactivity disorder (ADHD), safe and appropriate inpatient psychiatric care, and follow-up after

[11] National Behavioral Health Quality Framework, SAMHSA. http://www.samhsa.gov/data/national-behavioral-health-quality-framework

hospitalization. As shown in the chart below, these measures map to all but two of the NBHQF goals: there are no measures in the areas of person and family center care (Goal #2) and affordable, accessible care (Goal #6). The portfolio contains 32 measures: 28 process measures and four outcome measures. Six of these existing measures were evaluated by the Behavioral Health Committee in this phase.

NQF Behavioral Health Portfolio of Measures

NBHQF Goals	Measures in Behavioral Health Portfolio	Process	Outcome
Goal 1: Effective Prevention, and: · Goal 4: Healthy Living · Goal 5: Safe Care	Tobacco, alcohol, substance use (screening and assessment, intervention and treatment, follow-up)	11	
	Schizophrenia, Bipolar Disorders, Depression, MDD (screening and assessment, including suicide risk; intervention and treatment; follow-up)	6	4
	ADHD screening and assessment	1	
Goal 2: Person- Family-Centered Care	No measures		
Goal 3: Coordinated Care	Medication reconciliation	1	
	Health screening and assessment for those with SMI; those prescribed anti-psychotic medications		
	Care plan created, transmitted	2	
	Follow-up after hospitalization, ED visit	2	
Goal 5: Safe Care	Medication management/adherence	3	
	Safe, appropriate care in inpatient treatment settings	2	
Goal 6: Affordable, Accessible Care	No measures		
Total		28	4

Four measures endorsed in phase one of this project that address health screening and assessment for those with serious mental illness including schizophrenia, bipolar disorders and MDD have since been assigned to the Cardiovascular and the Endocrine portfolios. One measure addressing experience of behavioral health care and health outcomes is assigned to the Patient and Family Centered Care portfolio.

Endorsement of measures by NQF is valued not only because the evaluation process itself is both rigorous and transparent, but also because evaluations are conducted by multi-stakeholder committees comprised of clinicians and other experts from hospitals and other healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis to ensure better care. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, legislative mandate requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Over time, and for various reasons, some previously-endorsed behavioral health-related measures have been dropped from the full NQF portfolio (see Appendix A). In some cases, the measure steward may want to continue maintain the measure for endorsement (e.g., update specifications as new drugs/tests become available or as diagnosis/procedure codes evolve or go through NQF's measure maintenance process). In other cases, measures may lose endorsement upon maintenance review. Loss of endorsement can occur for many different reasons including—but not limited to—a change in evidence without an associated change in specifications, high performance on a measure signifying no further opportunity for improvement, and endorsement of a superior measure.

Use of Measures in the Portfolio

The Behavioral Health measures are used in a variety of public reporting and federal programs, including:

- Dual Eligibles Core Quality Measures – Capitated Demonstrations
- Dual Eligibles Core Quality Measures – Managed Fee for Service Demonstrations
- Initial Core Set of Health Care Quality Measures for Medicaid
- Meaningful Use (EHR Incentive Program)
- Physician Quality Reporting System (PQRS)
- Medicare Shared Savings Program

See Appendix C for details of federal program use for the measures in the portfolio that are currently under review.

Improving NQF's Behavioral Health Portfolio

Committee input on gaps in the portfolio

During its discussions over the multiple phases of this work, the Committee has identified numerous areas where additional measure development is needed, including:

- Measures specific to child and adolescent behavioral health needs; in particular, a measure on primary care screening and appropriate follow-up for behavioral health disorders in children
- Outcome measures for substance abuse/dependence that can be used by substance use specialty providers
- Quality measures assessing care for persons with and intellectual disabilities across the lifespan;
- Quality measures that better align indicators of clinical need and treatment selection and, ideally, incorporate patient preferences
- Measures that assess aspects of recovery-oriented care for individuals with serious mental illness
- Quality measures related to coordination of care across sectors involved in the care or support of persons with chronic mental health problems (general medical care, mental health care, substance abuse care and social services).
- The adaptation of measure concepts that have been developed for and applied to inpatient care to other outpatient care settings (e.g., polypharmacy, follow up after discharge)

- Quality measures that assess whether evidence-based psychosocial interventions are being applied with a level of fidelity consonant with their evidence base
- The expansion of the number of conditions for which the quality of care can be assessed in the context of a "measurement-based care" approach (as is possible now with the suite of measures that have been endorsed for depression)
- Further develop measurement strategies for assessing the adequacy of screening and prevention interventions for general medical conditions among individuals with severe mental illness (as well as care for their co-morbid general medical conditions)
- Screening for alcohol and drugs, specifically using tools such as the Screening Brief Intervention and Referral to Treatment (SBIRT)
- Screening for post-traumatic stress disorder (PTSD) and bipolar disorder in all patients diagnosed with depression, attempting to differentiate between the disorders
- A measure assessing gaps in local service areas (i.e. does the immediate local area have the ability to help a patient with specific behavioral health needs?)
- Outcome measures that assess improvement in depressive symptoms
- Primary care measures that screen for multiple behavioral health disorders
- A measure examining a patient's ability to access specialty care
- Measures of community tenure, assessing how long patients who frequently readmit stay out of hospitals between admissions
- Measures aimed at the elderly population that attempt to distinguish behavioral health conditions and intellectual issues related to aging

Behavioral Health Measure Evaluation

On October 1-2, 2014 the Behavioral Health Standing Committee evaluated 13 new measures and six measures undergoing maintenance review against NQF's standard evaluation criteria. To facilitate the evaluation, the committee and candidate standards were divided into four workgroups for preliminary review of the measures against the evaluation sub-criteria prior to consideration by the entire Standing Committee. The Committee's discussion and ratings of the criteria are summarized in the evaluation tables beginning in Appendix A.

Behavioral Health Summary

	Maintenance	New	Total
Measures under consideration	6	13	19
Measures deferred	0	1	1
Measures recommended	5	12	17
Measures Approved for Trial Use	0	1	1
Measures not recommended	1	0	1
Reasons for not recommending	Importance – 0 Scientific Acceptability – 1 Overall – 0 Competing Measure – 0		

	Maintenance	New	Total

Overarching Issues

During the Steering Committee's discussion of several of the measures, an overarching issue emerged that was factored into the Committee's ratings and recommendations for multiple measures and is not repeated in detail with each individual measure: screening measures that are focused on specific populations.

Measures Focused on Special Populations

The Committee reviewed nine measures submitted by NCQA that assess the prevention and monitoring of chronic conditions for people with serious mental illness (SMI). The SMI population has been shown to be at higher risk of having the specified conditions, and there is evidence of a disparity in access to care for this population. The measures in the group are harmonized with related, existing NQF-endorsed measures that are focused on the general population and are in national quality measurement programs. The submitted measures address:

- Controlling Blood Pressure for People with Serious Mental Illness (SMI)
- Diabetes Care for People with Serious Mental Illness (six measures)
- Body Mass Index Screening and Follow-up for People with Serious Mental Illness
- Tobacco Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence (AOD)
- Alcohol Screening and Follow-up for People with Serious Mental Illness

The Committee noted that those with SMI tend to be at higher risk of not receiving the specified screenings, stressing that this in turn significantly impacts this population's morbidity and mortality. In addition, this is a high risk group that is of particular interest within the Medicaid, Medicare and dual-eligible population. The Committee agreed that all of the measures are important to measure and report, scientifically acceptable, are feasible to report and are usable.

Consistent with Committee discussions, one of the themes of the public comment period was the cumulative burden of the measures for this specific sub-population. As indicated at the in-person meeting, the developer reiterated the rationale for separate measures (small sample size when assessing through stratification), and the importance of measures with special focus on the SMI population. The developer indicated willingness to monitor the measures and at such time it would be reasonable and scientifically acceptable to incorporate into population health measures will consider alternative approaches to reduce burden. ~~Even so, the Committee was concerned about the potential cumulative burden of the measures and struggled with how best to address the issue of measurement addressing specific vulnerable or at-risk populations without proliferating multiple sets of measures. It was noted that one approach might be to include such sub-populations within broader population measures as needed; another approach would be to develop composites addressing high priority~~

~~vulnerable and at-risk sub-populations. Comments on this issue are encouraged during the Public and Member Commenting period.~~

Summary of Measure Evaluation

The following brief summaries of the measures and the evaluation highlight the major issues that were considered by the Committee. Details of the Committee's discussion and ratings of the criteria are included in Appendix A.

Measures Recommended

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

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;* **Measure Type:** *Process;* **Level of Analysis:** *Health Plan, Integrated Delivery System;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic;* **Data Source:** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy*

This measure was originally endorsed in 2009 and is specified at the health plan level. The measure is currently used in the CMS Physician Quality Reporting System (PQRS) program, and used is also by the National Committee for Quality Assurance (NCQA) in their HEDIS program to assess Medicaid health plan performance. The committee brought up concerns about the 30-day timeframe and potential barriers such as copays and summer lapses but overall felt the measure will have a high impact. While the committee noted the adherence rate has changed very little over the years, they agreed a performance gap persists. Following additional input from the developer addressing these concerns, the Committee agreed the measure meets the importance to measure and report criteria. The Committee expressed concern about the reliability and validity of the measure, citing summer medication lapses and the unaccounted dropout rate; however, the Committee ultimately concluded the measure was reliable and valid and voted to recommend the measure for continued endorsement.

0710: Depression Remission at Twelve Months (MN Community Measurement): Recommended

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;* **Measure Type:** *PRO;* **Level of Analysis:** *Facility, Clinician : Group/Practice;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Electronic Clinical Data : Electronic Health Record, Paper Medical Records*

This measure was first endorsed in 2011 and is specified at the individual clinician and group practice levels. 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), assessing for the patient-reported outcome of absence of depressive symptoms as measured by the PHQ-9 tool. The measures apply to patients with new diagnoses as well as existing depression whose PHQ-9 score

indicates the need for treatment. The measure is publically reported on the developer's website and has been selected for inclusion in CMS' Meaningful Use Program. MN Community measurement acknowledged that it has been difficult to see movement in the overall statewide average for performance. Even so, the Committee strongly supported these measures, noting they are two of the only true population-based outcome measures for mental health and substance use disorder that are widely used and publically reported.

0711: Depression Remission at Six Months: Recommended

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;* **Measure Type:** *PRO;* **Level of Analysis:** *Facility, Clinician : Group/Practice;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Electronic Clinical Data : Electronic Health Record, Paper Medical Records*

This measure was first endorsed in 2011 and is specified at the individual clinician and group practice levels. 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), assessing for the patient-reported outcome of absence of depressive symptoms as measured by the PHQ-9 tool. The measures apply to patients with new diagnoses as well as existing depression whose PHQ-9 score indicates the need for treatment. The measure is publically reported on the developer's website and has been selected for inclusion in CMS' Meaningful Use Program. MN Community measurement acknowledged that it has been difficult to see movement in the overall statewide average for performance. Even so, the Committee strongly supported these measures, noting they are two of the only true population-based outcome measures for mental health and substance use disorder that are widely used and publically reported.

0712: Depression Utilization of the PHQ-9 Tool: Recommended

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;* **Measure Type:** *Process;* **Level of Analysis:** *Facility, Clinician : Group/Practice;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Electronic Clinical Data : Electronic Health Record, Paper Medical Records*

This measure was first endorsed in 2011 and is specified at the individual clinician and group practice levels. This 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 to this phase of work. The measure, unlike the outcome measures, examines the entire population that has depression or dysthymia, regardless of the PHQ-9 score. The measure has been collected in the state of Minnesota as part of a suite of measures. It is also included in CMS' Meaningful Use Program. The Committee agreed

that this is a strong measure for quality improvement on both an individual and system level and voted overwhelmingly for its endorsement.

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

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;* **Measure Type:** *Process;* **Level of Analysis:** *Clinician : Individual;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Electronic Clinical Data : Electronic Health Record*

This eMeasure was originally endorsed in 2011 and is specified at the individual clinician level. The measure is currently used in the CMS Physician Quality Reporting System (PQRS) program, and the CMS Meaningful Use, Stage 2 EHR Incentive Program. The Committee agreed the measure addresses a gap in performance and that the measure will have a high impact, but questioned the younger end of the age range specified in the measure (ages 6-17) and the linkage between screening and improved outcomes. Following additional input from the developer addressing these concerns, the Committee agreed the measure meets the importance to measure and report criteria. The Committee expressed concern about the reliability and validity of the measure, citing the variability in the ways in which suicide assessments are conducted and documented and the infrequency of MDD diagnoses in primary care settings. The Committee ultimately did not reach consensus on the validity of the measure, and comments on the measure's validity are encouraged during the Public and Member Commenting period. One comment was received regarding this measure. The comment questioned the lack of specificity related to the assessment tools that would apply. The developer indicated they have revised the specifications to be more prescriptive, yet remaining flexible and within clinical guideline recommendations for specific suicide assessment parameters. The Committee did not feel the additional comments, nor information provided by the developer, warranted a re-vote on their prior decision. The Committee agreed the measure is feasible and usable, and voted to recommend the measure for continued endorsement.

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

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. 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;* **Measure Type:** *Process;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric: Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Paper Medical Records*

This is a newly submitted measure for endorsement and will be used by the National Committee for Quality Assurance (NCQA) in their HEDIS program to assess Medicaid health plan performance. This

measure is part of a group of health plan measures for patients with behavioral health conditions that assess prevention and monitoring for general medical conditions. In its review, the Committee noted that current evidence indicates pharmacotherapy for alcohol is most effective when it also includes counseling. The developer explained that as the measure assesses both serious mental illness (SMI) and alcohol and other drug dependence (AOD) populations, allowing the flexibility of using medication or counseling to meet the measure helps reduce burden on providers. The Committee raised concerns about the high rates of missing records, noting that this presents a challenge for the generalizability of the population. The Committee also expressed that the pediatric population should be included in the denominator of this measure. As this measure is based on administrative claims data the Committee expressed no concerns regarding the feasibility of this measure and also noted that this measure is widely used in routine care. Ultimately the Committee agreed to recommend this measure for endorsement.

2601: Body Mass Index Screening and Follow-Up for People with Serious Mental Illness (NCQA): Recommended

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;* **Measure Type:** *Process;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Paper Medical Records*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures submitted by NCQA focusing on assessing the management of conditions comorbid to serious mental illness. When reviewing the measures, the Committee agreed that there is sufficient evidence to support the focus of the measure, that there is a significant opportunity for performance improvement in how diabetics with SMI are screened for BMI, and that managing the quality of care that is provided to this population is a high priority. The measure uses commonly defined denominator criteria for identifying the population, and the developer supplied sufficient validity and reliability testing results to support these definitions. Committee members also agreed that acceptable indicators of face validity were presented. Given the sufficient importance, evidence, reliability and validity of the measure, the Committee recommended the measure for endorsement.

2602: Controlling High Blood Pressure for People with Serious Mental Illness (NCQA): Recommended

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; **Measure Type:** *Outcome;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Paper Medical Records*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures submitted by NCQA focusing on assessing the management of conditions comorbid to serious mental illness. When reviewing the measure, the Committee agreed that that there is sufficient evidence to support the focus of the measure, that there is a significant opportunity for improvement in how those with SMI are managed for hypertension, and that managing the quality of care that is provided to this population is a high priority. The measure uses commonly defined denominator criteria for identifying the population, and the developer supplied sufficient validity and reliability testing results to support these definitions. Committee members also agreed that acceptable indicators of face validity were presented. Given the sufficient importance, evidence, reliability and validity of the measure, the Committee recommended the measure for endorsement.

2603: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing (NCQA): Recommended

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;* **Measure Type:** *Process;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures submitted by NCQA focusing on assessing the management of conditions comorbid to serious mental illness. When reviewing the measure, the Committee agreed that evidence indicates the importance of assessing and managing comorbidities and that there are disparities in the treatment of patients with serious mental illness. The measure uses commonly defined denominator criteria for identifying the population, and the developer supplied information on validity and reliability testing to support these definitions. Committee members also agreed that the NCQA development, stakeholder and public comment and review processes were an acceptable indicator of face validity. Given the sufficient importance, evidence, reliability and validity of the measure, the Committee recommended the measure for endorsement.

2604: Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy (NCQA): Recommended

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;* **Measure Type:** *Process;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic;* **Data Source:** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures assessing prevention and monitoring of chronic conditions for people with serious mental illness. This population has been shown to be at higher risk of having the specified conditions and there is evidence of a disparity in access to evidence-based care for this population. The Committee agreed that there is sufficient evidence to support the focus of the measure, that there is a disparity as to how diabetics with SMI are screened for this major complication of diabetes, and that managing the quality of care that is provided to this population is important as this is a high risk, high cost complication in both financial and human terms. The Committee agreed the measure is clearly specified and it was noted that the measure uses commonly defined denominator criteria for identifying the population. The Committee agreed that sufficient validity and reliability testing results are presented to support the measure and the face validity results presented are acceptable. The Committee also found that the measure is feasible to report as the measure is currently being collected for the general population, and agreed the measure is usable. As such, the Committee recommended the measure for endorsement.

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

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*; **Measure Type:** *Process*; **Level of Analysis:** *Health Plan, Population : State*; **Setting of Care:** Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient, Hospital/Acute Care Facility; **Data Source:** *Administrative claims*

This is a newly submitted measure for endorsement and will be used by the National Committee for Quality Assurance (NCQA) in their HEDIS program to assess Medicaid health plan performance. The measure is part of a group of health plan measures for patients with behavioral health conditions that assess prevention and monitoring for general medical conditions. In its review, 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. The Committee questioned the exclusion of individuals with an alcohol use disorder who have been transferred to sub-acute residential treatment from the numerator and also questioned the exclusion of individuals with secondary and tertiary diagnosis of mental health or alcohol or other drug dependence. The Committee inquired 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 discussed the measurement timeframe, stating that seven days is not a long enough time to achieve quality improvement, but also cautioning that thirty days is also too long a timeframe since patients have the potential to be 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. Ultimately the Committee agreed to recommend this measure for endorsement.

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

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;* **Measure Type:** *Outcome;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures assessing prevention and monitoring of chronic conditions for people with serious mental illness. This population has been shown to be at higher risk of having the specified conditions and there is evidence of a disparity in access to evidence-based care for this population. While there is a measure within the set that addresses blood pressure control for individuals with SMI who are hypertensive, this measure assesses comprehensive diabetes management with a focus on a hypertension, a common co-morbidity.

The Committee expressed concern 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. The Committee accepted the developer's explanation and 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. The Committee agreed that sufficient validity and reliability testing results are presented to support the measure and the face validity results presented are acceptable. The Committee also found that the measure is feasible to report and is usable, and recommended the measure for endorsement.

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

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; **Measure Type:** *Outcome;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures assessing prevention and monitoring of chronic conditions for people with serious mental illness. This population has been shown to be at higher risk of having the specified conditions and there is evidence of a disparity in access to evidence-based care for this population. This measure assesses diabetes management for individuals with SMI whose diabetes is poorly controlled. The Committee agreed that there is sufficient evidence to support the focus of the measure, that there is a disparity as to how diabetics with SMI are managed, and that managing the quality of care that is provided to this population is important. The Committee agreed the measure is clearly specified and it was noted that the measure uses commonly defined denominator criteria for identifying the population. Committee members expressed concern about the potential harms if HbA1c levels consistently fall too low. The developer explained that they do report a measure addressing HbA1c levels at less than seven percent; however that measure has not been brought forward for NQF endorsement. The Committee ultimately agreed that sufficient validity and reliability testing results are presented to support the measure and that the face validity results presented are acceptable. The Committee also found that the measure is feasible to report and is usable, and recommended the measure for endorsement.

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

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;* ***Measure Type****: Outcome;* ***Level of Analysis****: Health Plan; Setting of Care: Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient; Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures assessing prevention and monitoring of chronic conditions for people with serious mental illness. This population has been shown to be at higher risk of having the specified conditions and there is evidence of a disparity in access to evidence-based care for this population. This measure assesses diabetes management for individuals with SMI whose diabetes is well controlled. The Committee agreed that there is sufficient evidence to support the focus of the measure, that there is an even greater disparity as to how diabetics with SMI are managed when it comes to good control of diabetes, and that managing the quality of care that is provided to this population is important. The Committee agreed the measure is clearly specified and it was noted that the measure uses commonly defined denominator criteria for identifying the population. The Committee agreed that sufficient validity and reliability testing results are presented to support the measure and the face validity results presented are acceptable. The Committee also found that the measure is feasible to report and is usable, and recommended the measure for endorsement.

2609: Diabetes Care for People with Serious Mental Illness: Eye Exam (NCQA): Recommended

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;* **Measure Type:** *Process;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy*

This is a newly submitted measure for endorsement and will be used by NCQA in their HEDIS program to assess Medicaid health plan performance. This measure is part of a set of measures assessing prevention and monitoring of chronic conditions for people with serious mental illness. This population has been shown to be at higher risk of having the specified conditions and there is evidence of a disparity in access to evidence-based care for this population. The Committee agreed that there is sufficient evidence to support the focus of the measure, that there is a significant disparity as to how readily diabetics with SMI are able to access eye exams, and that managing the quality of diabetes care that is provided to this population is important. Upon clarification that the eye exam must be conducted by an eye care professional, and the Committee agreed the measure is clearly and precisely specified. The Committee agreed that sufficient validity and reliability testing results are presented to support the measure and the face validity results presented are acceptable. The Committee also found that the measure is feasible to report and is usable, and recommended the measure for endorsement.

2599: Alcohol Screening and Follow-up for People with Serious Mental Illness: Consensus Not Reached on Reliability and Feasibility

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); **Measure Type:** *Process;* **Level of Analysis:** *Health Plan;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Administrative claims, Electronic Clinical Data, Paper Medical Records*

This is a newly submitted measure for endorsement and will be used by the National Committee for Quality Assurance (NCQA) in their HEDIS program to assess Medicaid health plan performance. This measure is part of a group of health plan measures for patients with behavioral health conditions that assess prevention and monitoring for general medical conditions. In its review, the Committee expressed concerns about the measure's link to proven outcomes. There was also some disagreement about whether health plans should be held accountable for ensuring that patients ultimately receive follow-up care. The Committee also expressed concern that the measure was not tested in commercial health plans but rather in a variety of Medicaid and Medicare plans. Although the Committee ultimately recommended the measure for endorsement, it did not reach consensus on the reliability or validity of this measure. Comments on the measure's reliability and validity are encouraged during the Public and Member Commenting period. Public and Member commenting did not result in additional areas of consideration for the Committee.

Measure(s) Approved for Trial Use

2597: Substance Use Screening and Intervention Composite: Approved for Trial Use

Description: *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;* **Measure Type:** *Composite; Level of Analysis: Clinician : Group/Practice, Clinician : Individual;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient;* **Data Source:** *Electronic Clinical Data : Electronic Health Record*

- This is a new composite measure that was submitted to NQF as a trial eMeasure. Consequently, the Committee recommendations pertain to whether the measure is approved for trial use to undergo further testing and be re-submitted to NQF within three years for an evaluation of the measure's reliability and validity. The Committee evaluated each of the four major criteria, but, when voting on Scientific Acceptability, only voted on whether the measure specifications are precise. The measure was submitted as a composite area with four focus areas. The measure examines screening and brief intervention for tobacco use, alcohol use, illicit drug use and prescription drug abuse. The alcohol and tobacco components of the measure are also individually-endorsed NQF measures already in use. The Committee was in general agreement that the alcohol and tobacco components of the composite are well supported by the evidence. There was less agreement, however, about the drug components of the measure. The Committee questioned what precisely would be tested if the measure were approved for trial use along with whether each of the component areas would be tested separately. NQF clarified that a requirement for endorsement of composites is that each individual measure can be

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unpacked and evaluated and tested. The Committee ultimately felt that although there is a lack of evidence for specific components of the measure, the focus is important enough for it to move forward to be tested. The evidence exception was used and the Committee voted for the measure to move forward for testing as an approved trial eMeasure.

Measure(s) Not Recommended

0722 Pediatric Symptom Checklist (PSC)

Description: *The Pediatric Symptom Checklist (PSC) is a brief parent-report questionnaire that is used to assess overall psychosocial functioning in children from 3 to 18 years of age. Originally developed to be a screen that would allow pediatricians and other health professionals to identify children with poor overall functioning who were in need of further evaluation or referral, the PSC has seen such wide use in large systems that it has increasingly been used as a quality indicator and as an outcome measure to assess changes in functioning over time. In addition to the original 35 item parent report form of the PSC in English, there are now many other validated forms including translations of the original form into about two dozen other languages, a youth self-report, a pictorial version, and a briefer 17 item version for both the parent and youth forms;* **Measure Type:** *Outcome;* **Level of Analysis:** *Population : Community, Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Population : National, Population : Regional, Population : State, Clinician : Team;* **Setting of Care:** *Ambulatory Care : Clinician Office/Clinic, Emergency Medical Services/Ambulance, Home Health, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Urgent Care;* **Data Source:** *Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Patient Reported Data/Survey*

This measure was originally endorsed in 2011 and is specified at the hospital and clinician levels. The measure is currently used in the CMS Physician Quality Reporting System (PQRS) program and is also used by the National Committee for Quality Assurance (NCQA) in its HEDIS program to assess Medicaid health plan performance. The committee expressed concerns that at this time, the United States Preventive Services Task Force (USPSTF) has not found there to be sufficient evidence to recommend routine global psychosocial screening; however, the committee did agree that psychosocial problems in children are common but underecognized and undertreated. While the committee acknowledged that this was an important measure, it was not possible to determine if the measure was reliable in its current state. The committee strongly recommended that the developer bring back the measure once the four aspects of the measure were broken up into four different measures as part of a composite or paired together so each measure could be evaluated separately. This measure was not recommended for endorsement. The Committee was asked to reconsider their previous recommendation based on public comment of the measure and the following knowledge: 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 Committee stood by their decision to not recommend this measure and encouraged the developer to resubmit when suggested changes have been made.

Appendix A: Details of Measure Evaluation

Measures Recommended

Measures Approved for Trial Use

Measures Not Recommended

Measures Deferred

Measures Recommended

Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable; Y=Yes; N=No

0710 Depression Remission at Twelve Months

Submission | Specifications

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.

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

0710 Depression Remission at Twelve Months
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 will discuss 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.
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 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 | Specifications
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

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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: <u>The measure meets the Importance criteria</u>

(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**

<u>Rationale</u>:

- The Committee noted that this measure is nearly identical to measure #0712; 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.
- 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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)

0711 Depression Remission at Six Months

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.

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 will discuss 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.*

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 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 | Specifications

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

0712 Depression Utilization of the PHQ-9 Tool

STANDING COMMITTEE MEETING- October 1-2, 2014

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

(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**

<u>Rationale</u>:

- 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: <u>The measure meets the Scientific Acceptability criteria</u>

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

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

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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.

0712 Depression Utilization of the PHQ-9 Tool

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 will discuss 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 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*.

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 | Specifications

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.
- Committee members also questioned the linkage between screening and improved outcomes. The

1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
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: <u>Consensus Not Reached</u> (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** <u>Rationale</u>:, • 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 explained that 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 future the measure be characterized as a screening measure. • Ultimately, the Committee did not reach consensus on the validity of the measure. Comments are encouraged to be submitted during the Public and Member Commenting period on the validity 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)* <u>Rationale</u>: • The Committee agreed the measure is feasible; however, it was noted that the Workgroup 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 EHRs. • 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)* <u>Rationale</u>: • The Committee noted that the measure is in use; performance data is not yet available.
5. Related and Competing Measures • No related or competing measures noted.
Standing Committee Recommendation for Endorsement: **Y-15**; **N-9**
6. Public and Member Comment • <u>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</u>

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

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 | Specifications

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.

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 that the measure addresses just one aspect of ADHD care, follow-up visits with providers, and its focus is on monitoring potential side effects and responses to medication.

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
• 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: <u>The measure meets the Scientific Acceptability criteria</u> (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** <u>Rationale</u>: • 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 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)* <u>Rationale</u>: • The Committee agreed that the data is 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)* <u>Rationale</u>: • 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 that 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.

0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
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: Thank you. 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 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 | Specifications
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

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

(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**

<u>Rationale</u>:

- 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 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 how substance use treatment is paid for. 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, that 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: <u>Consensus Not Reached</u>

(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**

<u>Rationale</u>:

- 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 within.
- The developer also confirmed that 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. Comments on the measure's reliability are encouraged during the Public and Member Commenting period.

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)

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- The Committee expressed some concern about the ability of the health plan to influence outcomes for this measure.

2599 Alcohol Screening and Follow-up for People with Serious Mental Illness

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 will discuss related measures on its January 8, 2015 post-comment call

- 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.

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: Thank you. 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 | Specifications

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.

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

2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
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: <u>The measure meets the Importance criteria</u>** (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** <u>Rationale</u>: • 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 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.

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- 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)

Rationale:

- 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)

Rationale:

- 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 will discuss related measures on its January 8, 2015 post-comment call.

- *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# 2599:* 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.

Standing Committee Recommendation for Endorsement: **Y-19**; **N-2**

6. Public and Member Comment

- 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

2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
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 | Specifications
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 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.
- 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

- 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)

2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness

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 will discuss 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.
- 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.

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: Thank you. 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

2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
8. Board of Directors Vote: Yes/No
9. Appeals

2602 Controlling High Blood Pressure for People with Serious Mental Illness
Submission | Specifications
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: <u>The measure meets the Importance criteria</u>** (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** <u>Rationale</u>: • 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: <u>The measure meets the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-9**; **M-7**; **L-6**; **I-4** 2b. Validity: **H-9**; **M-8**; **L-4**; **I-2**

2602 Controlling High Blood Pressure for People with Serious Mental Illness

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 will discuss 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.

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

2602 Controlling High Blood Pressure for People with Serious Mental Illness

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: Thank you. 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 | Specifications

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 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

2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing

(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, 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

2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
Committee will discuss 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.
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: Thank you. 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

2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
Submission | Specifications
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:

2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy

-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: <u>The measure meets the Importance criteria</u>

(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-0**

<u>Rationale</u>:

- 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<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-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)

<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.

2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
• 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.
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 will discuss 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.
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: Thank you. 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 | Specifications

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

(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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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 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)

<u>Rationale</u>:

- 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)

<u>Rationale</u>:

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

- 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 | Specifications

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.

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
-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: <u>The measure meets the Importance criteria</u>** (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** <u>Rationale</u>: • 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. • 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

2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
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)* 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 #0061 Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg) as it is adapted from this existing general population measure. The Committee will discuss 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.
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: Thank you. 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 | Specifications

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.

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)

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

2a. Reliability: **H-13**; **M-8**; **L-2**; **I-0** 2b. Validity: **H-10**; **M-10**; **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, 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 will discuss 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 issues.

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

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

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

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING - October 1-2, 2014

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

(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**

<u>Rationale</u>:

- 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<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-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)

<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-11; M-6; 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 #0575 Comprehensive Diabetes

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

Care: Hemoglobin A1c (HbA1c) Control (<8.0%)as it is adapted from this existing general population measure. The Committee will discuss 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.

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: Thank you. 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.
- 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 | Specifications

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.

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

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:

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: <u>The measure meets the Importance criteria</u>

(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**

<u>Rationale</u>:

- 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: <u>The measure meets the Scientific Acceptability criteria</u>

(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**

<u>Rationale</u>:

- 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:

- 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 will discuss 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.

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: Thank you. 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.
- The developer further responded with: Thank you. 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

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

Measures Approved for Trial Use

2597 Substance Use Screening and Intervention Composite

Submission | Specifications

Description: 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

Numerator Statement: Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results:

Tobacco use component

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

Unhealthy alcohol use component

Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

Drug use component (nonmedical prescription drug use and illicit drug use)

Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user

Denominator Statement: All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period

Exclusions: Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)

Adjustment/Stratification:

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

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

Type of Measure: Composite

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

Measure Steward: American Society of Addiction Medicine

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-3**; **M-5**; **L-0**; **I-0; IE-13**; 1b. Performance Gap: **H-17**; **M-5**; **L-0**; **I-0;** 1c. Impact: **H-20**; **M-2**; **L-0**; **I-0;** 1d. Composite: **H-8**; **M-9**; **L-3**; **I-2**

Rationale:

- This measure was submitted as a trial eMeasure. Any Committee recommendations relate to whether the measure is recommended to undergo further testing and be re-submitted within three years to NQF for an evaluation of the measure's reliability and validity. In the meantime, the measure will not be used in accountability applications. The Committee evaluated each of the four major criteria, but, when voting on Scientific Acceptability, only voted on whether the measure specifications are precise.
- The measure was submitted as a composite area with four focus areas: tobacco use, unhealthy alcohol use, and illicit drug use and prescription drug abuse. The alcohol and tobacco components of the composite are existing NQF-endorsed measures.
- The Committee agreed that the tobacco and alcohol screening components of the measure are well supported by the evidence. There was less agreement about the drug components, which are mostly untested and have not been recommended by the USPSTF. In addition, two recent studies in JAMA have indicated that the screening and intervention tool for drug use are not only untested, but in not effective. One Committee member noted that the recent JAMA article involved a 40 percent homeless population, which is not the focus population of this measure. Therefore the study should not be weighed as heavily against the measure.

2597 Substance Use Screening and Intervention Composite

- The Committee requested clarification on the extent and purpose of the proposed testing and asked specifically if the developers hoped to assess the efficacy of brief interventions through the metric. The developer indicated they do intend to assess efficacy by looking at utilization of substances for each specific measure component after intervention; and also wanted to gain an understanding of wide scale implementation and consistency of evaluations.
- The Committee expressed concern that the inclusion of the drug components could add additional burden and confusion in the reporting of the measure and could result in a negative effect on tobacco and alcohol screening. The developer explained that each component of the measure is able to be assessed separately even though the measure is presented as a composite.
- The measure allows for either a counseling session or pharmacotherapy; the Committee stressed that the evidence indicates the combination of both is most effective. The Committee further noted that the measure specifications are relatively vague and could more explicitly require both counseling and pharmacotherapy. The developer explained that trying to over-specify the brief intervention could potentially be a problematic given the significant heterogeneity that exists within practice styles and approaches. As currently specified, the measure allows for flexibility in using the measure.
- There was also discussion around the use of EHR to understand requirements of both the screening and brief intervention components. Concern was expressed about the ability to glean such information from various EHRS in a consistent format allowing comparability. The developers and members indicated EHR developers have been able to adapt to the specific requirements and procedure codes are used where available.
- The Committee ultimately agreed that, although there is a lack of evidence for specific components of the measure the benefits of the measure outweigh potential harms. The Committee exercised the evidence exception, agreeing that the measure focus is important enough for it to move forward as a trial eMeasure to be tested.
- The Committee asked the developer to be sure to update future submissions to reflect current evidence; it was noted that what was written in the submission did not reflect verbal updates on evidence translation.
- The Committee agreed there is an opportunity for improvement and that the measure addresses a high priority.

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: **Reliability is not voted on for trial eMeasures.** 2b. Validity: **Validity is not voted on for trial eMeasures.**

Specifications: **H-4**; **M-16**; **L-0**; **I-2**

Rationale:

- The Committee questioned what precisely would be tested if the measure were approved for trial use. The developer explained that the screening piece is not the aspect of the measure being directly tested as there is already knowledge that screening and referral and the treatment for drug use has a significant high impact. Instead, the aspects being tested are: (1) whether this eMeasure measure is implementable and usable and consistently valid within larger-scale systems and (2) whether the measure contributes to improved outcomes and/or have efficacy.
- One Committee member questioned whether each of the component areas would be tested separately. NQF clarified that a requirement for endorsement of composites is that each individual measure can be unpacked and evaluated and tested.
- Committee members questioned whether the interventions must be provided by a billable provider. The developer explained that the measure does *not* need to be met by a billable provider. The developer also confirmed that the brief intervention does not have to happen on the same day of the screen, only within the specified 24-month period. Because this measure is specified at the individual clinician level, the visits would have to be with the same provider.

3. Feasibility: H-4; M-14; 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:

2597 Substance Use Screening and Intervention Composite

- The Committee agreed the measure is feasible to collect and report.

4. Use and Usability: H-10; M-9; L-1; I-2

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

Rationale:

- The Committee expressed confusion as to how this measure would ultimately be reported. The developer clarified that it would include those who are screened and are negative as well as those who are positive and have appropriate follow up. The developer explained if that there are different rates of substance use in the underlying population, it would be challenging to control for this different prevalence. For instance, during an evaluation of the quality of health services in the Veteran's Administration (VA), the VA performed well on most measures because in the population that was studied, there was a 23 percent prevalence of substance abuse (compared to much lower percentages in the general population). The developer argued that if any system says very few members of its population have a use problem, it is not screening well. As reported, the measure will include the percentage of people who screen positive and contribute to the ability to benchmark performance.
- Members expressed concerns about the potential burden of the measure.

5. Related and Competing Measures

This measure was identified by NQF staff as relating to measures NQF # 2599: Alcohol Screening & Follow-Up for People with SMI and NQF # 2600: Tobacco Use Screening & Follow-Up for People with SMI. The Committee will discuss related measures on its January 8, 2015 post-comment call. The Committee will discuss related measures on its January 8, 2015 post-comment call

- Description NQF# 2599: 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.
- 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.

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 the strength of the evidence provided by the developer. The developer responded with: Measure 2597 is intended to promote screening and intervention for abuse of several categories of substances, including tobacco, alcohol, and drugs. Because many patients will not self-identify or have not yet developed detectable problems associated with substance use, screening can identify patients for whom intervention may be indicated. Brief motivational counseling (and pharmacotherapy for tobacco use) for these various substances has been shown to be an effective treatment for reducing problem use, particularly in primary care settings. Rather than encourage providers to screen for just one of these categories of abuse, this measure instead encourages a more comprehensive screening and accompanying intervention. The composite measure does not, however, mitigate the importance of the individual component measures – two of which are existing NQF endorsed measures. Performance on each individual component of the composite measure should be reported. The component measures within the composite each look independently at the percent of patients screened and provided the brief intervention or counseling. The composite then aggregates the component outcome data using an opportunity-based composite scoring approach where each component contributes equally to the composite outcome. As it was designed, the measure focuses on reporting and monitoring of each component separately, while also giving an overall picture of performance at the composite level.
  Regarding the evidence to support the component measure on drug use screening and brief counseling, we offer the following information in response to the noted concerns.

2597 Substance Use Screening and Intervention Composite

Regarding the USPSTF evidence review
A current recommendation statement from the USPSTF states that "current evidence is insufficient to assess the balance of benefits and harms of screening adolescents, adults, and pregnant women for illicit drug use."1 This statement is somewhat outdated given that it is based on a 2008 systematic evidence review conducted for the USPSTF. This systematic review noted that all but one study available addressing illicit drug use treatment (including brief interventions) utilized treatment-seeking patients as their target population, which differs from the asymptomatic, primary-care target population of the measure. The review did include one trial which recruited patients through screening an asymptomatic, outpatient population for drug use. This randomized-controlled trial by Bernstein et al. provided evidence that a brief intervention decreases drug misuse in these patients. Additionally, the systematic evidence review focused exclusively on screening for illicit drug use and did not address issues related to screening for non-medical prescription drug use. At the time of the review, there was no evidence addressing the effectiveness of screening and brief counseling in reducing non-medical use of prescription drugs. The review authors state that misuse of prescription medication is a significant public health issue and that it should be considered in future USPSTF updates for drug use screening.
Regarding the recent JAMA articles by Saitz and Roy-Byrne
We believe the formal SAMHSA response to the recent publications as provided below summarizes the key issues with the studies and highlights the importance of screening and brief interventions for primary care patients. There are many benefits to universal screening including the detection of current medical problems related to at-risk alcohol and other drug use at an early stage before they result in more serious disease or other health problems, the detection of alcohol and other drug use patterns that can increase future injury or illness risks, and the opportunity to intervene and educate patients about at-risk alcohol and other drug use, making use of physicians' 'teachable moment' to reach patients in primary care settings. It is imperative to include brief standardized and validated substance use screening questions in electronic health record (EHRs) systems to facilitate screening and intervention in primary care settings. Drug and alcohol use contribute to or exacerbate numerous commonly co-occurring health conditions both by direct effects of the drug on health as well as by patients' risk of poor medication adherence for treatment of other conditions. Furthermore, treatment of substance abuse serves also to reduce risky behaviors (unsafe sex; injection drug use) that contribute to the transmission of HIV and other sexually transmitted infections (STIs).
SAMHSA's responds to recent publications in JAMA (available at: http://worldofsbirt.wordpress.com/2014/08/19/samhsa-responds-to-recent-publications-in-jama/)
Most likely many of you are familiar with the recently published studies on SBIRT published in the Journal of the American Medical Association (JAMA). Although these studies contain some very solid research data, their focus does not do justice to the benefits SBIRT brings to behavioral health. SAMHSA believes these two papers are of substantial interest. However, it is important to look at the papers from the proper perspective.
Both papers focused on the Brief Intervention (BI) part of SBIRT, not the Screening part and not the referral to treatment (RT) part. These two studies were well done and elaborate. However, the value of SBIRT could not be challenged by either study. Furthermore, the value of SBIRT to behavioral health and primary care providers is the ability of SBIRT to identify when a patient is in need. When patients have chronic medical problems, there are multiple opportunities to address the issue of substance use. Roy-Byrne noted the majority of his participants had a single brief intervention contact, with only 47% receiving a follow-up booster call. Saitz reported a single session approach for his two test conditions. During the 11 years since SAMHSA's SBIRT program has been in existence, over 2 million people have been screened. Of those, only a small percentage screened positive for any "at risk" behaviors, with about 11 percent of those screened receiving a brief intervention. Without screening many of these people might have remained invisible. SBIRT gives providers and primary care physicians an opportunity to identify potential alcohol and substance misuse or abuse and, through brief intervention, an opportunity to use that "teachable moment" to educate patients and, potentially, change the behavior of "at risk" individuals for the better.
Roy-Byrne's title "Brief Intervention for Problem Drug Use in Safety-Net Primary Care Settings" really is applicable to both papers. Ninety-one percent of Roy-Byrne's participants were unemployed, while 81% of Saitz participants were on Medicaid or Medicare. Fifty-six percent of Roy-Byrne's participants had greater than one ICD-9 Mental Illness code, while 46% of Saitz's participants had a co-morbid mood

disorder. Saitz required his participants to have an ASSIST score of greater than 4 in order to participate. That is understandable, since the World Health Organization (WHO) recommends that an ASSIST score of 4 to 26 should result in brief intervention and a score of 27+ should result in more intensive treatment.

It is important to remember brief intervention does not work for everyone. For many, learning the consequences of their "at risk" behavior or abuse can provide the wake-up call they need to either stop using or seek appropriate treatment. For individuals with more severe and complex substance use disorders, brief intervention will most likely not be sufficient to change their behaviors. For this group it is important that a treatment referral be made.

When dealing with complex patients with complex problems, is it reasonable to expect BI to "cure" the substance use disorder? No. The question for SBIRT is whether it is feasible to screen for drug use disorders in primary care, just as it is feasible to screen for alcohol use disorders. Both papers implicitly say "Yes." Thus, if it is feasible, the next question is whether it should be done. We believe that if we are to promote integrated treatment, primary care providers (PCPs) must have the basic skills necessary to identify SUDs in primary care settings. SAMHSA's SBIRT program accomplishes this. SBIRT is not a panacea, it is an important process that can help primary care providers identify alcohol and drug use problems. We have to wait for research on more representative populations to determine whether BI works.

Additional detail added to NQF's evidence form

We have taken a closer look at the literature and in addition to the 3 articles cited in 1a.8.2., we have offered additional articles and detail for the committee's consideration as described below:

1. InSight Project Research Group. SBIRT outcomes in Houston: Final report on InSight a hospital district-based program for patients at risk for alcohol or drug use problems. Alcoholism: Clin and Exper Res 2009;33: 1374-81.

Description: A study of SBI implementation in the Harris County Hospital District in Houston, Texas examined changes in adult patient drug use from intake to 6-month follow-up.

Results: Of almost 60,000 patients screened by generalists during routine patient encounters, 26 percent were positive and received further assessment (ie, use of a systematic screening instrument to determine severity of alcohol and drug use) and services including a brief intervention. Almost 1300 patients were followed for 6-months, among whom the number of patients reporting any days of drug use decreased from 82% at intake to 33% at follow-up, and the mean number of days of drug use declined from 8.3 days at intake to 4.2 days at follow-up.

Impact on conclusions for systematic review: The results were consistent with but of greater magnitude than most other studies reporting positive outcomes for SBIRT patients. Drug use and heavy alcohol use were found to decrease substantially from admission to follow-up. This finding holds good for all levels of drug or alcohol misuse severity, with the highest severity patients showing the largest decreases.

2. Gelberg L, Andersen RM, Leake B, Arangua L, Vahidi M, Singleton K, et al. Project quit: a primary care based screening and brief intervention efficacy trial to reduce risky drug use. Poster Session Presented at: Comprehensive and Coordinated Prevention Systems-Building Partnerships and Transcending Boundaries. 22nd Annual Conference of Society of Prevention Research, Washington, DC (2014). Available from: http://spr.confex.com/spr/spr2014/webprogram/Paper21817.html NOTE: This randomized controlled trial's journal article publication is pending and expected to be published soon.

Description: A randomized-controlled trial to determine whether a brief (<5 minutes) intervention delivered by primary care clinicians can reduce drug use days more in an intervention group compared to a control group of risky (nondependent) drug users. Adult patients were screened for drug use using the WHO ASSIST on an electronic Tablet. Subjects with "at risk" (4-26) scores were invited to participate based on their highest scoring risky drug (HSD).

Results: 334 patients enrolled in the trial (171 intervention; 163 control condition). Three month follow-up surveys were completed by 261 patients (78%). The average reduction in HSD drug use days was 3.9 days higher ($p < 0.001$) in the intervention than in the control group, after adjustment for clinic, baseline HSD use, and time between assessments. The intervention effect was stronger in patients with high baseline HSD use (6.6 days greater reduction, P<.001) and also stronger with 2 than with 0-1 telephone reinforcement sessions (p<.001).

Impact on conclusions for systematic review: This study demonstrates the efficacy of screening and brief intervention for risky drug use in the primary care setting.

2597 Substance Use Screening and Intervention Composite
We also included detail regarding the one study from the USPSTF evidence review that did not use treatment-seeking patients as their target population. This randomized-controlled trial by Bernstein et al. provided evidence that a brief intervention decreases drug misuse in screened, asymptomatic individuals. Reference: Bernstein J, Bernstein E, Tassiopoulos K, Heeren T, Levenson S, Hingson R. Brief motivational intervention at a clinic visit reduces cocaine and heroin use. Drug Alcohol Depend 2005; 77(1):49-59.
7. Consensus Standards Approval Committee (CSAC) Vote: Y-X; N-X; A-X
8. Board of Directors Vote: Yes/No
9. Appeals

Measures Not Recommended

0722 Pediatric Symptom Checklist (PSC)
Submission | Specifications
Description: The Pediatric Symptom Checklist (PSC) is a brief parent-report questionnaire that is used to assess overall psychosocial functioning in children from 3 to 18 years of age. Originally developed to be a screen that would allow pediatricians and other health professionals to identify children with poor overall functioning who were in need of further evaluation or referral, the PSC has seen such wide use in large systems that it has increasingly been used as a quality indicator and as an outcome measure to assess changes in functioning over time. In addition to the original 35 item parent report form of the PSC in English, there are now many other validated forms including translations of the original form into about two dozen other languages, a youth self-report, a pictorial version, and a briefer 17 item version for both the parent and youth forms. **Numerator Statement**: The PSC is an outcome and a process measure. In the Numerator Statement and in the sections that follow we will delineate specifications for two different meanings of each of these uses of the PSC. i. The PSC is an "OUTCOME MEASURE OF PSYCHOSOCIAL PROBLEM PREVALENCE" Number of children aged 3-18 with an initial positive PSC screen for psychosocial problems (cutoff is >23 for ages 3-5 and >27 for ages 6-18). ii. The PSC is an "OUTCOME MEASURE OF PROBLEM REMISSION/IMPROVEMENT" Number of children aged 3-18 with an initial positive PSC screen for psychosocial problems who screen negative on the PSC at their next well child visit; or, more precisely, the number of children aged 3-18 with an initial positive PSC screen for psychosocial problems who show a clinically significant improvement (reliable change of six or more points and screen negative at their next well child visit). iii. The PSC is a "PROCESS MEASURE OF WHETHER SCREENING HAS TAKEN PLACE" Children aged 3-18 who had documentation of screening with the PSC or another approved, standardized instrument. iv. The PSC is a "PROCESS MEASURE OF WHETHER FOLLOW-UP HAS OCCURRED FOR PATIENTS WITH A POSITIVE SCREEN" Children aged 3-18 with a positive screening on the PSC or another standardized psychosocial measure who had a follow up visit with a behavioral health provider within 90 days. **Denominator Statement**: i. Number of children aged 3-18 receiving a well child visit. ii. Number of children aged 3-18 with an initial positive screening on PSC at their annual well child visit who were seen for a subsequent well child visit and rescreened with the PSC. iii. Number of children aged 3-18 seen for a well child visit in the given measurement year. iv. Number of children aged 3-18 who had screened positive for a psychosocial problem during a well child visit. **Exclusions**: Children aged 3.0 to 17.99 who did not have a well-child visit during the measurement period. **Adjustment/Stratification**: **Level of Analysis:** Population : Community, Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Population : National, Population : Regional, Population : State, Clinician : Team

0722 Pediatric Symptom Checklist (PSC)
Setting of Care: Ambulatory Care : Clinician Office/Clinic, Emergency Medical Services/Ambulance, Home Health, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Urgent Care **Type of Measure**: Outcome **Data Source**: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Patient Reported Data/Survey **Measure Steward**:Massachusetts General Hospital
STANDING COMMITTEE MEETING - October 1-2, 2014 **1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>** (1a. Evidence: 1b. Performance Gap, 1c. High Priority) 1a. Evidence: **H-16**; **M-7**; **L-0; I-0; IE-0** 1b. Performance Gap: **H-19**; **M-3**; **L-1**; **I-0** 1c. High Priority: **H-20**; **M-3**; **L-0**; **I-0** <u>Rationale</u>: • The Committee expressed concerns that at this time, the United States Preventive Services Task Force (USPSTF) has not found there is sufficient evidence to recommend routine global psychosocial screening. Committee members questioned whether routine screening improves outcomes, including reduced scores for psychosocial problems over time and improved functioning. The developer noted that new evidence has recently emerged showing a stronger link between screening, identification of individuals who need treatment, and improved outcomes. • The Committee agreed that psychosocial problems in children are common but underecognized and undertreated. Screening has lead to early identification of psychosocial problems and could result in earlier or better treatment and therefore fewer mental, emotional and behavioral disorders, which, in turn, could lead to better life outcomes for individuals who are screened and served. • The committee determined there is a performance gap on two levels: (1) psychosocial problems are prevalent in 12 percent of the 3-18 year old population, unrecognized greater than 50 percent of the time and only treated less than 33 percent of the time, and (2), there is a need for behavioral health measures that focus on children.
2. Scientific Acceptability of Measure Properties: <u>The measure does not meet the Scientific Acceptability criteria</u> (2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity) 2a. Reliability: **H-1**; **M-4**; **L-3**; **I-15** <u>Rationale</u>: • While the Committee acknowledged that this measure addresses and important area, the Committee did not agree the measure is reliable in its current state. The Committee strongly recommended that the developer bring the measure back once the four aspects of the measure are broken up into four different measures as part of a composite or paired together so that each component can be evaluated separately.

Measures Deferred

The following measures submitted for the Standing Committee's review during the project have been deferred for future consideration:

Measure	Reason for deferral
2620 Multidimensional Mental Health Screening Assessment	Measure will undergo additional testing and be re-submitted to a later phase of work.

Appendix B: NQF Behavioral Health Portfolio

NQF Number	Measure Title
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement
0027	Medical Assistance With Smoking Cessation
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0104	Major Depressive Disorder: Suicide Risk Assessment
0105	New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
0418	Screening for Clinical Depression
0518	Depression Assessment Conducted
0557	HBIPS-6 Post discharge continuing care plan created
0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
0560	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification
0576	Follow-Up After Hospitalization for Mental Illness
0640	HBIPS-2 Hours of physical restraint use
0641	HBIPS-3 Hours of seclusion use
0710	Depression Remission at Twelve Months
0711	Depression Remission at Six Months
0712	Depression Utilization of the PHQ-9 Tool
0722	Pediatric Symptom Checklist (PSC)
1364	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
1651	TOB-1 Tobacco Use Screening

NQF Number	Measure Title
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
1661	SUB-1 Alcohol Use Screening
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge
1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
1884	Depression Response at Six Months- Progress Towards Remission
1885	Depression Response at Twelve Months- Progress Towards Remission
1922	HBIPS-1 Admission Screening
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
1937	Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Appendix C: Behavioral Health Portfolio—Use in Federal Programs

NQF Number	Measure Title	Federal Programs: Finalized as of November 11, 2014
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement	Dual Eligibles Core Quality Measures- Captiated Demonstrations Dual Eligibles Core Quality Measures- Managed Fee For Service Demonstrations Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)
0027	Medical Assistance With Smoking Cessation	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Meaningful Use (EHR Incentive Program) - Eligible Professionals Medicare Shared Savings Program Physician Quality Reporting System (PQRS)
0103	Major Depressive Disorder: Diagnostic Evaluation	Physician Feedback Physician Quality Reporting System (PQRS)
0104	Major Depressive Disorder: Suicide Risk Assessment	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Feedback Physician Quality Reporting System (PQRS)
0105	New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment	Dual Eligibles Core Quality Measures- Captiated Demonstrations Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Meaningful Use (EHR Incentive Program) - Eligible Professionals Medicare Part C Plan Rating Physician Feedback Physician Quality Reporting System (PQRS)
0108	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication.	Children's Health Insurance Program Reauthorization Act Quality Reporting Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)
0110	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)
0418	Screening for Clinical Depression	Dual Eligibles Core Quality Measures- Captiated Demonstrations Dual Eligibles Core Quality Measures- Managed Fee For Service Demonstrations Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Meaningful Use (EHR Incentive Program) - Eligible Professionals Medicare Shared Savings Program Physician Feedback Physician Quality Reporting System (PQRS)

NQF Number	Measure Title	Federal Programs: Finalized as of November 11, 2014
0518	Depression Assessment Conducted	Home Health Quality Reporting
0552	HBIPS-4: Patients discharged on multiple antipsychotic medications.	Inpatient Psychiatric Hospital Quality Reporting
0557	HBIPS-6 Post discharge continuing care plan created	Inpatient Psychiatric Hospital Quality Reporting
0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Inpatient Psychiatric Hospital Quality Reporting
0560	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	Inpatient Psychiatric Hospital Quality Reporting
0576	Follow-Up After Hospitalization for Mental Illness	Children's Health Insurance Program Reauthorization Act Quality Reporting Dual Eligibles Core Quality Measures- Captiated Demonstrations Dual Eligibles Core Quality Measures- Managed Fee For Service Demonstrations Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Inpatient Psychiatric Hospital Quality Reporting Medicare Part C Plan Rating
0640	HBIPS-2 Hours of physical restraint use	Inpatient Psychiatric Hospital Quality Reporting
0641	HBIPS-3 Hours of seclusion use	Inpatient Psychiatric Hospital Quality Reporting
0690	Percent of Residents Who Have Depressive Symptoms (Long-Stay)	Nursing Home Quality Initiative and Nursing Home Compare
0710	Depression Remission at Twelve Months	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)
0712	Depression Utilization of the PHQ-9 Tool	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)
1401	Maternal Depression Screening	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Quality Reporting System (PQRS)

Appendix D: Project Standing Committee and NQF Staff

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Appendix E: Measure Specifications

	0710 Depression Remission at Twelve Months
Status	Public and Member Commenting
Steward	MN Community Measurement
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.
Type	PRO
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records An excel template with formatted columns for data fields is provided. Please refer to the attached data dictionary for data field definitions. All data is uploaded in electronic format (.csv file) to a HIPAA secure, encrypted and password protected data portal. PROM The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at www.phqscreeners.com. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available. The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010] Available at measure-specific web page URL identified in S.1 Attachment MNCM_Depression_Measures_Data_Dictionary_and_Risk_Adj__6-18-2014-635397255382479839.xlsx
Level	Facility, Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	PHQ-9 scores are collected for each patient from the time they meet the inclusion criteria of diagnosis ICD-9 codes and PHQ-9 score greater than nine (this is the index or anchor date) until thirteen months have elapsed. This allows for calculation of a remission rate twelve months +/- 30 days from the index date.
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.
Numerator Details	This PROM-PM outcome measure is of a longitudinal nature, seeking to measure the absence of depression symptoms (remission) within twelve months for the patient with depression having an instance of elevated PHQ-9. The numerator is defined as patients with a twelve month (+/- 30 days) PHQ-9 score of less than five. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia with a PHQ-9 score < 5 at 12 months(+/- 30 days)/ # adult pts with major depression or dysthymia with index contact PHQ-9 > 9 Patients who do not have a twelve month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure.
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.

	0710 Depression Remission at Twelve Months
Denominator Details	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients who do not have a twelve month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure. Please refer to attached data dictionary for an inclusive list of all ICD-9/ ICD-10 codes and data element definitions.
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.
Exclusion details	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes in the attached data dictionary. •Personality Disorder (in any position). See personality disorder codes in the attached data dictionary. Our direct data submission process in MN allows for both up-front exclusions of the population and because this is a longitudinal outcome measure, processes are in place to allow exclusions that may occur after index during the course of the measurement period. Please see field specifications in the attached data dictionary.
Risk Adjustment	Stratification by risk category/subgroup Like its companion measure, # 0711 Depression Remission at Six Months, this measure could be risk adjusted based on severity of depression (initial PHQ-9 score of 10 to 14- moderate depression, 15 to 19- moderately severe depression and 20 to 27- severe depression), insurance product type (commercial, Medicare, and MN government programs/ self-insured) and age bands (18-25, 26-50, 51-65 and 66+). #0711 Depression Remission at Six Months was risk adjusted for inclusion in the MN Department of Health Statewide Quality Reporting and Measurement System. Depression Remission at Twelve Months was not a part of this strategy, but would use an identical model which is included in the Risk Adjustment attachments and in the measure testing appendices enclosed with this application. Depression Remission at Twelve months could be included in the future risk adjustment strategy discussed below. MN Community Measurement's Board of Directors has reviewed and discussed the issues surrounding risk adjustment of outcome data that is currently reported on our consumer facing public website at www.mnhealthscores.org and used in many health plan and state contracts for demonstrating excellence in outcomes. Historically, the Board has favored the public reporting of unadjusted rates determining that the wide variation in results for chronic disease measures were the result of variation in care process, rather than patient risk factors. As the breadth and complexity of the measures we are reporting have expanded and care processes and tools used by the community have become more standardized, the Board has convened a Risk Adjustment Task Force to evaluate methodologies for public reporting. Their preliminary recommendations indicate that publicly reported data should be risk adjusted

	0710 Depression Remission at Twelve Months
	using the "Actual to Expected" methodology, which would allow the unadjusted rate to be simultaneously preserved and displayed. Available in attached Excel or csv file at S.2b
Stratification	This measure is currently not stratified.
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is calculated by submitting a visit level file for the eligible patients, each record in the file represents a contact with the patient and PHQ-9 score associated with this contact. Data file is submitted to a HIPAA secure data portal. Programming within the data portal determines the starting point (index visit) and then calculates based on dates if a twelve month +/- 30 days PHQ-9 was obtained and the resulting score. Calculation logic: Is patient eligible for inclusion with diagnosis codes of either 296.2x, 296.3x or 300.4 and PHQ-9 > 9? If yes, mark the visit as index (anchor) and include this patient in the denominator. Does patient have a PHQ-9 score completed with a contact date that is twelve months +/- 30 days from the index date? If yes, include this score to calculate rate. Programming logic includes the most recent score within the +/- 30 day window. If no, patient is included in the denominator only. Not having a PHQ-9 score within the 60 day window is considered a numerator miss. If the patient does have a twelve month +/- 30 day PHQ-9 score is it less than five? If twelve month +/- 30 day PHQ-9 is less than five; is considered a numerator case for rate calculation. Available at measure-specific web page URL identified in S.1
Copyright / Disclaimer	5.1 Identified measures: 1885 : Depression Response at Twelve Months- Progress Towards Remission 1884 : Depression Response at Six Months- Progress Towards Remission 0712 : Depression Utilization of the PHQ-9 Tool 0711 : Depression Remission at Six Months 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response and use of the PQH-9. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the "gold standard" of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms. There are no other NQF endorsed measures that utilize a patient reported outcome tool to assess outcomes for patients with depression.

	0711 Depression Remission at Six Months
Status	Public and Member Commenting
Steward	MN Community Measurement
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.
Type	PRO
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records An excel template with formatted columns for data fields is provided. Please refer to the attached data dictionary for data field definitions. All data is uploaded in electronic format (.csv file) to a HIPAA secure, encrypted and password protected data portal. PROM The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at www.phqscreeners.com. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available. The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010] Available at measure-specific web page URL identified in S.1 Attachment MNCM_Depression_Measures_Data_Dictionary_and_Risk_Adj__6-18-2014.xlsx
Level	Facility, Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	PHQ-9 scores are collected for each patient from the time they meet the inclusion criteria of diagnosis ICD-9 codes and PHQ-9 score greater than nine (this is the index or anchor date) until seven months have elapsed. This allows for calculation of a remission rate +/- 30 days from the index date.
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.
Numerator Details	This PROM-PM outcome measure is of a longitudinal nature, seeking to measure the absence of depression symptoms (remission) within six months for the patient with depression having an instance of elevated PHQ-9. The numerator is defined as patients with a six month (+/- 30 days) PHQ-9 score of less than five. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia with a PHQ-9 score < 5 at 6 months(+/- 30 days)/ # adult pts with major depression or dysthymia with index contact PHQ-9 > 9 Patients who do not have a six month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure.
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.

	0711 Depression Remission at Six Months
Denominator Details	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients who do not have a six month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure. Please refer to attached data dictionary for an inclusive list of all ICD-9/ ICD-10 codes and data element definitions.
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.
Exclusion details	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes in the attached data dictionary. •Personality Disorder (in any position). See personality disorder codes in the attached data dictionary. Our direct data submission process in MN allows for both up-front exclusions of the population and because this is a longitudinal outcome measure, processes are in place to allow exclusions that may occur after index during the course of the measurement period. Please see field specifications in the attached data dictionary.
Risk Adjustment	Stratification by risk category/subgroup This measure is risk adjusted based on severity band of the PHQ-9 which is based on the initial PHQ-9 score. Severity bands are defined as 10 to 14- moderate depression, 15 to 19- moderately severe depression and 20 to 27- severe depression. The measures is also risk adjusted for insurance product type (commercial, Medicare, and MN government programs/ self-insured) and age bands (18-25, 26-50, 51-65 and 66+). Available in attached Excel or csv file at S.2b
Stratification	This measure is currently not stratified.
Type Score	Rate/proportion better quality = higher score

	0711 Depression Remission at Six Months
Algorithm	This measure is calculated by submitting a visit level file for the eligible patients, each record in the file represents a contact with the patient and PHQ-9 score associated with this contact. Data file is submitted to a HIPAA secure data portal. Programming within the data portal determines the starting point (index visit) and then calculates based on dates if a six month +/- 30 days PHQ-9 was obtained and the resulting score. Calculation logic: Is patient eligible for inclusion with diagnosis codes of either 296.2x, 296.3x or 300.4 and PHQ-9 > 9? If yes, mark the visit as index (anchor) and include this patient in the denominator. Does patient have a PHQ-9 score completed with a contact date that is +/- 30 days from the index date? If yes, include this score to calculate rate. Programming logic includes the most recent score within the +/- 30 day window. If no, patient is included in the denominator only. Not having a PHQ-9 score within the 60 day window is considered a numerator miss. If the patient does have a six month +/- 30 day PHQ-9 score is it less than five? If six month +/- 30 day PHQ-9 is less than five; is considered a numerator case for rate calculation. Available at measure-specific web page URL identified in S.1
Copyright / Disclaimer	5.1 Identified measures: 0712 : Depression Utilization of the PHQ-9 Tool 1885 : Depression Response at Twelve Months- Progress Towards Remission 1884 : Depression Response at Six Months- Progress Towards Remission 0710 : Depression Remission at Twelve Months 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response and use of the PQH-9. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the “gold standard” of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms. There are no other NQF endorsed measures that utilize a patient reported outcome tool to assess outcomes for patients with depression.

	0712 Depression Utilization of the PHQ-9 Tool
Status	Public and Member Commenting
Steward	MN Community Measurement
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.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records PROM The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at www.phqscreeners.com. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available. The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010] Available at measure-specific web page URL identified in S.1 Attachment MNCM_Depression_Measures_Data_Dictionary_6-18-2014-635398339200168900.xlsx
Level	Facility, Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Adult patients age 18 and older with the diagnosis of major depression or dysthymia who are either seen in the office or contacted via another method (phone, email) during a four month time period defined by dates of service that fall into that time period, for example 6/1/2013 to 9/30/2013 and have a documented PHQ-9 tool administered as evidenced by at least one PHQ-9 score during that same time period.
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.
Numerator Details	Patients with the diagnosis of depression or dysthymia, regardless of severity of PHQ-9 score, have been administered the PHQ-9 tool at least once during the four month time period in which a visit or contact with the patient has occurred. Rate calculation as follows: Adult patients administered PHQ-9 tool > one time (numerator) All patients with major depression or dysthymia with a visit/ encounter/ contact during the measurement period (denominator)
Denominator Statement	Adult patients age 18 and older with the diagnosis of major depression or dysthymia.
Denominator Details	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may

	0712 Depression Utilization of the PHQ-9 Tool
	have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients with the above diagnosis codes who are either seen in the office or contacted via another method (phone, email) during a four month time period defined by dates of service that fall into that time period, for example 6/1/2013 to 9/30/2013.
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.
Exclusion details	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes in the attached data dictionary. •Personality Disorder (in any position). See personality disorder codes in the attached data dictionary. Our direct data submission process in MN allows for both up-front exclusions of the population and because this is a longitudinal outcome measure, processes are in place to allow exclusions that may occur after index during the course of the measurement period. Please see field specifications in the attached data dictionary.
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment necessary.
Stratification	Stratification is not applicable for this process/ PRO based measure.
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is calculated by submitting a count of patients for the denominator and a count of patients in the numerator to a HIPAA secure data portal as part of the process in uploading a detailed patient file to calculate the six and twelve month remission outcome rates. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia (296.2x, 296.3x or 300.4) with at least one PHQ-9 tool administered during the four month measurement period/ # adult pts with major depression or dysthymia (296.2x, 296.3x or 300.4) Query processes that medical groups follow to obtain counts: During the four month measurement period (e.g. dates of service 6/1/2013 to 9/30/2013) how many patients had an office visit or other contact (phone, email) and diagnosis codes for major depression or dysthymia? (296.2x, 296.3x or 300.4). (denominator) Of these patients, how many had a PHQ-9 tool administered? (numerator) The counting process is validated during the denominator certification process (where groups document all steps in identifying the depression population). Groups are asked to describe the process they use for obtaining the counts. Denominator documents are reviewed (certified) by MNCM staff prior to data collection and submission. This is to insure that all groups are identifying their population correctly. Available at measure-specific web page URL identified in S.1
Copyright / Disclaimer	5.1 Identified measures: 1885 : Depression Response at Twelve Months- Progress Towards Remission 1884 : Depression Response at Six Months- Progress Towards Remission 0711 : Depression Remission at Six Months 0710 : Depression Remission at Twelve Months 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact:

	0712 Depression Utilization of the PHQ-9 Tool
	5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response that are PAIRED with this process measure. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the "gold standard" of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms.

	0722 Pediatric Symptom Checklist (PSC)
Status	Public and Member Commenting
Steward	Massachusetts General Hospital
Description	The Pediatric Symptom Checklist (PSC) is a brief parent-report questionnaire that is used to assess overall psychosocial functioning in children from 3 to 18 years of age. Originally developed to be a screen that would allow pediatricians and other health professionals to identify children with poor overall functioning who were in need of further evaluation or referral, the PSC has seen such wide use in large systems that it has increasingly been used as a quality indicator and as an outcome measure to assess changes in functioning over time. In addition to the original 35 item parent report form of the PSC in English, there are now many other validated forms including translations of the original form into about two dozen other languages, a youth self-report, a pictorial version, and a briefer 17 item version for both the parent and youth forms.
Type	Outcome
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Management Data, Paper Medical Records, Patient Reported Data/Survey The PSC can be collected via paper forms, software (CHADIS), internet (CNS Vital Signs, MGH Patient Gateway); digital pens/software (FusionForm), Electronic Health Record (Epic, Cerner, MGH LMR) as either free form text note, score in a field in a well child visit template or flowsheet for lab data or vitals, or a scanned PDF; telephone voice administration (Minnesota Somali form), billing records (CPT code 96110) with modifiers to indicate positive vs negative screen (U2 vs U1) in the Commonwealth of Massachusetts and BCBS of MA. Each of these sources keeps its own database. Available at measure-specific web page URL identified in S.1 No data dictionary
Level	Population : Community, Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual, Integrated Delivery System, Population : National, Population : Regional, Population : State, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Emergency Medical Services/Ambulance, Home Health, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Outpatient, Ambulatory Care : Urgent Care
Time Window	PSC scores are collected for each patient at the annual pediatric well child visit. Repeat administrations of the PSC can also occur at shorter or longer intervals. In the outpatient child psychiatry services at Massachusetts General Hospital the PSC is administered at intake and then every 3 months. In a national school based mental health program in Chile, the PSC is administered to students at intervals of 2 and 5 years (in preschool, 1st, 3rd, and 8th grades).
Numerator Statement	The PSC is an outcome and a process measure. In the Numerator Statement and in the sections that follow we will delineate specifications for two different meanings of each of these uses of the PSC. i. The PSC is an "OUTCOME MEASURE OF PSYCHOSOCIAL PROBLEM PREVALENCE" Number of children aged 3-18 with an initial positive PSC screen for psychosocial problems (cutoff is >23 for ages 3-5 and >27 for ages 6-18). ii. The PSC is an "OUTCOME MEASURE OF PROBLEM REMISSION/IMPROVEMENT" Number of children aged 3-18 with an initial positive PSC screen for psychosocial problems who screen negative on the PSC at their next well child visit; or, more precisely, the number of children aged 3-18 with an initial positive PSC screen for psychosocial problems who show a clinically significant improvement (reliable change of six or more points and screen negative at their next well child visit). iii. The PSC is a "PROCESS MEASURE OF WHETHER SCREENING HAS TAKEN PLACE" Children aged 3-18 who had documentation of screening with the PSC or another approved, standardized instrument. iv. The PSC is a "PROCESS MEASURE OF WHETHER FOLLOW-UP HAS OCCURRED FOR PATIENTS WITH A POSITIVE SCREEN"

	0722 Pediatric Symptom Checklist (PSC)
	Children aged 3-18 with a positive screening on the PSC or another standardized psychosocial measure who had a follow up visit with a behavioral health provider within 90 days.
Numerator Details	i. PSC score above predefined cutoff score; Modifier U2 given in conjunction with CPT code 96110; ii. PSC score below predefined cutoff score (or below cutoff score and -6+ points); Modifier U1 given in conjunction with CPT code 96110; iii. PSC score mentioned in note for well child visit; CPT code 96110 given on same day as well child visit (CPT 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395); iv. At least one CPT code for a mental health visit (90801-90829, 90846-90849, 90853, 90857, 90862, 90870,99058, 99212, 99241-99245) given within 3 months of an indication in the medical record of a positive screening or of CPT code 96110/U2.
Denominator Statement	i. Number of children aged 3-18 receiving a well child visit. ii. Number of children aged 3-18 with an initial positive screening on PSC at their annual well child visit who were seen for a subsequent well child visit and rescreened with the PSC. iii. Number of children aged 3-18 seen for a well child visit in the given measurement year. iv. Number of children aged 3-18 who had screened positive for a psychosocial problem during a well child visit.
Denominator Details	i. All children seen for well child visits (CPT codes for age groups infants through young adults, for new and established patients: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395); ii. All children who had an indication in their medical records of a positive screen on the PSC in previous well child visit who were seen for a subsequent well child visit; all children who had CPT code 96110/U2 in conjunction with previous well child visit who were seen for a subsequent well child visit; iii. All children seen for well child visits (CPT codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, 99395); iv. All children who had had an indication of a positive screening score on the PSC(or 96110/U2)in the previous well child visit with at least one CPT code for a mental health visit: 90801-90829, 90846-90849, 90853, 90857, 90862, 90870, 99058, 99212, 99241-99245 within 90 days of the well child visit.
Exclusions	Children aged 3.0 to 17.99 who did not have a well-child visit during the measurement period.
Exclusion details	N/A
Risk Adjustment	Other Risk-adjustment devised specifically for this measure/condition. We will collect the following variables for study for potential use in future risk adjustment for the PSC as both a screening tool and a delta measure of outcome: gender, socioeconomic status, race, ethnicity, primary language, psychiatric comorbidity, medical comorbidity and presence of externalizing behaviors.
Stratification	This measure is not currently stratified. We plan to take up the issue of stratification as a part of a planned renorming project.
Type Score	Categorical better quality = score within a defined interval
Algorithm	Total continuous score is sum of all 35 weighted items; (often=2; sometimes=1; 0=never); 4 or more items missing = invalid test. Continuous score from 0-70 that can be recoded into a dichotomous (case/not case) variable based on established cutoffs. Change scores can be based on either continuous (post-pre test global or subscale total) change scores or categorical change scores (percent of pre-test cases no longer cases at post-test) or clinically significant improvement (case > non case + post-pretest total score => 6). Process measures of outcome assess rate/proportion of cases screened or of positive screens followed up on [1] Higher PSC total score indicates more psychosocial problems. In the US, cutoff scores for positive screen are 28 or higher = psychosocial problem for 6-18 year olds on PSC 35 parent form; 24 or higher = problem for 3-5 year olds on PSC 35 parent report, 15 or higher on PSC 17 parent report; 30 or higher on PSC-Y form for youth aged 12 and older. Changes from case to

	0722 Pediatric Symptom Checklist (PSC)
	non case on the PSC indicate psychosocial problem remission. For process measures of screening and follow up rates, higher rates indicate higher quality care. In Medicaid of Massachusetts, 90th percentile benchmarks are 97% for rate of screening and 79% for rate of follow up [2]. 1. Murphy JM, Blais M, Baer L, McCarthy A, Kamin H, Masek B, Jellinek M. Measuring outcomes in outpatient child psychiatry: Reliable improvement, deterioration, and clinically significant improvement. Clinical Child Psychology and Psychiatry, 2013; 0 (0):1-14. 2. MassHealth. PCC and service location comparison: MGH-Chelsea HealthCare Center Report Card, April 2012. Appendix p. 55. Available at measure-specific web page URL identified in S.1
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

	1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
Status	Public and Member Commenting
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
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
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record Not Applicable No data collection instrument provided No data dictionary
Level	Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	At each visit for major depressive disorder during the measurement period
Numerator Statement	Patient visits with an assessment for suicide risk
Numerator Details	Numerator Definition: 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. Suicide risk assessment can include "specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (eg, psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (eg, positive reasons for living, strong social support); and identification of any family history of suicide or mental illness." "Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can [also] be used." Numerator Guidance: Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic below. FOR EHR SPECIFICATIONS: For HQMF eCQM, see reference attachment in field S2a. For value sets, please reference the VSAC.
Denominator Statement	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder
Denominator Details	Denominator Guidance: This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. A minimum of two encounters are required during the measurement period for a patient to be included in this measure to establish that the eligible professional has an existing relationship with the patient; if the patient is only seen once by the eligible professional, the patient is not included in the measure. Once it has been established that the patient has been seen at least twice by the eligible professional, every visit for major depressive disorder should be counted as a measurable episode for the measure calculation. For example, at every visit for MDD, the patient should have a suicide risk assessment. FOR EHR SPECIFICATIONS: For HQMF eCQM, see reference attachment in field S2a. For value sets, please reference the VSAC.
Exclusions	None
Exclusion details	N/A
Risk Adjustment	No risk adjustment or risk stratification

	1365 Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
	No risk adjustment or risk stratification. Provided in response box S.15a
Stratification	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnici
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure. No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment 0111 : Bipolar Disorder: Appraisal for risk of suicide 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Our measure addresses a different target population, children and adolescents with MDD, from the related measures that focus on adults with MDD and patients with bipolar disorder. As a result, the recommended frequency of suicide assessment is different in our measure from the other measures. 5b.1 If competing, why superior or rationale for additive value: Because our measure emphasizes a different target population and a different type/frequency of assessment, we feel multiple measures are justified to address suicide risk assessment differently in different high-risk populations.

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Pharmacy This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. No data collection instrument provided Attachment NQF_0108_Value_Sets.xlsx
Level	Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinician Office/Clinic
Time Window	The measurement year (i.e. 12 months)
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.
Numerator Details	INITIATION PHASE An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria: ADD Stand Alone Visits Value Set. ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set. ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set. Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. CONTINUATION AND MAINTENANCE PHASE Children who are numerator compliant for Rate 1—Initiation Phase, AND have documentation of at least two follow-up visits from 31–300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication with any practitioner. One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits: ADD Stand Alone Visits Value Set. ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set. ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set. Telephone Visits Value Set.
Denominator Statement	Children 6-12 years of age newly prescribed ADHD medication.
Denominator Details	INITIATION PHASE: Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year who were dispensed a new ADHD medication during the 12-month Intake

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	Period (Table ADD-A). Patients must have all of the following: (1) A 120-day (4 month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History. (2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date. (3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set) Optional Exclusion: Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year Table ADD-A: ADHD Medications CNS stimulants: Amphetamine-dextroamphetamine, , dexmethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate Alpha-2 receptor agonists: Clonidine, guanfacine Miscellaneous: Atomoxetine --- CONTINUATION AND MAINTENANCE PHASE Children who meet the eligible population criteria for Rate 1—Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following: (1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). (2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set).
Exclusions	Children with a diagnosis of narcolepsy
Exclusion details	Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year
Risk Adjustment	No risk adjustment or risk stratification N/A
Stratification	N/A
Type Score	Rate/proportion better quality = higher score
Algorithm	Refer to items S.9 (Denominator details) and S.2b (Data Dictionary) for tables.

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	INITIATION PHASE: ELIGIBLE POPULATION Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period. Step 2: Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History. Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date. Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set). Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria: ADD Stand Alone Visits Value Set. ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set. ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set. Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit. Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date). --- CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase. Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of “continuous medication treatment” allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays). Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set). A principal diagnosis of chemical dependency (Chemical Dependency Value Set). Step 5: Identify all patients in the eligible population who meet the following criteria: (1) Numerator compliant for Rate 1—Initiation Phase, and

	0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
	(2) At least two follow-up visits from 31–300 days (9 months) after the Index Prescription Start Date with any practitioner. One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits: ADD Stand Alone Visits Value Set. ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set. ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set. Telephone Visits Value Set. Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31-300 days after the Index Prescription Start Date). ADDITIONAL EXCLUSION: Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year NOTE (1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug). (2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the Index Prescription Start Date). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0106 : Diagnosis of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents 0107 : Management of attention deficit hyperactivity disorder (ADHD) in primary care for school age children and adolescents 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: NQF #0106 and this measure (NQF #0108) address the same clinical condition of ADHD, but different aspects of care. NQF#0106 assesses whether ADHD was properly diagnosed. This measure assesses patients who are newly prescribed ADHD medication and whether they receive proper follow-up visits during initiation and continuation and maintenance phase of treatment. In addition NQF#0106 is a physician-level measure while this measure is a health plan level measure. Measure NQF#0107 is a provider-level measure, whereas the NCQA measure is a health-plan level measure. The measures are aligned in that they both require two visits after a new medication for ADHD, but this measure is more specific because it requires a visit in an initiation phase and a visit in a continuation and maintenance phase. NQF #0107 is not as nuanced and only measures whether the patient received two medical visits in the year following the start of a new prescription for ADHD. These measures assess two different dimensions of care within the same quality concept by drawing from separate data sources, with the NCQA measure (NQF #0108) using administrative claims data and NQF #0107 using paper and electronic health records. 5b.1 If competing, why superior or rationale for additive value: N/A

	2597 Substance Use Screening and Intervention Composite
Status	Public and Member Commenting
Steward	American Society of Addiction Medicine
Description	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
Type	Composite
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable. No data collection instrument provided No data dictionary
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Each of the components look for performance at least once within 24 months prior to the end of the measurement period (measurement period or year prior)
Numerator Statement	Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results: Tobacco use component Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user Unhealthy alcohol use component Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user Drug use component (nonmedical prescription drug use and illicit drug use) Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user
Numerator Details	For Tobacco HQMF eMeasure specification attached to this form. All measure specific value sets for the Tobacco component are available at https://vsac.nlm.nih.gov/. For Alcohol HQMF eMeasure specification attached to this form. 35/43 measure specific value sets are published by the VSAC and are currently in use. 8/43 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a]. Drug HQMF eMeasure specification attached to this form. 33/41 measure specific value sets are published by the VSAC and are currently in use. 8/41 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period
Denominator	For Tobacco

	2597 Substance Use Screening and Intervention Composite
Details	HQMF eMeasure specification attached to this form. All measure specific value sets for the Tobacco component are available at https://vsac.nlm.nih.gov/. For Alcohol HQMF eMeasure specification attached to this form. 35/43 measure specific value sets are published by the VSAC and are currently in use. 8/43 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a]. Drug HQMF eMeasure specification attached to this form. 33/41 measure specific value sets are published by the VSAC and are currently in use. 8/41 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].
Exclusions	Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)
Exclusion details	The components of this measure were created using the PCPI methodology. The PCPI exception methodology states that exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this composite measure, exceptions may include medical reason(s) (eg, limited life expectancy).Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For Tobacco HQMF eMeasure specification attached to this form. All measure specific value sets for the Tobacco component are available at https://vsac.nlm.nih.gov/. For Alcohol HQMF eMeasure specification attached to this form. 35/43 measure specific value sets are published by the VSAC and are currently in use. 8/43 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb

	2597 Substance Use Screening and Intervention Composite
	2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a]. Drug HQMF eMeasure specification attached to this form. 33/41 measure specific value sets are published by the VSAC and are currently in use. 8/41 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, payer, and administrative sex, and have included these variables as supplemental data elements to be collected in the HQMF eMeasure.
Type Score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rate for the overall composite measure: Our approach to the composite measure algorithm for the NIDA Substance Use Screen and Brief Counseling electronic clinical quality measure is to employ a simple scoring methodology which identifies the number of eligible patients who received recommended care for each component measure divided by the number of eligible patients (or "opportunities"). This scoring method, known as opportunity- based scoring, is identical to that used by the Centers for Medicare and Medicaid Services (CMS) in its pay-for-performance programs. The underlying calculation used for our opportunity-based provider-level composite score is as follows: (N1+N2+N3) ---------- [(D1+D2+D3) – (DE1+DE2+DE3)] Available in attached appendix at A.1
Copyright / Disclaimer	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: n/a 5b.1 If competing, why superior or rationale for additive value: While there are individual measures addressing screening and brief intervention for alcohol and tobacco use, there is no measure that looks at screening and brief intervention for more than one substance.

	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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).
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Alcohol_Screening_and_Follow-up_for_People_with_Serious_Mental_Illness_NQF_-2599-635427417613127062.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 15 months Denominator: 12 months Exclusion: 9 months
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.
Numerator Details	Alcohol Use Screening ADMINISTRATIVE: Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. MEDICAL RECORD: Patients who had systematic screening 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. Systematic Screening A systematic screening method is defined as: Asking the patient about their weekly use (alcoholic drinks per week), or Asking the patient about their per occasion use (alcoholic drinks per drinking day) or Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or Using another standardized tool Unhealthy Alcohol Use Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age. Follow-Up ADMINISTRATIVE: Patients who received two events of counseling (see Alcohol Screening and Brief Counseling

	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
	Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users. MEDICAL RECORD: Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count). Counseling Counseling may include at least one of the following: Feedback on alcohol use and harms Identification of high risk situations for drinking and coping strategies Increase the motivation to reduce drinking Development of a personal plan to reduce drinking
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.
Denominator Details	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set

	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
	BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set
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).
Exclusion details	Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year. Step 2: Identify Numerator. Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop. Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.) No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated disparities in care - What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental

	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
	illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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. 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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on medical record documentation collected in the course of providing care to patients. No data collection instrument provided Attachment Tobacco_Use_Screening_-_Follow-up_for_People_with_Serious_Mental_Illness_or_Alcohol_and_Other_Drug_Dependence__NQF_-2600-635425023511668833.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 24 months Denominator: 12 months Exclusions: This measure has no exclusions.
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.
Numerator Details	Tobacco Use Screening: MEDICAL RECORD: Patients who had screening for tobacco use documented any time during the year prior to the measurement year or during the first 9 months of the measurement year. Tobacco Use Definition: 'Tobacco Use' is defined to include any type of tobacco. Follow-up: ADMINISTRATIVE: Patients who received follow-up care within three months of screening if identified as a tobacco user. Follow-up care is defined as: 1) Two events of counseling (see Tobacco Cessation Counseling Value Set), on different dates, for tobacco use with the provider who did the screening or another provider including health plan clinical case managers (Participation in community-based programs such as quit lines or non-clinical support activities can count as counseling if documented in the health record (referrals alone do not count)). 2) One event of counseling (see Tobacco Cessation Counseling Value Set) and one event of medication fill (see Tobacco Cessation Medication Value Set) or use for tobacco cessation.

	2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
	MEDICAL RECORD: Patients who received follow-up care within three months of screening if identified as a tobacco user. Follow-up care is defined as: 1) Two events of counseling, on different dates, for tobacco use with the provider who did the screening or another provider including health plan clinical case managers (Participation in community-based programs such as quit lines or non-clinical support activities can count as counseling if documented in the health record (referrals alone do not count)). One event of counseling and one event of medication fill or use for tobacco cessation.
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.
Denominator Details	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one-month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Serious Mental Illness Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: • BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: • BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • ED Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set

	2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
	• BH Stand Alone Non-acute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set Alcohol or Other Drug Dependence Diagnosis Criteria: Identify patients with alcohol or other drug as those who met at least one of the following criteria during the measurement year: • An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria: – IET Stand Alone Visits Value Set with AOD Dependence Value Set. – IET Visits Group 1 Value Set with IET POS Group 1 Value Set and AOD Dependence Value Set. – IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set. • A detoxification visit (Detoxification Value Set). • An ED visit (ED Value Set) with a diagnosis of AOD (AOD Dependence Value Set). • An inpatient discharge with a diagnosis of AOD as identified by either of the following: – An inpatient facility code with a diagnosis of AOD (AOD Dependence Value Set). – An inpatient facility code with an AOD procedure code (AOD Procedures Value Set).
Exclusions	Not applicable.
Exclusion details	Not applicable.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	RATE 1: Tobacco Use Screening and Follow-up for People with Serious Mental Illness Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness Step 2: Identify the numerator. Step 2A: Identify the date of screening for tobacco use during the year prior to the measurement year or during the first 9 months of the measurement year. Step 2B: Identify the tobacco use screening result. If negative for tobacco use, stop. Step 2C: If positive for tobacco use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for tobacco use (from Step 2B) plus the number of patients with positive screening for tobacco use who received follow-up care (from Step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after step 1A is complete). ---------- RATE 2: Tobacco Use Screening and Follow-up for People with Alcohol or Other Drug Dependence Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with alcohol or other drug dependence. Step 2: Identify the numerator. Step 2A: Identify the date of screening for tobacco use during the year prior to the measurement

	2600 Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
	year or during the first 9 months of the measurement year. Step 2B: Identify the tobacco use screening result. If negative for tobacco use, stop. If positive for tobacco use Step 2C: If positive for tobacco use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for tobacco use (from Step 2B) plus the number of patients with positive screening for tobacco use who received follow-up care (from Step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after step 1A is complete). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0028 : Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028) for use at the health plan level for the high risk subpopulation of people with serious mental illness and alcohol or other drug dependence. This measure is harmonized with the existing measure (Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028) and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed subpopulation measure were developed with expert input and are described here: -The population focus: This measure focuses on people with serious mental illness or alcohol or other drug dependence, who are at a higher risk of tobacco use than the general population and have demonstrated disparities in care. -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling or one event of counseling and one event of medication fill or use for tobacco cessation, raising expectations for the intensity of service for the serious mental illness/alcohol or other drug dependence population compared to the original measure for the general population, and are reasonably achievable, particularly in the health plan context. -USPSTF recommendation concluded that even brief counseling (<3 minutes) is effective, there is a dose–response relationship between quit rates and the number of sessions of counseling; and the combination of counseling and pharmacotherapy is more effective than either component alone. -In addition, the existing measure (NQF #0028) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on tobacco screening for patients with serious mental illness or alcohol or other drug dependence and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on medical record documentation collected in the course of providing care to patients. No data collection instrument provided Attachment Body_Mass_Index_Screening_-_Follow-up_for_People_with_Serious_Mental_Illness__NQF_-2601-635427433253915264.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 24 months Denominator: 12 months Exclusions: 24 months
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 mass index is greater than or equal to 30 kg/m2.
Numerator Details	Calculated body mass index: Body mass index is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared Self-reported values cannot be used. The screening must be documented any time during the year prior to the measurement year or during the first 9 months of the measurement year. Follow-Up: Follow-up documented within three months of screening for patients with a body mass index greater than or equal to 30 kg/m2: - Two events of counseling (see Above Normal BMI With Follow-Up Plan Value Set), on different dates, for weight management (such as nutrition or exercise counseling) (see Nutrition or Exercise Counseling Value Set) with the provider who did the screening or another provider including health plan clinical case managers, or - One event of counseling and one fill of medication (Orlistat) for weight management.
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.

	2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
Denominator Details	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one-month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: -BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: -BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set -BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set -ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set -BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set -BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set -BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set
Exclusions	Active diagnosis of pregnancy during the measurement year or the year prior to the measurement year.
Exclusion details	Denominator exclusions (diagnosis of pregnancy) are found through medical record or claims data (see Pregnancy Value Set).
Risk Adjustment	No risk adjustment or risk stratification Not applicable.

	2601 Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness. Step 1B: Exclude patients from step 1A who are pregnant during the measurement year or year prior to the measurement year. Step 2: Identify the numerator. Step 2A: Identify the date of screening for body mass index during during the year prior to the measurement year or during the first 9 months of the measurement year. Step 2B: Identify the body mass index result. If body mass index is less than 30 kg/m2, stop. Step 2C: If body mass index is greater than or equal to 30 kg/m2, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a body mass index less than 30 kg/m2 from Step 2B plus the number of patients with a body mass index greater than or equal to 30 kg/m2 who received follow-up care in Step 2C and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.) No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0421 : Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up NQF #0421) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized with NQF #0421 and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here: -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of obesity than the general population and have demonstrated disparities in care. - People needing follow-up care: SMI patients with obesity are at increased risk, so specifications focus on patients with a body mass index greater than or equal to 30 kg/m2) - What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling or counseling with medication fill raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. The US Preventive Services Task Force recommends intensive (more than 1 person-to-person session per month for at least the first 3 months of the intervention) counseling and behavioral interventions; Orlistat is recommended only in combination with counseling and behavioral interventions. In addition, the existing measure (NQF #0421) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on BMI screening for patients with SMI and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2602 Controlling High Blood Pressure for People with Serious Mental Illness
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Outcome
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records The denominator for this measure is based on administrative claims and medical record documentation (this is used to confirm the diagnosis of hypertension identified in claims/encounter data). The numerator for this measure is based on medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Controlling_High_Blood_Pressure_for_People_with_Serious_Mental_Illness_NQF_-2602.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 12 months Denominator: 6-24 months Exclusions: 12 months-life time (for the ESRD or kidney transplant exclusion)
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.
Numerator Details	The number of patients whose most recent blood pressure (BP) is adequately controlled during the measurement year, but after the diagnosis of hypertension (See Essential Hypertension Value Set). For an individual's BP to be adequately controlled, both the systolic and diastolic BP must -85meet 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. To determine if an individual's BP is adequately controlled, the representative BP (i.e., the

	2602 Controlling High Blood Pressure for People with Serious Mental Illness
	most recent BP reading during the measurement year but after the diagnosis of hypertension was made) must be identified. Note: Only the medical records of one practitioner or provider team should be used for both the confirmation of the diagnosis of hypertension and the representative BP. All eligible BP measurements recorded in the records from one practitioner or provider team (even if obtained by a different practitioner) should be considered (e.g., from a consultation note or other note relating to a BP reading from a health care practitioner or provider team). If an organization cannot find the medical record, the patient remains in the measure denominator and is considered noncompliant for the numerator. The numerator should be calculated using the following steps: Step 1: Identify the patient's Primary Care Provider (PCP). -If the patient had more than one PCP for the time period, identify the PCP who most recently provided care to the patient. -If the patient did not visit a PCP for the time period or does not have a PCP, identify the practitioner who most recently provided care to the patient. -If a practitioner other than the patient's PCP manages the hypertension, the organization may use the medical record of that practitioner. Step 2: Identify the representative BP level, defined as the most recent BP reading during the measurement year. -The reading must occur after the date when the diagnosis of hypertension was made or confirmed. -If multiple BP measurements occur on the same date, or are noted in the chart on the same date, the lowest systolic and lowest diastolic BP reading should be used. The systolic and diastolic results do not need to be from the same reading -If no BP is recorded during the measurement year, assume that the individual is "not controlled." -Do not include BP readings that meet the following criteria: - Taken during an acute inpatient stay or an ED visit - Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole) - Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) - Reported by or taken by the patient
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.
Denominator Details	Age: 18-85 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). Identify Serious Mental Illness: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I

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	disorder, or major depression using any of the following code combinations: - BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set - BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: - BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set Identify Hypertension: A diagnosis of hypertension is identified if there is at least one outpatient visit (Outpatient CPT Value Set) with a diagnosis of hypertension (Essential Hypertension Value Set) during the first six months of the measurement year and confirmed with a notation of one of the following in the medical record on or before June 30 of the measurement year: Hypertension Intermittent HTN HTN History of HTN High BP Hypertensive vascular disease (HVD) Hyperpiesia

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	Hyperpiesis Borderline HTN Intermittent HTN The notation of hypertension may appear on or before June 30 of the measurement year, including prior to the measurement year. It does not matter if hypertension was treated or is currently being treated. The notation indicating a diagnosis of hypertension may be recorded in any of the following documents: Problem list (this may include a diagnosis prior to June 30 of the measurement year or an undated diagnosis; see Note at the end of this section) Office note Subjective, Objective, Assessment, Plan (SOAP) note Encounter form Telephone call record Diagnostic report Hospital discharge summary Statements such as “rule out HTN,” “possible HTN,” “white-coat HTN,” “questionable HTN” and “consistent with HTN” are not sufficient to confirm the diagnosis if such statements are the only notations of hypertension in the medical record. If an organization cannot find the medical record, the patient remains in the measure denominator and is considered noncompliant for the numerator. Flag to identify diabetes: After the denominator is identified, assign each patient a flag to identity if the patient does or does not have diabetes as identified by claims/encounter and pharmacy data (see description below). The flag is used to determine the appropriate BP threshold to use during numerator assessment. Assign a flag of diabetic to patients who were identified as diabetic using claims/encounter and pharmacy data. The organization must use both methods to identify patients with diabetes, but a patient only needs to be identified by one method. Claim/encounter data: -At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits. -At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: -Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1). TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin

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	Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents: Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas: Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone Assign a flag of not diabetic to patients who do not have a diagnosis of diabetes during the measurement year or year prior to the measurement year and who meet either of the following criteria: - A diagnosis of polycystic ovaries (Polycystic Ovaries Value Set), in any setting, any time during the patient's history through December 31 of the measurement year. - A diagnosis of gestational diabetes or steroid-induced diabetes (Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to 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
Exclusion details	All patients who meet one or more of the following criteria may be excluded from the measure: - All patients with evidence of end-stage renal disease (ESRD) (see ESRD Value Set; ESRD Obsolete Value Set) or kidney transplant (see Kidney Transplant Value Set) on or prior to December 31 of the measurement year. Documentation in the medical record must include a dated note indicating evidence of ESRD, kidney transplant or dialysis. - All patients with a diagnosis of pregnancy (see Pregnancy Value Set) during the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify patients with serious mental illness (schizophrenia, bipolar I disorder, and major depression). Step 2: Identify patients from step 1 who also have a diagnosis of hypertension in claims and confirmed the hypertension diagnosis in medical records. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. This is the denominator. Step 4: Of those in the denominator, identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record.

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	Step 5: Calculate the rate by dividing the number of patients whose most recent blood pressure is adequately controlled by the denominator (after exclusions). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0018 : Controlling High Blood Pressure 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing measure (Controlling High Blood Pressure NQF #0018) for the subpopulation of people with serious mental illness who have a higher risk of disease 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 facilitate an adequate number of individuals with serious mental illness. NCQA is the owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. Note: The specifications for the existing measure (Controlling High Blood Pressure NQF #0018) have been updated based on 2013 JNC-8 guidelines. 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. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy The denominator for this measure is based on claim/encounter and pharmacy data. The numerator for this measure is based on claim/encounter data and medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Comprehensive_Diabetes_Care_for_People_with_Serious_Mental_Illness_-_Diabetes_Hemoglobin_A1c_Testing_NQF_-2603.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 12 months Denominator: 24 months Exclusions: 24 months-life time (for polycystic ovaries)
Numerator Statement	Patients who had Hemoglobin A1c (HbA1c) testing during the measurement year.
Numerator Details	ADMINISTRATIVE: Patients who had HbA1c testing (see HbA1c Tests Value Set) as identified by claim/encounter data or automated laboratory data during the measurement year. MEDICAL RECORD: Patients who had HbA1c testing, as identified by their medical record. At a minimum, documentation in the medical record must include a note indicating the date when the HbA1ctest was performed and the result. The following notations in the medical record count as HbA1c testing: A1c, Hemoglobin A1c, HgbA1c, HbA1c, Glycohemoglobin A1c.
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 year before.
Denominator Details	Age: 18-75 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). All patients 18-75 years of age as of December 31 of the measurement year with a serious mental illness [see SMI Value Set] and diabetes (type 1 and type 2) [see Diabetes Value Set] The following steps should be followed to identify patients with a serious mental illness and a

	2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
	diagnosis for diabetes: (1) Identify Serious Mental Illness Step 1: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: -Schizophrenia Value Set -Bipolar Disorder Value Set -Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set (2) Identify Diabetes Step 2: Of the patients identified in Step 1, identify patients with diabetes (see Diabetes Value Set) during the measurement year or the year prior using the following data: Claim/encounter data: - At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits.

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	- At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: - Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1) Both methods to identify the eligible population should be used, however, an individual need only be identified by one to be included in the measure. TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents: Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas: Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone
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.
Exclusion details	Patients who do not have a diagnosis of diabetes (see Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria: -A diagnosis of polycystic ovaries (see Polycystic Ovaries Value Set), in any setting, any time during the person's history through December 31 of the measurement year. -A diagnosis of gestational diabetes or steroid-induced diabetes (see Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify patients with serious mental illness.

	2603 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
	Step 2: Identify patients from step 1 who also have a diagnosis of diabetes during the measurement year or the year prior. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. This is the denominator. Step 4. Identify patients who had HbA1c testing performed. This is the numerator. Step 5. Calculate the rate by dividing the numerator (Step 4) by the denominator (after exclusion) (from Step 3). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0057 : Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing measure (Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) testing NQF #0057) for the high risk subpopulation of people with serious mental illness who have a higher risk of disease 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 2017serious mental illness. NCQA is the owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy Not applicable. No data collection instrument provided Attachment Comprehensive_Diabetes_Care_for_People_with_Serious_Mental_Illness_and_Diabetes_Medical_Attention_to_Nephropathy_-2604.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic
Time Window	Numerator: 12 months Denominator: 12 months Exclusions: 24 months-life time (for polycystic ovaries)
Numerator Statement	Patients who received a nephropathy screening test or had evidence of nephropathy during the measurement year.
Numerator Details	ADMINISTRATIVE CLAIMS: A nephropathy screening test or evidence of nephropathy, as documented through administrative data. This includes diabetics who had one of the following during the measurement year: -A nephropathy screening test (Nephropathy Screening Tests Value Set). -Evidence of treatment for nephropathy or ACE/ARB therapy (Nephropathy Treatment Value Set). -Evidence of stage 4 chronic kidney disease (CKD Stage 4 Value Set). -Evidence of ESRD (ESRD Value Set). -Evidence of kidney transplant (Kidney Transplant Value Set). -A visit with a nephrologist, as identified by the organization's specialty provider codes (no restriction on the diagnosis or procedure code submitted). -A positive urine macroalbumin test (Positive Urine Macroalbumin Tests Value Set). -A urine macroalbumin test (Urine Macroalbumin Tests Value Set) where laboratory data indicates a positive result ("trace" urine macroalbumin test results are not considered numerator compliant). -At least one ACE inhibitor or ARB dispensing event . MEDICAL RECORD: Patients who received a nephropathy screening test or have evidence of nephropathy using the following criteria: 1. Nephropathy screening test. At a minimum, documentation must include a note indicating the date when a urine microalbumin test was performed, and the result. Any of the following meet the criteria for a urine microalbumin test:

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	-24-hour urine for microalbumin -Timed urine for microalbumin -Spot urine for microalbumin -Urine for microalbumin/creatinine ratio -24-hour urine for total protein -Random urine for protein/creatinine ratio 2. Evidence of nephropathy. Any of the following meet the criteria for evidence of nephropathy. -Documentation of a visit to a nephrologist. -Documentation of a renal transplant. -Documentation of medical attention for any of the following (no restriction on provider type): -Diabetic nephropathy -ESRD -CRF -Chronic kidney disease (CKD) -Renal insufficiency -Proteinuria -Albuminuria -Renal dysfunction -Acute renal failure (ARF) -Dialysis, hemodialysis or peritoneal dialysis A positive urine macroalbumin test. At a minimum, documentation in the medical record must include a note indicating the date when the test was performed, and a positive result. Any of the following meet the criteria for a positive urine macroalbumin test: -Positive urinalysis (random, spot or timed) for protein -Positive urine (random, spot or timed) for protein -Positive urine dipstick for protein -Positive tablet reagent for urine protein -Positive result for albuminuria -Positive result for macroalbuminuria -Positive result for proteinuria -Positive result for gross proteinuria Note: “Trace” urine macroalbumin test results are not considered numerator compliant. Evidence of ACE inhibitor/ARB therapy. Documentation in the medical record must include, at minimum, a note indicating that the patient received an ambulatory prescription for ACE inhibitors/ARBs in 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.
Denominator Details	Age: 18-75 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in

	2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
	coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). All patients 18-75 years of age as of December 31 of the measurement year with a serious mental illness [see SMI Value Set] and diabetes (type 1 and type 2) [see Diabetes Value Set] The following steps should be followed to identify patients with a serious mental illness and a diagnosis for diabetes: (1) Identify Serious Mental Illness Step 1: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: • BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: • BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • ED Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set (2) Identify Diabetes Step 2: Of the patients identified in Step 1, identify patients with diabetes (see Diabetes Value

	2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
	Set) during the measurement year or the year prior using the following data: Claim/encounter data: • At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: • Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1) Both methods to identify the eligible population should be used, however, an individual need only be identified by one to be included in the measure. TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents: Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas: Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone
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.
Exclusion details	Patients who do not have a diagnosis of diabetes (see Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria: -A diagnosis of polycystic ovaries (see Polycystic Ovaries Value Set), in any setting, any time during the person's history through December 31 of the measurement year. -A diagnosis of gestational diabetes or steroid-induced diabetes (see Diabetes Exclusions Value

	2604 Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
	Set), in any setting, during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify patients with serious mental illness Step 2: Identify patients from step 1 who also have a diagnosis of diabetes during the measurement year or the year prior. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. This is the denominator. Step 4: Identify patients who received a nephropathy screening test or had evidence of nephropathy during the measurement year. This is the numerator. Step 5: Calculate the rate by dividing the numerator (step 4) by the denominator (step 3 after exclusion). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0062 : Comprehensive Diabetes Care: Medical Attention for Nephropathy 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was designed to be adapted from the existing measure (Comprehensive Diabetes Care: Medical Attention for Nephropathy NQF #0062) for the high risk subpopulation of people with serious mental illness who have a higher risk of disease 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. NCQA is the owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
Status	Public and Member Commenting
Steward	National Committee for Quality Assurrance
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.
Type	Process
Data Source	Administrative claims Both the numerator and the denominator for this measure are based on administrative claims data. No data collection instrument provided Attachment Follow-up_After_Emergency_Department_Use_for_Mental_Health_Conditions_or_AOD_Abuse_or_Dependence_NQF-2605.xlsx
Level	Health Plan, Population : State
Setting	Ambulatory Care : Clinician Office/Clinic, Hospital/Acute Care Facility, Behavioral Health/Psychiatric : Outpatient
Time Window	Denominator: 11 months Numerator: 12 months Exclusions: 11 months
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
Numerator Details	Mental Health Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any

	2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
	provider with a primary diagnosis of mental health within 7 days after emergency department discharge - A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set). - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge - A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set). - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set). - Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit. Alcohol or Other Drug Dependence Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge. Any of the following code combinations meet criteria: - IET Stand Alone Visits Value Set with a primary diagnosis of AOD (AOD Dependence Value Set). - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis

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	of AOD (AOD Dependence Value Set). - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set). Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis alcohol or other drug dependence within 30 days after emergency department discharge. Any of the following code combinations meet criteria: - IET Stand Alone Visits Value Set with AOD Dependence Value Set - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set). - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).
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.
Denominator Details	Age: 18 years and older as of the date of discharge Benefit: Medical and Behavioral Health Continuous Enrollment: Date of emergency department visit through 30 days after discharge Diagnosis criteria: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health (see Mental Health Diagnosis Value Set) or alcohol or other drug dependence (see AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Use only facility claims to identify denominator events (including admissions or direct transfers). Do not use professional claims.
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
Exclusion details	See Section S.10 for exclusion details
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Mental Health Step 1: Determine the eligible population. Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section. Step 2: Identify the numerator. Step 2A: Identify those who had a qualifying follow-up visit within 7 days. Step 2B: Identify those who had a qualifying follow-up visit within 30 days. Step 3: Calculate the rates. Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up

	2605 Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence
	visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B). Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B). Alcohol or Other Drug Dependence Step 1: Determine the eligible population. Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence. Step 1B: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. Step 2: Identify the numerator. Step 2A: Identify those who had a qualifying follow-up visit within 7 days. Step 2B: Identify those who had a qualifying follow-up visit within 30 days. Step 3: Calculate the rates. Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B). Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH) 1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: Portions of the specifications for this measure have been adapted from the existing health plan measures (Follow-up After Hospitalization for Mental Illness NQF #0576 and Follow-up After Hospitalization for Schizophrenia NQF#1937). The proposed measure is harmonized with the two existing NQF-endorsed measures. The following highlights the differences between the measures: -Population focus (denominator): The proposed measure targets patients discharged from the emergency department (not inpatient) and also focuses on patients with alcohol or other drug dependence disorders.-Numerator: The proposed measure captures follow-up with a primary mental health or alcohol or other drug dependence diagnosis (regardless of the type of provider). 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Outcome
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy The denominator for this measure is based on claim/encounter and pharmacy data. The numerator for this measure is based on medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Comprehensive_Diabetes_Care_for_People_with_Serious_Mental_Illness_and_Diabetes_Blood_Pressure_Control_NQF_-2606.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 12 months Denominator: 12 months Exclusions: 24 months-life time (for polycystic ovaries)
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.
Numerator Details	ADMINISTRATIVE: Use automated data to identify the most recent BP reading taken during an outpatient visit (see Outpatient Visit Value Set) or a nonacute inpatient encounter (Nonacute Inpatient Value Set) during the measurement year. The patient is numerator compliant if the BP is <140/90 mm Hg. The patient is not compliant if the BP is =140/90 mm Hg, if there is no BP reading during the measurement year or if the reading is incomplete (e.g., the systolic or diastolic level is missing). If there are multiple BPs on the same date of service, use the lowest systolic and lowest diastolic BP on that date as the representative BP. Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent codes during the measurement year to determine numerator compliance for both systolic and diastolic levels. VALUE SET / NUMERATOR COMPLIANCE Systolic Less Than 140 Value Set / Systolic compliant Systolic Greater Than/Equal To 140 Value Set / Systolic not compliant Diastolic Less Than 80 Value Set / Diastolic compliant Diastolic 80–89 Value Set / Diastolic compliant Diastolic Greater Than/Equal To 90 Value Set / Diastolic not compliant MEDICAL RECORD: The organization should use the medical record from which it abstracts data for the other

	2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
	diabetes care indicators such as HbA1c test. If the organization does not abstract for other indicators, it should use the medical record of the provider that manages the patient's diabetes. If that medical record does not contain a BP, the organization may use the medical record of another PCP or specialist from whom the patient receives care. To determine if BP is adequately controlled, the organization must identify the representative BP following the steps below. Identify the most recent BP reading noted during the measurement year. Do not include BP readings that meet the following criteria: -Taken during an acute inpatient stay or an ED visit. -Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole). -Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy). Reported by or taken by the patient. Identify the lowest systolic and lowest diastolic BP reading from the most recent BP notation in the medical record. If there are multiple BPs recorded for a single date, use the lowest systolic and lowest diastolic BP on that date as the representative BP. The systolic and diastolic results do not need to be from the same reading when multiple readings are recorded for a single date. The patient is not numerator compliant if the BP does not meet the specified threshold or is missing, or if there is no BP reading during the measurement year or if the reading is incomplete (i.e., the systolic or diastolic level is missing).
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.
Denominator Details	Age: 18-75 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). All patients 18-75 years of age as of December 31 of the measurement year with a serious mental illness [see SMI Value Set] and diabetes (type 1 and type 2) [see Diabetes Value Set] The following steps should be followed to identify patients with a serious mental illness and a diagnosis for diabetes: (1) Identify Serious Mental Illness Step 1: Identify Patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: • BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses:

	2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
	o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: • BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • ED Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set (2) Identify Diabetes Step 2: Of the patients identified in Step 1, identify patients with diabetes (see Diabetes Value Set) during the measurement year or the year prior using the following data: Claim/encounter data: • At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits. • At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: • Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1) Both methods to identify the eligible population should be used, however, an individual need only be identified by one to be included in the measure. TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol

	2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
	Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents: Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas: Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone
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.
Exclusion details	Patients who do not have a diagnosis of diabetes (see Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria: -A diagnosis of polycystic ovaries (see Polycystic Ovaries Value Set), in any setting, any time during the person's history through December 31 of the measurement year. -A diagnosis of gestational diabetes or steroid-induced diabetes (see Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify patients with serious mental illness. Step 2: Identify patients from step 1 who also have a diagnosis of diabetes during the measurement year or the year prior. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. Step 4: Identify the lowest systolic and lowest diastolic blood pressure reading from the most recent blood pressure notation in the medical record. Step 5. Determine whether the result was <140/90 mm Hg. Step 6: Calculate the rate by dividing the numerator (Step 5) by the denominator (after exclusions) (Step 3). No diagram provided
Copyright /	5.1 Identified measures: 0061 : Comprehensive Diabetes Care: Blood Pressure Control

	2606 Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
Disclaimer	(<140/90 mm Hg) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing measure (Comprehensive Diabetes Care: Blood Pressure Control <140/90 mm Hg NQF #0061) for the subpopulation of people with serious mental illness who have a higher risk of disease 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. NCQA is the current owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Outcome
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy The denominator for this measure is based on claim/encounter and pharmacy data. The numerator for this measure is based on claim/encounter data and medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Comprehensive_Diabetes_Care_for_People_with_Serious_Mental_Illness_and_Diabetes_Hemoglobin_A1c_Poor_Control__NQF_-2607.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 12 months Denominator: 12 months Exclusions: 24 months-life time (for polycystic ovaries)
Numerator Statement	Patients whose most recent HbA1c level is greater than 9.0% (poor control) during the measurement year. 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.
Numerator Details	ADMINISTRATIVE: Use codes (see HbA1c Tests Value Set) to identify the most recent HbA1c test during the measurement year. The patient is numerator compliant if the most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year. The patient is not numerator compliant if the result for the most recent HbA1c test during the measurement year is =9.0%. Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant. VALUE SET / NUMERATOR COMPLIANCE HbA1c Level Less Than 7.0 Value Set / Not compliant HbA1c Level 7.0–9.0 Value Set / Not compliant HbA1c Level Greater Than 9.0 Value Set / Compliant MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The patient is numerator compliant if the result for the most recent HbA1c level during the measurement year is >9.0% or is missing, or if an HbA1c test was not done during the measurement year. The patient is not numerator

	2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	compliant if the most recent HbA1c level during the measurement year is =9.0%. Ranges and thresholds do not meet criteria for this indicator. A distinct numeric result is required for numerator compliance.
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.
Denominator Details	Age: 18-75 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). All patients 18-75 years of age as of December 31 of the measurement year with a serious mental illness [see SMI Value Set] and diabetes (type 1 and type 2) [see Diabetes Value Set] The following steps should be followed to identify patients with a serious mental illness and a diagnosis for diabetes: (1) Identify Serious Mental Illness Step 1: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set

	2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set (2) Identify Diabetes Step 2: Of the patients in Step 1, identify patients with diabetes (see Diabetes Value Set) during the measurement year or the year prior using the following data: Claim/encounter data: - At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits. - At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: - Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1) Both methods to identify the eligible population should be used, however, an individual need only be identified by one to be included in the measure. TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents: Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas:

	2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone
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.
Exclusion details	Patients who do not have a diagnosis of diabetes (see Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria: -A diagnosis of polycystic ovaries (see Polycystic Ovaries Value Set), in any setting, any time during the person's history through December 31 of the measurement year. -A diagnosis of gestational diabetes or steroid-induced diabetes (see Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = lower score
Algorithm	Step 1: Identify patients with serious mental illness. Step 2: Identify patients from step 1 who also have a diagnosis of diabetes during the measurement year or the year prior. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. This is the denominator. Step 4: Identify patients with a most recent HbA1c test performed. Step 5: Identify patients whose most recent HbA1c level is >9.0% or is missing a result or if an HbA1c test was not done during the measurement year. This is the numerator. Step 6: Calculate the rate by dividing the numerator (step 5) by the denominator (after exclusions) (Step 3). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0059 : Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing measure (Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) NQF #0059) for the high risk subpopulation of people with serious mental illness who have a higher risk of disease 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. NCQA is the owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues.

	2607 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
	5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
Status	Public and Member Commenting
Steward	National Committee for Quality Assurance
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.
Type	Outcome
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Laboratory, Paper Medical Records, Electronic Clinical Data : Pharmacy The denominator for this measure is based on claim/encounter and pharmacy data. The numerator for this measure is based on claim/encounter data and medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Comprehensive_Diabetes_Care_for_People_with_Serious_Mental_Illness_and_Diabetes_Hemoglobin_A1c_Control_NQF_-2608.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 12 months Denominator: 12 months Exclusions: 24 months-life time (for polycystic ovaries)
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 reduces the risk for complications including renal failure, blindness, and neurologic damage. There is no need for risk adjustment for this intermediate outcome measure.
Numerator Details	ADMINISTRATIVE CLAIMS: Use codes (HbA1c Tests Value Set) to identify the most recent HbA1c test during the measurement year. The patient is numerator compliant if the most recent HbA1c level is <8.0%. The patient is not numerator compliant if the result for the most recent HbA1c test is =8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Organizations that use CPT Category II codes to identify numerator compliance for this indicator must search for all codes in the following value sets and use the most recent code during the measurement year to evaluate whether the patient is numerator compliant. VALUE SET / NUMERATOR COMPLIANCE HbA1c Level Less Than 7.0 Value Set / Not compliant HbA1c Level 7.0–9.0 Value Set / Not compliant HbA1c Level Greater Than 9.0 Value Set / Compliant MEDICAL RECORD: At a minimum, documentation in the medical record must include a note indicating the date when the HbA1c test was performed and the result. The patient is numerator compliant if the result for the most recent HbA1c level during the measurement year is <8.0%. The patient is not numerator compliant if the result for the most recent HbA1c test is =8.0% or is missing a result, or if an HbA1c test was not done during the measurement year. Ranges and thresholds do not meet criteria for this measure. A distinct numeric result is required for numerator compliance.

	2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
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.
Denominator Details	Age: 18-75 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). All patients 18-75 years of age as of December 31 of the measurement year with a serious mental illness [see SMI Value Set] and diabetes (type 1 and type 2) [see Diabetes Value Set] The following steps should be followed to identify adults with a serious mental illness and a diagnosis for diabetes: (1) Identify Serious Mental Illness Step 1: Identify adults with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set

	2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
	BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set (2) Identify Diabetes Step 2: Of the adults identified in Step 1, identify adults with diabetes (see Diabetes Value Set) during the measurement year or the year prior using the following data: Claim/encounter data: - At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits. - At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: - Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1) Both methods to identify the eligible population should be used, however, an individual need only be identified by one to be included in the measure. TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents: Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas: Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone

	2608 Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)
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.
Exclusion details	Patients who do not have a diagnosis of diabetes (see Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria: - A diagnosis of polycystic ovaries (see Polycystic Ovaries Value Set), in any setting, any time during the patient's history through December 31 of the measurement year. - A diagnosis of gestational diabetes or steroid-induced diabetes (see Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify patients with serious mental illness. Step 2: Identify patients from step 1 who also have a diagnosis of diabetes during the measurement year or the year prior. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. This is the denominator. Step 4: Identify patients with a most recent HbA1c test performed. Step 5: Identify patients whose result was <8.0%. This is the numerator. Step 6: Calculate the rate by dividing the numerator (step 5) by the denominator (Step 3 after exclusion). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0575 : Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing measure (Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%):NQF #0575) for the subpopulation of people with serious mental illness who have a higher risk of disease 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. NCQA is the current owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

	2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
Status	Public and Member Commenting
Steward	National Committee of Quality Assurance
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.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Paper Medical Records, Electronic Clinical Data : Pharmacy The denominator for this measure is based on claim/encounter and pharmacy data. The numerator for this measure is based on claim/encounter data and medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Comprehensive_Diabetes_Care_for_People_with_Serious_Mental_Illness_and_Diabetes_Eye_Exam_NQF__-2609.xlsx
Level	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Numerator: 12 months Denominator: 12 months Exclusions: 24 months-life time (for polycystic ovaries)
Numerator Statement	Patients who received an eye exam during the measurement year.
Numerator Details	ADMINISTRATIVE: An eye screening for diabetic retinal disease as identified by administrative data. This includes diabetics who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement year or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year. Any of the following meet criteria: 1) Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the measurement year. 2) Any code in the Diabetic Retinal Screening Value Set billed by an eye care professional (optometrist or ophthalmologist) during the year prior to the measurement year, with a negative result (negative for retinopathy). 3) Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the measurement year. 4) Any code in the Diabetic Retinal Screening With Eye Care Professional Value Set billed by any provider type during the year prior to the measurement year, with a negative result (negative for retinopathy. 5)Any code in the Diabetic Retinal Screening Negative Value Set billed by any provider type during the measurement year. MEDICAL RECORD: At a minimum, documentation in the medical record must include one of the following: 1) A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results. 2) A chart or photograph of retinal abnormalities indicating the date when the fundus

	2609 Diabetes Care for People with Serious Mental Illness: Eye Exam
	photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist. 3) Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional (optometrist or ophthalmologist) meets criteria.
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.
Denominator Details	Age: 18-75 years as of December 31 of the measurement year Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the individual may not have more than a 1-month gap in coverage (i.e., an individual whose coverage lapses for 2 months [60 days] is not considered continuously enrolled). All patients 18-75 years of age as of December 31 of the measurement year with a serious mental illness [see SMI Value Set] and diabetes (type 1 and type 2) [see Diabetes Value Set] The following steps should be followed to identify patients with a serious mental illness and a diagnosis for diabetes: (1) Identify Serious Mental Illness Step 1: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: -BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set -BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: -BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set -BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: o Schizophrenia Value Set

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	o Bipolar Disorder Value Set -ED Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set -BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set -BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set -BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set (2) Identify Diabetes Step 2: Of the patients identified in Step 1, identify patients with diabetes (see Diabetes Value Set) during the measurement year or the year prior using the following data: Claim/encounter data: -At least two outpatient visits (see Outpatient Value Set), observation visits (see Observation Value Set), ED visits (ED Value Set) or nonacute inpatient encounters (see Nonacute Inpatient Value Set) on different dates of service, with a diagnosis of diabetes (see Diabetes Value Set). Visit type need not be the same for the two visits. -At least one acute inpatient encounter (see Acute Inpatient Value Set) with a diagnosis of diabetes (see Diabetes Value Set). Pharmacy data: -Patients who were dispensed insulin or hypoglycemics/ antihyperglycemics on an ambulatory basis during the measurement year or the year prior to the measurement year (see Table 1) Both methods to identify the eligible population should be used, however, an individual need only be identified by one to be included in the measure. TABLE 1. PRESCRIPTIONS TO IDENTIFY PATIENTS WITH DIABETES Alpha-glucosidase inhibitors: Acarbose, Miglitol Amylin analogs: Pramlinitide Antidiabetic combinations: Glimepiride-pioglitazone, Glimepiride-rosiglitazone, Glipizide-metformin, Glyburide-metformin, Metformin-pioglitazone, Metformin-rosilitazone, Metformin-sitagliptin, Saxagliptin, Sitagliptin-simvastatin Insulin: Insulin aspart, Insulin aspart-insulin aspart protamine, Insulin detemir, Insulin glargine, Insulin glulisine, Insulin inhalation, Insulin isophane beef-pork, Insulin isophane human, Insulin isophane-insulin regular, Insulin lispro, Insulin lispro-insulin lispro protamine, Insulin regular human, Insulin zinc human Meglitinides: Nateglinide, Repaglinide Miscellaneous antidiabetic agents:

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	Exenatide, Liraglutide, Metformin-repaglinide, Sitagliptin Sulfonylureas: Acetohexamide, Chlorpropamide, Glimepiride, Glipizide, Glyburide, Tolazamide, Tolbutamide Thiazolidinediones: Pioglitazone, Rosiglitazone
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.
Exclusion details	Patients who do not have a diagnosis of diabetes (see Diabetes Value Set), in any setting, during the measurement year or year prior to the measurement year and who meet either of the following criteria: - A diagnosis of polycystic ovaries (see Polycystic Ovaries Value Set), in any setting, any time during the patient's history through December 31 of the measurement year. - A diagnosis of gestational diabetes or steroid-induced diabetes (see Diabetes Exclusions Value Set), in any setting, during the measurement year or the year prior to the measurement year.
Risk Adjustment	No risk adjustment or risk stratification Not applicable.
Stratification	Not applicable.
Type Score	Rate/proportion better quality = higher score
Algorithm	Step 1: Identify patients with serious mental illness. Step 2: Identify patients from step 1 who also have a diagnosis of diabetes during the measurement year or the year prior. Step 3: Exclude patients who meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. This is the denominator. Step 4: Identify patients who received an eye screening for diabetic retinal disease. This is the numerator. Step 5: Calculate the rate by dividing the numerator (step 4) by the denominator (after exclusions) (step 3). No diagram provided
Copyright / Disclaimer	5.1 Identified measures: 0055 : Comprehensive Diabetes Care: Eye Exam (retinal) performed 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing measure (Comprehensive Diabetes Care: Eye Exam NQF #0055) for the high risk subpopulation of people with serious mental illness who have a higher risk of disease 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. NCQA is the owner and steward of the existing NQF-endorsed measure and the specifications are harmonized. Building on this existing measure helps to reduce the burden of implementation for organizations and to align incentives for providers and organizations to focus on key quality of care issues. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

Appendix F: Related and Competing Measures

Comparison of NQF #0710 and NQF # 0711

	0710 Depression Remission at Twelve Months	0711 Depression Remission at Six Months
Steward	MN Community Measurement	MN Community Measurement
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.	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.
Type	PRO	PRO
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records An excel template with formatted columns for data fields is provided. Please refer to the attached data dictionary for data field definitions. All data is uploaded in electronic format (.csv file) to a HIPAA secure, encrypted and password protected data portal. PROM The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at www.phqscreeners.com. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available. The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010]	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records An excel template with formatted columns for data fields is provided. Please refer to the attached data dictionary for data field definitions. All data is uploaded in electronic format (.csv file) to a HIPAA secure, encrypted and password protected data portal. PROM The PHQ-9 depression assessment tool is a patient reported outcome tool that is in the public domain and can be obtained for free use on the Patient Health Questionnaire (PHQ) Screeners website at www.phqscreeners.com. Modes of administration include traditional paper, mail, electronic and telephonic. The tool is available on the website with 79 language translations available. The PHQ-9 tool is validated for use as a measure to assess the level of depression severity (for initial treatment decisions) as well as an outcome tool (to determine treatment response). [Löwe B, Unutzer J, Callahan CM, Perkins AJ, Kroenke K. Monitoring depression treatment outcomes with the Patient Health Questionnaire-9. Med Care 2004;42:1194-1201 and Kroenke K, Spitzer RL, Williams JBW, Löwe B. The Patient Health Questionnaire somatic, anxiety, and depressive symptom scales: a systematic review. Gen Hosp Psychiatry 2010]

	Available at measure-specific web page URL identified in S.1 Attachment MNCM_Depression_Measures_Data_Dictionary_and_Risk_Adj__6-18-2014-635397255382479839.xlsx	Available at measure-specific web page URL identified in S.1 Attachment MNCM_Depression_Measures_Data_Dictionary_and_Risk_Adj__6-18-2014.xlsx
Level	Facility, Clinician : Group/Practice	Facility, Clinician : Group/Practice
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	PHQ-9 scores are collected for each patient from the time they meet the inclusion criteria of diagnosis ICD-9 codes and PHQ-9 score greater than nine (this is the index or anchor date) until thirteen months have elapsed. This allows for calculation of a remission rate twelve months +/- 30 days from the index date.	PHQ-9 scores are collected for each patient from the time they meet the inclusion criteria of diagnosis ICD-9 codes and PHQ-9 score greater than nine (this is the index or anchor date) until seven months have elapsed. This allows for calculation of a remission rate +/- 30 days from the index date.
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.	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.
Numerator Details	This PROM-PM outcome measure is of a longitudinal nature, seeking to measure the absence of depression symptoms (remission) within twelve months for the patient with depression having an instance of elevated PHQ-9. The numerator is defined as patients with a twelve month (+/- 30 days) PHQ-9 score of less than five. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia with a PHQ-9 score < 5 at 12 months(+/- 30 days)/ # adult pts with major depression or dysthymia with index contact PHQ-9 > 9 Patients who do not have a twelve month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure.	This PROM-PM outcome measure is of a longitudinal nature, seeking to measure the absence of depression symptoms (remission) within six months for the patient with depression having an instance of elevated PHQ-9. The numerator is defined as patients with a six month (+/- 30 days) PHQ-9 score of less than five. The numerator rate is calculated as follows: # adult pts with major depression or dysthymia with a PHQ-9 score < 5 at 6 months(+/- 30 days)/ # adult pts with major depression or dysthymia with index contact PHQ-9 > 9 Patients who do not have a six month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure.
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.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.
Denominator Details	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND	Adults age 18 and older; no upper age limit Have the diagnosis of major depression or dysthymia defined by any of the following ICD-9* codes: 296.2x Major depressive disorder, single episode 296.3x Major depressive disorder, recurrent episode 300.4 Dysthymic disorder AND

	PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients who do not have a twelve month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure. Please refer to attached data dictionary for an inclusive list of all ICD-9/ ICD-10 codes and data element definitions.	PHQ-9 Score is greater than nine. * For primary care providers the diagnosis codes can be in any position (primary or secondary). For behavioral health providers the diagnosis codes need to be in the primary position. This is to more accurately define major depression and exclude patients who may have other more serious mental health diagnoses (e.g. schizophrenia, psychosis) with a secondary diagnosis of depression. Patients who do not have a six month +/- 30 day PHQ-9 score obtained are included in the denominator for this measure. Please refer to attached data dictionary for an inclusive list of all ICD-9/ ICD-10 codes and data element definitions.
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.	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.
Exclusion Details	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes in the attached data dictionary. •Personality Disorder (in any position). See personality disorder codes in the attached data dictionary. Our direct data submission process in MN allows for both up-front exclusions of the population and because this is a longitudinal outcome measure, processes are in place to allow exclusions that may occur after index during the course of the measurement period. Please see field specifications in the attached data dictionary.	•Patients who die during the measurement time frame •Patients who are a permanent nursing home resident during the measurement time frame •Patients who are enrolled in hospice during the measurement time frame •Bipolar Disorder (in any position) See bipolar disorder codes in the attached data dictionary. •Personality Disorder (in any position). See personality disorder codes in the attached data dictionary. Our direct data submission process in MN allows for both up-front exclusions of the population and because this is a longitudinal outcome measure, processes are in place to allow exclusions that may occur after index during the course of the measurement period. Please see field specifications in the attached data dictionary.
Risk Adjustment	Stratification by risk category/subgroup Like its companion measure, # 0711 Depression Remission at Six Months, this measure could be risk adjusted based on severity of depression (initial PHQ-9 score of 10 to 14- moderate depression, 15 to 19- moderately severe depression and 20 to 27- severe depression), insurance product type (commercial, Medicare, and MN government programs/ self-insured) and age bands (18-25, 26-50, 51-65 and 66+). #0711 Depression Remission at Six Months was risk	Stratification by risk category/subgroup This measure is risk adjusted based on severity band of the PHQ-9 which is based on the initial PHQ-9 score. Severity bands are defined as 10 to 14- moderate depression, 15 to 19- moderately severe depression and 20 to 27- severe depression. The measures is also risk adjusted for insurance product type (commercial, Medicare, and MN government programs/ self-insured) and age bands (18-25, 26-50, 51-65 and 66+).

	adjusted for inclusion in the MN Department of Health Statewide Quality Reporting and Measurement System. Depression Remission at Twelve Months was not a part of this strategy, but would use an identical model which is included in the Risk Adjustment attachments and in the measure testing appendices enclosed with this application. Depression Remission at Twelve months could be included in the future risk adjustment strategy discussed below. MN Community Measurement's Board of Directors has reviewed and discussed the issues surrounding risk adjustment of outcome data that is currently reported on our consumer facing public website at www.mnhealthscores.org and used in many health plan and state contracts for demonstrating excellence in outcomes. Historically, the Board has favored the public reporting of unadjusted rates determining that the wide variation in results for chronic disease measures were the result of variation in care process, rather than patient risk factors. As the breadth and complexity of the measures we are reporting have expanded and care processes and tools used by the community have become more standardized, the Board has convened a Risk Adjustment Task Force to evaluate methodologies for public reporting. Their preliminary recommendations indicate that publicly reported data should be risk adjusted using the "Actual to Expected" methodology, which would allow the unadjusted rate to be simultaneously preserved and displayed. Available in attached Excel or csv file at S.2b	Available in attached Excel or csv file at S.2b
Stratification	This measure is currently not stratified.	This measure is currently not stratified.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	This measure is calculated by submitting a visit level file for the eligible patients, each record in the file represents a contact with the patient and PHQ-9 score associated with this contact. Data file is submitted to a HIPAA secure data portal. Programming within the data portal determines the starting point (index visit) and then calculates based on dates if a twelve month +/- 30 days PHQ-9 was obtained and the resulting score. Calculation logic: Is patient eligible for inclusion with diagnosis codes of either 296.2x, 296.3x or 300.4 and PHQ-9 > 9? If yes, mark the visit as index (anchor) and	This measure is calculated by submitting a visit level file for the eligible patients, each record in the file represents a contact with the patient and PHQ-9 score associated with this contact. Data file is submitted to a HIPAA secure data portal. Programming within the data portal determines the starting point (index visit) and then calculates based on dates if a six month +/- 30 days PHQ-9 was obtained and the resulting score. Calculation logic: Is patient eligible for inclusion with diagnosis codes of either 296.2x, 296.3x or 300.4 and PHQ-9 > 9? If yes, mark the visit as index (anchor) and

	include this patient in the denominator. Does patient have a PHQ-9 score completed with a contact date that is twelve months +/- 30 days from the index date? If yes, include this score to calculate rate. Programming logic includes the most recent score within the +/- 30 day window. If no, patient is included in the denominator only. Not having a PHQ-9 score within the 60 day window is considered a numerator miss. If the patient does have a twelve month +/- 30 day PHQ-9 score is it less than five? If twelve month +/- 30 day PHQ-9 is less than five; is considered a numerator case for rate calculation. Available at measure-specific web page URL identified in S.1	include this patient in the denominator. Does patient have a PHQ-9 score completed with a contact date that is +/- 30 days from the index date? If yes, include this score to calculate rate. Programming logic includes the most recent score within the +/- 30 day window. If no, patient is included in the denominator only. Not having a PHQ-9 score within the 60 day window is considered a numerator miss. If the patient does have a six month +/- 30 day PHQ-9 score is it less than five? If six month +/- 30 day PHQ-9 is less than five; is considered a numerator case for rate calculation. Available at measure-specific web page URL identified in S.1
Submissi on items	5.1 Identified measures: 1885 : Depression Response at Twelve Months- Progress Towards Remission 1884 : Depression Response at Six Months- Progress Towards Remission 0712 : Depression Utilization of the PHQ-9 Tool 0711 : Depression Remission at Six Months 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response and use of the PQH-9. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the "gold standard" of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms. There are no other NQF endorsed measures that utilize a patient reported outcome tool to assess outcomes for patients with depression.	5.1 Identified measures: 0712 : Depression Utilization of the PHQ-9 Tool 1885 : Depression Response at Twelve Months- Progress Towards Remission 1884 : Depression Response at Six Months- Progress Towards Remission 0710 : Depression Remission at Twelve Months 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: There are related, complimentary measures for depression remission, response and use of the PQH-9. MN Community Measurement is the measure steward for these related measures and they are completely harmonized. The remission measures are considered the "gold standard" of depression outcomes and measure the same population of patients at two different points in time, six and twelve months after index contact with diagnosis and elevated PHQ-9. The response measures, also at six and twelve months are considered as progress towards the desired goal of remission with a reduction in PHQ-9 score of greater than 50% representing a reduction in the severity of symptoms. There are no other NQF endorsed measures that utilize a patient reported outcome tool to assess outcomes for patients with depression.

Comparison of NQF #2597, NQF #2599, and NQF #2600

	2597 Substance Use Screening and Intervention Composite	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
Steward	American Society of Addiction Medicine	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	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	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).	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. 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.
Type	Composite	Process	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record Not applicable.	Administrative claims, Electronic Clinical Data, Paper Medical Records The denominator for this measure	Administrative claims, Electronic Clinical Data, Paper Medical Records The denominator for this measure

	No data collection instrument provided No data dictionary	is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment Alcohol_Screening_and_Follow-up_for_People_with_Serious_Mental_Illness_NQF_-2599-635427417613127062.xlsx	is based on administrative claims. The numerator for this measure is based on medical record documentation collected in the course of providing care to patients. No data collection instrument provided Attachment Tobacco_Use_Screening_-_Follow-up_for_People_with_Serious_Mental_Illness_or_Alcohol_and_Other_Drug_Dependence__NQF_-2600-635425023511668833.xlsx
Level	Clinician : Group/Practice, Clinician : Individual	Health Plan	Health Plan
Setting	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient	Ambulatory Care : Clinician Office/Clinic, Behavioral Health/Psychiatric : Outpatient
Time Window	Each of the components look for performance at least once within 24 months prior to the end of the measurement period (measurement period or year prior)	Numerator: 15 months Denominator: 12 months Exclusion: 9 months	Numerator: 24 months Denominator: 12 months Exclusions: This measure has no exclusions.
Numerator Statement	Patients who received the following substance use screenings at least once within the last 24 months AND who received an intervention for all positive screening results: Tobacco use component Patients who were screened for tobacco use at least once within the last 24 months AND who received tobacco cessation intervention if identified as a tobacco user Unhealthy alcohol use component Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user Drug use component	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.	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.

	(nonmedical prescription drug use and illicit drug use) Patients who were screened for nonmedical prescription drug use and illicit drug use at least once within the last 24 months using a systematic screening method AND who received brief counseling if identified as a nonmedical prescription drug user or illicit drug user		
Numerator Details	For Tobacco HQMF eMeasure specification attached to this form. All measure specific value sets for the Tobacco component are available at https://vsac.nlm.nih.gov/. For Alcohol HQMF eMeasure specification attached to this form. 35/43 measure specific value sets are published by the VSAC and are currently in use. 8/43 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a]. Drug HQMF eMeasure specification attached to this form. 33/41 measure specific value sets are published by the VSAC and are currently in use. 8/41 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 41 value sets included	Alcohol Use Screening ADMINISTRATIVE: Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. MEDICAL RECORD: Patients who had systematic screening 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. Systematic Screening A systematic screening method is defined as: Asking the patient about their weekly use (alcoholic drinks per week), or Asking the patient about their per occasion use (alcoholic drinks per drinking day) or Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or Using another standardized tool Unhealthy Alcohol Use Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories	Tobacco Use Screening: MEDICAL RECORD: Patients who had screening for tobacco use documented any time during the year prior to the measurement year or during the first 9 months of the measurement year. Tobacco Use Definition: 'Tobacco Use' is defined to include any type of tobacco. Follow-up: ADMINISTRATIVE: Patients who received follow-up care within three months of screening if identified as a tobacco user. Follow-up care is defined as: 1) Two events of counseling (see Tobacco Cessation Counseling Value Set), on different dates, for tobacco use with the provider who did the screening or another provider including health plan clinical case managers (Participation in community-based programs such as quit lines or non-clinical support activities can count as counseling if documented in the health record (referrals alone do not count)). 2) One event of counseling (see Tobacco Cessation Counseling Value Set) and one event of medication fill (see Tobacco Cessation Medication Value

	in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].	representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age. Follow-Up ADMINISTRATIVE: Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users. MEDICAL RECORD: Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count). Counseling Counseling may include at least one of the following: Feedback on alcohol use and harms Identification of high risk situations for drinking and coping strategies Increase the motivation to reduce drinking	Set) or use for tobacco cessation. MEDICAL RECORD: Patients who received follow-up care within three months of screening if identified as a tobacco user. Follow-up care is defined as: 1) Two events of counseling, on different dates, for tobacco use with the provider who did the screening or another provider including health plan clinical case managers (Participation in community-based programs such as quit lines or non-clinical support activities can count as counseling if documented in the health record (referrals alone do not count)). One event of counseling and one event of medication fill or use for tobacco cessation.

		Development of a personal plan to reduce drinking	
Denominator Statement	All patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the 12 month measurement period	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 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.
Denominator Details	For Tobacco HQMF eMeasure specification attached to this form. All measure specific value sets for the Tobacco component are available at https://vsac.nlm.nih.gov/. For Alcohol HQMF eMeasure specification attached to this form. 35/43 measure specific value sets are published by the VSAC and are currently in use. 8/43 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 43 value sets included in this measure, 2/43 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a]. Drug HQMF eMeasure specification attached to this form. 33/41 measure specific value	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses:	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during the measurement year. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one-month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Serious Mental Illness Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: • BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses:

	sets are published by the VSAC and are currently in use. 8/41 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].	- Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and	o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set • BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set o Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: • BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • ED Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH ED Value Set with

		one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set	BH ED POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Stand Alone Non-acute Inpatient Value Set with one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set • BH Non-acute Inpatient Value Set with BH Non-acute Inpatient POS Value Set and one of the following diagnoses: o Schizophrenia Value Set o Bipolar Disorder Value Set Alcohol or Other Drug Dependence Diagnosis Criteria: Identify patients with alcohol or other drug as those who met at least one of the following criteria during the measurement year: • An outpatient visit, intensive outpatient visit or partial hospitalization with a diagnosis of AOD. Any of the following code combinations meet criteria: – IET Stand Alone Visits Value Set with AOD Dependence Value Set. – IET Visits Group 1 Value Set with IET POS Group 1 Value Set and AOD Dependence Value Set. – IET Visits Group 2 Value Set with IET POS Group 2 Value Set and AOD Dependence Value Set. • A detoxification visit (Detoxification Value Set). • An ED visit (ED Value

			Set) with a diagnosis of AOD (AOD Dependence Value Set). • An inpatient discharge with a diagnosis of AOD as identified by either of the following: – An inpatient facility code with a diagnosis of AOD (AOD Dependence Value Set). – An inpatient facility code with an AOD procedure code (AOD Procedures Value Set).
Exclusions	Denominator exceptions include documentation of medical reason(s) for not screening for tobacco use, unhealthy alcohol use, or nonmedical prescription drug/illicit drug use (eg, limited life expectancy, other medical reasons)	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).	Not applicable.
Exclusion Details	The components of this measure were created using the PCPI methodology. The PCPI exception methodology states that exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of exception reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale	Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).	Not applicable.

	to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this composite measure, exceptions may include medical reason(s) (eg, limited life expectancy).Where examples of exceptions are included in the measure language, value sets for these examples are developed and are included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For Tobacco HQMF eMeasure specification attached to this form. All measure specific value sets for the Tobacco component are available at https://vsac.nlm.nih.gov/. For Alcohol HQMF eMeasure specification attached to this form. 35/43 measure specific value sets are published by the VSAC and are currently in use. 8/43 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 43 value sets included in this measure, 2/43 measure		

	specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a]. Drug HQMF eMeasure specification attached to this form. 33/41 measure specific value sets are published by the VSAC and are currently in use. 8/41 measure specific value sets are currently in a draft authoring status in the VSAC. Of the 41 value sets included in this measure, 2/41 measure specific value sets are pending new content that is currently under development by the Regenstrief Institute (submitted Feb 2014). We have included place holders for the currently empty value sets in the value set MAT export; the place holders are included in [the HQMF zip package] or [S.2a].		
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.	No risk adjustment or risk stratification Not applicable.	No risk adjustment or risk stratification Not applicable.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, payer, and administrative sex, and have included these variables as supplemental data elements to be collected in the HQMF eMeasure.	Not applicable.	Not applicable.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rate for the overall composite measure: Our approach to the composite measure algorithm	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a	RATE 1: Tobacco Use Screening and Follow-up for People with Serious Mental Illness

	for the NIDA Substance Use Screen and Brief Counseling electronic clinical quality measure is to employ a simple scoring methodology which identifies the number of eligible patients who received recommended care for each component measure divided by the number of eligible patients (or "opportunities"). This scoring method, known as opportunity- based scoring, is identical to that used by the Centers for Medicare and Medicaid Services (CMS) in its pay-for-performance programs. The underlying calculation used for our opportunity-based provider-level composite score is as follows: (N1+N2+N3) ---------- [(D1+D2+D3) – (DE1+DE2+DE3)] Available in attached appendix at A.1	serious mental illness Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year. Step 2: Identify Numerator. Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop. Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.) No diagram provided	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness Step 2: Identify the numerator. Step 2A: Identify the date of screening for tobacco use during the year prior to the measurement year or during the first 9 months of the measurement year. Step 2B: Identify the tobacco use screening result. If negative for tobacco use, stop. Step 2C: If positive for tobacco use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for tobacco use (from Step 2B) plus the number of patients with positive screening for tobacco use who received follow-up care (from Step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after step 1A is complete). ---------- ---------- ---------- ---------- RATE 2: Tobacco Use Screening and Follow-up for People with Alcohol or Other Drug Dependence Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with alcohol or other drug dependence. Step 2: Identify the numerator.

			Step 2A: Identify the date of screening for tobacco use during the year prior to the measurement year or during the first 9 months of the measurement year. Step 2B: Identify the tobacco use screening result. If negative for tobacco use, stop. If positive for tobacco use Step 2C: If positive for tobacco use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for tobacco use (from Step 2B) plus the number of patients with positive screening for tobacco use who received follow-up care (from Step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after step 1A is complete). No diagram provided
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: n/a 5b.1 If competing, why superior or rationale for additive value: While there are individual measures addressing screening and brief intervention for alcohol and tobacco use, there is no measure that looks at screening and brief intervention for more than one substance.	5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized	5.1 Identified measures: 0028 : Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028) for use at the health plan level for the high risk subpopulation of people with serious mental illness and alcohol or other drug dependence. This measure is harmonized with

		and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated disparities in care -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why	the existing measure (Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention NQF #0028) and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed subpopulation measure were developed with expert input and are described here: -The population focus: This measure focuses on people with serious mental illness or alcohol or other drug dependence, who are at a higher risk of tobacco use than the general population and have demonstrated disparities in care. -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling or one event of counseling and one event of medication fill or use for tobacco cessation, raising expectations for the intensity of service for the serious mental illness/alcohol or other drug dependence population compared to the original measure for the general population, and are reasonably achievable, particularly in the health plan context. -USPSTF recommendation concluded that even brief counseling (<3 minutes) is effective, there is a dose–response relationship between quit rates and the number of sessions of counseling; and the combination of counseling and pharmacotherapy is more effective than either component alone. -In addition, the existing measure (NQF #0028) is reported at the provider level and is focused

		superior or rationale for additive value: Not applicable.	on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on tobacco screening for patients with serious mental illness or alcohol or other drug dependence and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.

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