NATIONAL QUALITY FORUM

Memo

TO: NQF Members

FR: NQF Staff

RE: Voting Draft Report: *NQF-Endorsed Measures for Behavioral Health Phase 3*

DA: January 20, 2015

Background

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 2012, NQF endorsed 10 behavioral health measures in the areas of tobacco and alcohol use, medication adherence, diabetes health screening and assessment, and hospitalization follow-up. A subsequent phase of work recommended 20 measures for endorsement in the areas of: tobacco and alcohol use, depression screening, medication adherence, and hospital-based inpatient psychiatric services. These recommendations were put forth for public comment in September, 2013; the project was completed by March of 2014. In the third phase of the behavioral health work, the 24 Standing Committee members recommend3ed 16 out of 18 measures for endorsement, deferred 1 measure and approved 1 measure for trial use. The comment period for these measures was open from November 10, 2014 to December 12, 2014.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public

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[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] Ibid.

[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, D.C.

after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from August 21-September 10, 2014 for 14 of the 19 measures under review. A total of nine pre-evaluation comments were received; the majority of which pertained to creating a composite of the Diabetes Care for People with Serious Mental Illness measures. All of these pre-evaluation comments were provided to the Committee prior to their initial deliberations held during the workgroups calls and in-person meeting. In addition, the measure developers were asked to respond to the issues raised from the pre-evaluation comments when they provided their measure introduction.

Post-evaluation comments

After the workgroup calls and in-person meeting, NQF staff prepared a report of the proceedings which captured the discussions of the Standing Committee during evaluations, the comments received to date and where the developers had provided any additional information. The Draft Report went out for Public and Member comment November 10, 2014 to December 12, 2014. During this commenting period, NQF received 58 comments from 12 organizations (two of which were members):

Consumers – 0	Professional – 0
Purchasers – 0	Health Plans – 1
Providers – 1	QMRI – 0
Supplier and Industry – 0	Public & Community Health - 0

A complete table of comments submitted pre- and post-evaluation, along with the responses to each comment and the actions taken by the Standing Committee, is posted to the project page on the NQF website, along with the measure submission forms.

The Committee reviewed all comments received and considered the pre-meeting comments prior to making an endorsement recommendation. The Committee also responded to all post-evaluation comments. Revisions to the draft report and the accompanying measure specifications are identified as red-lined changes. (Note: Typographical errors and grammatical changes have not been red-lined, to assist in reading.)

Comments and their Disposition

Two major themes were identified in the post-evaluation comments, as follows:

1. Stratifying Subpopulations in Current Diabetes Measures
2. Reconsider 0722: Pediatric Symptom Checklist (PSC)

Theme 1 - Stratifying Subpopulations in Current Diabetes Measures

Two commenters expressed concerns 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

Developer Response:

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 eye screening for diabetic retinal eye disease 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.

Committee Response:

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

Theme 2 – Reconsider 0722: Pediatric Symptom Checklist (PSC)

One commenter encouraged the committee to allow the measure developer to refine and resubmit this measure. NQF staff asked the Committee to reconsider their previous recommendation based on opportunities for re-consideration of the measure: If the measure is not recommended, the measure will lose endorsement and will not be re-evaluated until another Behavioral Health or related project is slated to begin. If the measure is deferred, the developer will be able to retain endorsement until a new project is slated to start. The measure previously received endorsement in 2013.

Committee Response:

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

Measure Specific Comments

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

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.

Developer Response:

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.

Committee Response:

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.

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

One commenter expressed concerns regarding the validity of the measure specifying one screening tool for treatment and encouraged that the developer allow more flexibility by allowing multiple approved screens. The Committee did not reach consensus on the validity of the measure during their deliberations.

Developer Response:

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

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used."

We hope that the by delineating minimum criteria to be included in a risk assessment and providing an example of a tool that would meet the measure, there will be less variability in how these assessments are performed and captured.

Committee Response:

While the Committee appreciated the responsiveness of the developer to comments, it did not feel that either the public comment nor the developer response warranted further consideration or re-vote on the consensus not reached criteria (Scientific

Acceptability) of the measure. 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.

NQF Member Voting

Information for electronic voting has been sent to NQF Member organization primary contacts. Accompanying comments must be submitted via the online voting tool.

Please note that voting concludes on February 6, 2015 at 6:00 pm ET – no exceptions.