NATIONAL QUALITY FORUM

TO: Behavioral Health Steering Committee
FR: Angela Franklin, Senior Director
Elisa Munthali, Managing Director
Lauralei Dorian, Project Manager
Poonam Bal, Project Analyst
SU: Behavioral Health Phase 2 – Post-Comment Call to Discuss Public and Member Comments
DA: November 8, 2013

The Behavioral Health Steering Committee will meet via conference call on Tuesday, November 12th from 1:00 – 3:00pm ET. The purpose of the meeting is to:

1. Discuss comments received during the public and member comment period.
2. Provide input on draft responses to comments.
3. Determine the need for reconsideration of any initial recommendations.

Steering Committee Action:

1. Review the comments received during the public and member comment period and the proposed responses. (The excel spreadsheet included in the meeting materials has been organized by comment theme. Filters have also been applied to the spreadsheet to enable sorting by measure title, measure developer, submitter, member council, etc.)
2. Review comment themes and proposed responses detailed in this memo.
3. Be prepared to provide feedback and input on proposed comment responses.

Conference Call Information: Tuesday, November 12th: 1:00-3:00pm ET

Please use the following information to access the conference call

Dial-in Number: 1-(888)-799-5160
Conference ID: 76866787
Event Title: Behavioral Health SC – Comment Review Call

Webinar: http://nqf.commpartners.com/se/Rd/Mt.aspx?104347
Please note that the registration link will be activated 15 minutes prior to the meeting.

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BEHAVIORAL HEALTH MEASURE REVIEW SUMMARY

	Maintenance	New	Total
Measures under consideration	11	13	24
Measures withdrawn from consideration	0	1	1
Measures recommended	9	11	20
Measures not recommended	2	2	4
Reasons for not recommending	Importance to measure and report – 2	Importance to measure and report - 2	Importance to measure and report - 2

NQF received **324** comments on the draft report from **40** organizations. The overarching themes of the comments and topics identified for Committee discussion are detailed below. Comments and questions related to measure specifications were sent to measure developers; developer responses are included below. For comments related to the application of measure criteria or Steering Committee deliberation, NQF has draft proposed responses for the Steering Committee to consider, also included. All comments and proposed responses are subject to discussion; the themes are not intended to limit the Committee's discussion. Please refer to the excel comment table to view the individual comments received and the proposed responses to each.

Overarching Themes Identified

The majority of comments received (60%) were supportive of the project and measures, including the Steering Committee's recommendation to expand the target populations for a number of tobacco and alcohol and substance use measures. Commenters also made several recommendations for future measure development. Other comments generally related to the following categories:

1. Evidence supporting the suites of The Joint Commission's Tobacco (TOB) and Alcohol/Substance (SUB) measures;
2. Appropriateness of the suites of The Joint Commission's Tobacco (TOB) and Alcohol/Substance (SUB) measures for use in the inpatient psychiatric setting;
3. Reliability of measure #1661 SUB-1Alcohol Use Screening (The Joint Commission); and
4. Support for measures not recommended.

Theme 1:
Evidence supporting The Joint Commission's suites of Tobacco (TOB) and Alcohol/Substance (SUB) Use measures

Tobacco (TOB) Measures

Description: Two commenters did not support the recommended endorsement of the following tobacco and substance use measures, and questioned whether the measures meet the evidence criterion relative to hospitalization and discharge: 1651 TOB-1 Tobacco Use Screening; 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. Commenters noted that there is incomplete evidence to suggest that offering any of the measured interventions results in lower rates of alcohol and drug abuse.

Developer Response:

Findings from a large number of hospital studies and 2 Cochrane meta-analyses concluded –

- Providing cessation follow-up post hospitalization is a key component of effective cessation interventions
- There is substantial evidence that cessation Interventions are effective regardless of the patient's reason for admission.
- Among the strategies that enhance effectiveness of cessation interventions are: 1) chart prompts, 2) provision of self-help information to patients, 3) counseling, and 4) post-discharge telephone calls

Specific results from the most recent 2012 Cochrane analysis of hospital interventions were quite robust across the 50 studies included in their meta-analysis. These results included-

- Fifty trials met the inclusion criteria. Intensive counseling interventions that began during the hospital stay and continued with supportive contacts for at least one month after discharge increased smoking cessation rates after discharge (risk ratio (RR) 1.37, 95% confidence interval (CI) 1.27 to 1.48; 25 trials).
- A specific benefit for post-discharge contact compared with usual care was found in a subset of trials in which all participants received a counseling intervention in the hospital and were randomly assigned to post-discharge contact or usual care.
- Adding nicotine replacement therapy (NRT) to an intensive counseling intervention increased smoking cessation rates compared with intensive counseling alone (RR 1.54, 95% CI 1.34 to 1.79, six trials)

Finally, in a recently published randomized control trial, Prochaska, et. al. demonstrated that supporting patients with mental illness who smoke by providing a smoking cessation intervention during their hospitalization is feasible. Furthermore, the authors demonstrated that such interventions can be completed with little burden on ongoing mental health service

delivery. Two key outcomes were: 1) a significant positive effect on cessation rates and, 2) no negative impact to mental health recovery. (Judith J. Prochaska, Stephen E. Hall, Kevin Delucchi, and Sharon M. Hall. August 15, 2013. Efficacy of Initiating Tobacco Dependence Treatment in Inpatient Psychiatry: A Randomized Controlled Trial. American Journal of Public Health. doi: 10.2105/AJPH.2013.301403)

The evidence clearly demonstrates that hospitalizations are an excellent venue for delivering smoking cessation interventions, for patients in general and for mental health patients in particular – a population that suffers from dramatically high rates of smoking. Such interventions both add years of life and substantially reduce readmission due to infections and other causes.

Proposed Committee Response: In the first phase of this project, the Steering Committee reviewed and rated the three importance criteria - impact, performance gap and evidence - for the tobacco use measures 1651 TOB-1, 1654 TOB-2 and 1656 TOB-3. Because the tobacco and alcohol suits of measures were deferred to the second phase of this project for additional testing, ratings and recommendations were carried over from the first phase of work. The Steering Committee agreed that there is sufficient evidence to support the measures and discussed at length the fact that, generally, the evidence presented to support the measures is not related exclusively to the inpatient setting, and observed that the evidentiary picture is incomplete as there are few studies specifically related to tobacco screening and brief intervention (rather than intensive intervention) in hospitalized inpatients. The Committee noted, however, that the U.S. Preventive Services Taskforce (USPSTF) evidence presented in the measure submissions is applicable to all settings, and the Cochrane review presented does include inpatient settings. The Committee also mentioned that there is a fair body of evidence across settings specifically linking intensive intervention to desired outcomes, but noted that brief intervention could also have an impact. As a result, the Committee ultimately agreed that sufficient evidence related to the inpatient setting was presented and the measures met the evidence criterion.

<u>Substance Use (SUB) Measures</u>

Description: Commenters did not support the recommended endorsement of the following substance use measures and questioned whether the measures meet the evidence criterion relative to hospitalization and 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; SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge (The Joint Commission),.

Developer Response: A 2011 Cochrane Collaboration review of brief interventions for risky alcohol use opportunistically identified among general hospital medically ill patients found brief interventions delivered during a single brief counseling session in the hospital have reduced risky alcohol use and alcohol-related health outcomes in multiple randomized trials . The review

summary states: Heavy or dangerous patterns of drinking alcohol can lead to accidents, injuries, physical and psychiatric illnesses, frequent sickness, absence from employment and social problems. Long term alcohol consumption has harmful effects on almost all organs of the body, particularly the brain and gastro-intestinal system.

Healthcare professionals have the opportunity to ask people about how much alcohol they drink and offer brief interventions to heavy drinkers. These brief interventions involve a time limited intervention focusing on changing behavior. They range from a single session providing information and advice to one to three sessions of motivational interviewing or skills-based counseling involving feedback and discussion on responsibility and self-efficacy. Different health professionals who are not alcohol specialists may give the intervention. Admission to hospital as an inpatient, in general medical wards and trauma centers, provides an opportunity whereby heavy alcohol users are accessible, have time for an intervention, and may be made aware of any links between their hospitalization and alcohol. The review authors identified 14 randomized controlled trials and controlled clinical trials involving 4041 mainly male adults (16 years or older) identified as heavy drinkers in hospital, mainly in the UK and USA. The main results of this review indicate that there are benefits to delivering brief interventions to heavy alcohol users in general hospital. Our results demonstrate that patients receiving brief interventions have a greater reduction in alcohol consumption compared to those in control groups at six month and nine month follow up but this is not maintained at one year. In addition there were significantly fewer deaths in the groups receiving brief interventions than in control groups at 6 months and one year. However, these findings are based on studies involving mainly male participants. Furthermore screening, asking participants about their drinking patterns, may also have a positive impact on alcohol consumption levels and changes in drinking behavior and this is an area that requires further investigation. Further research is required determine the optimal content and treatment exposure of brief interventions within general hospital settings and whether they are likely to be more successful in patients with certain characteristics.

A second review that examined research of screening and brief intervention for risky alcohol use in general hospital, emergency department and inpatient trauma patient population for general support for the efficacy of brief alcohol interventions, but point that the evidence is increasingly mixed. The authors of this review point to possible confounding factors; including the inconsistencies in interventions provided, differences in target population, study design and assessment procedures. Recent studies investigating potential moderators of treatment outcomes suggest that a more sophisticated approach to evaluating the effectiveness of brief interventions across varying patient populations is needed in order to further understand its effectiveness. Current dissemination efforts represent a significant advance in broadening the base of treatment for alcohol problems by providing an evidenced based intervention in health care settings and should not be curtailed.

SUB-3 specifies that patients with a substance use diagnosis must be offered pharmacotherapy OR a specific referral to psychosocial treatment/support as part of discharge planning. The

measure permits discharge to patients' primary care or medical specialists for post-discharge treatment, as well as to specialty substance use or mental health treatment programs. Treatment of substance use disorders (SUD) with pharmacotherapy, also termed medication assisted treatment (MAT), generally includes medications such as naltrexone, extended-release naltrexone, disulfiram and acamprosate for alcohol abuse and dependence and buprenorphine and methadone for opioid dependence. Use of pharmacotherapy in treating SUD is widely promoted by clinical protocols and policy recommendations, increasingly adopted in outpatient settings, and now covered by many insurers. In 2007, the National Quality Forum (NQF), as part of consensus standards for the treatment of SUD, noted that "pharmacotherapy should be a standard component of treatment for SUD when effective drugs exist". The standards specify that once a patient is diagnosed with a substance use disorder, pharmacotherapy should be offered and therapeutic counseling recommended:

Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. Pharmacotherapy should be recommended and available to all adult patients diagnosed with opioid dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support.

The Veterans Administration/Department of Defense clinical guidelines for substance use disorders directly tie recommendations to research evidence using the US Preventive Services research rating criteria of scientific rigor, generalizability, effectiveness and cost-effectiveness. The guidelines recommend consideration of pharmacotherapy for alcohol and drug dependence: Routinely consider oral naltrexone, an opioid antagonist, and/or acamprosate for patients with alcohol dependence. [A] Medications should be offered combined with addiction-focused counseling. [A] Provide access to OAT for all opioid dependent patients, under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment as indicated. [A] Strongly recommend methadone or sublingual buprenorphine/naloxone maintenance as first line treatments due to their documented efficacy in improving retention and reducing illicit opioid use and craving. [A]

Proposed Committee Response: In the first phase of this project the Steering Committee reviewed and rated the three importance sub-criteria - impact, performance gap and evidence - for the substance use measures (1661 SUB-1, 1663 SUB-2 and 1664 SUB-3) and agreed that sufficient evidence was presented to support the measures. The Committee noted that the majority of the evidence, generally, is related to the outpatient setting. However, following substantial discussion, committee members agreed that certain evidence could be generalizable from the primary care setting to the inpatient setting, and that sufficient evidence was presented related to the inpatient setting based on the USPSTF and Cochrane review evidence to

support the measures.

Theme 2:
Appropriateness of Tobacco (TOB) and Alcohol/Substance (SUB) use measures in the inpatient psychiatric setting

Description: 14 commenters did not support the recommended endorsement of the tobacco and alcohol/substance use suites of measures for use in the inpatient psychiatric setting, citing concerns about the appropriateness of brief interventions given the intensive treatment provided to patients in this setting, and the burden of collecting data and providing referrals at discharge.

Developer Response: The Joint Commission specified this measure for use in all hospitals; therefore, since testing was conducted in psychiatric settings as well as general acute care hospitals, it is equally appropriate for use in IPFs.

Proposed Committee Response: For discussion.

Theme 3:
Reliability of SUB-1 measure

Description: One commenter did not support the recommended endorsement of the substance use measure 1661 SUB-1 Alcohol Use Screening, concerned by the measure's reliability. In particular, the overall agreement rate for re-abstraction (75 percent) and the agreement rate for the data element 'alcohol use status' (64.7 percent) were noted.

Developer Response: A 2011 Cochrane Collaboration review of brief interventions for risky alcohol use opportunistically identified among general hospital medically ill patients found brief interventions delivered during a single brief counseling session in the hospital have reduced risky alcohol use and alcohol-related health outcomes in multiple randomized trials . The review summary states: Heavy or dangerous patterns of drinking alcohol can lead to accidents, injuries, physical and psychiatric illnesses, frequent sickness, absence from employment and social problems. Long term alcohol consumption has harmful effects on almost all organs of the body, particularly the brain and gastro-intestinal system. Healthcare professionals have the opportunity to ask people about how much alcohol they drink and offer brief interventions to heavy drinkers. These brief interventions involve a time limited intervention focusing on changing behavior. They range from a single session providing information and advice to one to three sessions of motivational interviewing or skills-based counseling involving feedback and discussion on responsibility and self-efficacy. Different health professionals who are not alcohol specialists may give the intervention. Admission to hospital as an inpatient, in general medical wards and trauma centers, provides an opportunity whereby heavy alcohol users are accessible, have time for an intervention, and may be made aware of any links between their hospitalization

and alcohol. The review authors identified 14 randomized controlled trials and controlled clinical trials involving 4041 mainly male adults (16 years or older) identified as heavy drinkers in hospital, mainly in the UK and USA. The main results of this review indicate that there are benefits to delivering brief interventions to heavy alcohol users in general hospital. Our results demonstrate that patients receiving brief interventions have a greater reduction in alcohol consumption compared to those in control groups at six month and nine month follow up but this is not maintained at one year. In addition there were significantly fewer deaths in the groups receiving brief interventions than in control groups at 6 months and one year. However, these findings are based on studies involving mainly male participants. Furthermore screening, asking participants about their drinking patterns, may also have a positive impact on alcohol consumption levels and changes in drinking behavior and this is an area that requires further investigation. Further research is required determine the optimal content and treatment exposure of brief interventions within general hospital settings and whether they are likely to be more successful in patients with certain characteristics.

A second review that examined research of screening and brief intervention for risky alcohol use in general hospital, emergency department and inpatient trauma patient population for general support for the efficacy of brief alcohol interventions, but point that the evidence is increasingly mixed. The authors of this review point to possible confounding factors; including the inconsistencies in interventions provided, differences in target population, study design and assessment procedures. Recent studies investigating potential moderators of treatment outcomes suggest that a more sophisticated approach to evaluating the effectiveness of brief interventions across varying patient populations is needed in order to further understand its effectiveness. Current dissemination efforts represent a significant advance in broadening the base of treatment for alcohol problems by providing an evidenced based intervention in health care settings and should not be curtailed.

It should be noted that reliability testing was performed via reabstraction of the same medical records that were originally abstracted and not randomly selected records as asserted by the commenter. Further we note that reliability scores were considered to be acceptable according to generally accepted guidelines. The Joint Commission had no influence on the decision by CMS to include this measure in the IPFQR program. The Joint Commission specified this measure for use in all hospitals; therefore, since testing was conducted in psychiatric settings as well as general acute care hospitals it is equally appropriate for use in IPFs.

Proposed Committee Response: The Steering Committee reviewed the reliability of the measure 1661 SUB-1 based on additional testing presented by the Joint Commission. The additional testing gauged the sensitivity and specificity of the measure and the Committee noted improvements from previous reliability testing presented. NQF's measure evaluation criteria requires reliability testing to demonstrate that either the measure data elements are repeatable, producing the same results a high proportion of the time when assessed in the same population in the same time period, and/or that the overall measure score is precise.

The Committee noted that the overall measure agreement rate of 75 percent between the originally abstracted data and the re-abstracted data is at the threshold of an acceptable agreement rate, and ultimately determined it was sufficient to meet the criterion. The Committee also noted that further improvement is expected over time as the measure is more widely adopted.

Theme 4:
Support for measures not recommended

0103 Adult Major Depressive Disorder-MDD (AMA-PCPI)

Description: Commenters suggested that the Committee recommend for endorsement measure 0103 Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity, expressing a belief that by ensuring accurate diagnosis and severity assessment of MDD, measure 0103 could lead to improvement in the appropriateness of treatment and follow-up.

Proposed Committee Response: The Steering Committee concluded that there is a lack of evidence to support the causal pathway for this measure, and agreed the measure did not meet the evidence criterion. The Committee further agreed the measure did not need to be considered for an exception to the evidence criterion, as the potential benefits of the measure did not outweigh potential harms.

0552 HBIPS-4 (TJC)

Description: Commenters suggested that the Committee recommend for endorsement measure 0552 HBIPS-4 Patients discharged on multiple antipsychotic medications to ensure there is context for HBIPS-5 and that important data to assess prevalence is captured.

Proposed Committee Response: Understanding that this measure assesses the prevalence of patients discharged on multiple antipsychotics, the Committee determined that the data captured in HBIPS-4 is also captured in HBIPS-5, and therefore is unnecessary as a separate measure. The Steering Committee did note, however, that the clinical data gathered in HBIPS-4 may still be used by providers to assess prevalence without endorsement.

1657 TOB-4 Tobacco Use (TJC)

Description: Commenters suggested that the Committee recommend for endorsement measure 1657 TOB-4 Tobacco Use: Assessing Status after Discharge as an important continuation of the suite of tobacco measures. One commenter suggested the measure could be strengthened by connecting post-discharge tobacco or substance abuse status with documentation that the

patient has received follow-up treatment.

Proposed Committee Response: The Steering Committee reviewed this measure at length and agreed that there is evidence that certain types of follow-up contact with patients post-discharge leads to tobacco use cessation. However, the Committee concluded that there is insufficient evidence that the type of follow-up contact specified in this measure (inquiring about quit status) would achieve the intended result.