NATIONAL QUALITY FORUM

Memo

May 8, 2018

To: Consensus Standards Approval Committee (CSAC)

From: Behavioral Health and Substance Use Project Team

Re: Behavioral Health and Substance Use Fall 2017 Cycle

CSAC Action Required

The CSAC will review recommendations from the Behavioral Health and Substance Use project at its May 8, 2018 meeting and vote on whether to uphold the recommendations from the Standing Committee.

This memo includes a summary of the project, recommended measures, and themes identified and responses to the public and member comments. The following documents accompany this memo:

1. **Behavioral Health and Substance Use Fall 2017 Cycle Draft Report**. The draft report has been updated to reflect the changes made following the Standing Committee's discussion of public and member comments. The complete draft report and supplemental materials are available on the project webpage.
2. **Comment Table**. Staff has identified themes within the comments received. This table lists 23 comments received during the post-meeting comment period and the NQF staff and Standing Committee responses.

Background

The Behavioral Health and Substance Use project aims to foster the endorsement of behavioral health and substance use performance measures that improve the quality of healthcare delivery and, ultimately, promote better health outcomes for the U.S. population. The most recent work of the project examines measures specific to the continuity and follow-up of care, use of antipsychotic medications, medication reconciliation, and psychosocial screening for children. The 25-member Behavioral Health and Substance Use Standing Committee evaluated five newly submitted measures against the NQF standard evaluation criteria: four measures were recommended for endorsement and one was not recommended for endorsement. NQF's Behavioral Health and Substance Use portfolio includes 50 measures covering areas relating to tobacco, alcohol and substance use; depression; medication use and adherence; care coordination; and physical health.

Draft Report

The **Behavioral Health and Substance Use Fall 2017 Cycle** draft report presents the results of the evaluation of five measures considered under the Consensus Development Process (CDP). Four are recommended for endorsement and one was not recommended.

The measures were evaluated against the 2017 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	0	5	5
Measures recommended for endorsement	0	4	4
Measures recommended for inactive endorsement with reserve status	0	0	0
Measures approved for trial use	0	0	0
Measures not recommended for endorsement or trial use	0	1	1
Measures withdrawn from consideration	0	0	0
Reasons for not recommending	Importance – N/A Scientific Acceptability – N/A Overall – N/A Competing Measure – N/A	Importance - 1 Scientific Acceptability - 0 Overall - 0 Competing Measure - 0	

CSAC Action Required

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

Measures Recommended for Endorsement

- 3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs (Mathematica Policy Research)

Overall Suitability for Endorsement: Yes-17; No-0

- 3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (Mathematica Policy Research)

Overall Suitability for Endorsement: Yes- 16; No-0

- 3317 Medication Reconciliation on Admission (Health Services Advisory Group, Inc.)

Overall Suitability for Endorsement: Yes-19; No-2

- 3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PCS-Tool) (Massachusetts General Hospital)

Overall Suitability for Endorsement: Yes-20; No-1

Measure Not Recommended

(See Appendix B for the Committee's votes and rationale)

- 3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (CMS)

Comments and Their Disposition

NQF received 23 comments from six member organizations pertaining to the draft report and to the measures under consideration.

A table of comments submitted during the comment period, with the responses to each comment and the actions taken by the Standing Committee and measure developers, is posted to the Behavioral Health and Substance Use project webpage.

Comment Themes and Committee Responses

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

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

Themed Comments

Theme 1 – Data Collection Challenges

Two comments focused on data collection challenges and reliance on manual data abstraction. One comment focused on measure 3313 urged NQF to be mindful of data collection challenges related to health plans where state Medicaid programs carve out pharmacy and/or behavioral health benefits. In such states, health plans are obligated to provide data before follow-up care can be initiated, which could potentially cause additional burden. A second commenter voiced concerns about the reliance on manual data abstraction and the associated burden specific to measure 3317. The commenter urged the developer to revise and retest the measure to enable electronic capture, stating that development of an eMeasure in this area would promote interoperability and ensure that the relevant information is available for use at the point of care.

Committee Response

We appreciate the of potential data collection challenges for some health plans, but also see this as an opportunity to incentivize states and health plans to improve data sharing to support measures like this.

Developer Response

Some health plans may face challenges identifying beneficiaries who would benefit from follow-up care after receipt of a newly prescribed antipsychotic and providing necessary data to calculate the measure. Measure 3313 presents a valuable opportunity for the healthcare system to improve the quality of care delivered to individuals who are prescribed antipsychotic medications. States and health plans may want to work together to improve timely data sharing so that data for this and other behavioral health measures are available.

Developer Response

Measure 3317 was developed as a chart-abstracted measure because among IPFs that participate in the Inpatient Psychiatric Facility Quality Reporting Program, only about 36 percent attested to using an electronic health record (EHR) system for fiscal year 2016 (CMS, 2016). We anticipate that if this measure were to be implemented, the data elements could be captured in structured fields and the average abstraction time per record to collect the eight data elements is likely to decrease. Re-specification of the measure to allow for electronic capture may be considered in the future to promote interoperability as more facilities adopt EHR systems.

Theme 2 – NQF Measure Evaluation Criteria

NQF received two comments related to the evaluation of measure 3332 and the lack of clarity on the voting process during the measure evaluation meetings for the scientific acceptability criterion. Specifically, the commenters questioned why the data element validity testing satisfied the reliability requirement given the fact that the developer provided inter-rater reliability results in addition to data element validity

NQF Response

If a developer provides inter-rater reliability testing results and data element validity testing results for a measure, the Committee must vote on both reliability and validity. The Behavioral Health and Substance Use Standing Committee voted on both reliability and validity for this measure. However, in the draft report released for public comment, NQF staff incorrectly reported voting results for validity only.

Action Item

NQF will update the draft report to include the voting results for both validity and reliability.

Measure-Specific Comments

3317 Medication Reconciliation on Admission (Health Services Advisory Group, Inc.)

NQF received four comments for this measure during the post-evaluation commenting period. One commenter supported the intent of the measure to improve patient safety through a comprehensive medication reconciliation process, but was concerned that while this measure contains elements that are essential to generating a comprehensive prior to admission (PTA) medication list, the process is still subject to human error. A second commenter raised two concerns with the measures specifications, including that “external source" reliability should not be assumed and that the measure imparts significant burden due to the six minutes it takes to compute the measure scores. Two commenters also suggested that the measure be specified as an eMeasure.

Committee Response

We agree that future measurement efforts should focus on electronic capture or electronic clinical quality measures. In addition, we welcome broader conversation on medication reconciliation measures and opportunities for a more holistic approach to measurement.

Developer Response

The Medication Reconciliation on Admission measure does not attempt to assess the accuracy of the medication information collected. The intent of this measure is to set a minimum standard by assessing whether an attempt has been made to collect PTA medications so that these can be reconciled in a timely manner and in a dedicated location in the medical record. While the measure requires a minimum of one external source of PTA medication information, such as an electronic prescribing network, providers are encouraged to consult as many sources as needed to compile the most accurate list of PTA medications.

We anticipate that if this measure were to be implemented, the data elements could be captured in structured fields and the average abstraction time per record to collect the eight data elements is likely to decrease. Re-specification of the measure to allow for electronic capture may be considered in the future to promote interoperability as more facilities adopt EHR systems.

3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) (Massachusetts General Hospital)

Six comments on this measure were received during the post-evaluation commenting period. Five of the commenters shared general support for the measure. One comment noted adoption of the PSC in primary care practices in North Carolina where they track rates using claims data, and another commenter noted that the measure fills a gap in quality measurement for behavioral health. Another commenter recommended the measure be linked to a specific disease-associated rating scale and referral to treatment. Two commenters expressed concern with the capture of the numerator CPT code 96110 to identify use of the PSC screening tool in the measure as specified in the administrative claims version.

Committee Response

We agree with the comments raised questioning the validity of the CPT code 96110 in the numerator. The Committee voted 17-2 to rescind the initial recommendation for endorsement for the claims-based version of the measure. The Committee still recommends endorsement for the chart abstraction version of the measure.

Developer Response

Although we appreciate the comment by the American Psychiatric Association Foundation and its general support for the PSC screening tool, we do not agree that adding a diagnosis-specific screening tool as a second step to follow a positive screen on the PSC can be justified at this time. Since the proposal for NQF endorsement for "Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)" is based heavily on the American Academy of Pediatrics recommendation for a single, general, first stage mental health screen as a part of all well child visits (and the EPSDT requirement for the same) we believe that adding a second stage to the required first stage of general screening would go beyond current guidelines as well as the available evidence for positive outcomes based on such a step. If the PSC is endorsed by NQF as a single stage screen, it may be possible in the future to request additional endorsements for follow up assessments (as is now done with the PHQ-9) or second stage screens.

We appreciate the chance to respond to the comment by the Federation of American Hospitals (FAH). Comment 6870 states that although FAH supports the overall intent of measure 3332, the FAH comment: 1) questions whether the measure truly meets the Scientific Acceptability criteria [as specified]; and 2) expresses confusion about the process used to evaluate the measure. Since the process used to evaluate the measure pertains to NQF Measure Evaluation Criteria, we will defer to NQF to respond to this issue. With regard to the first part of the comment, the FAH reviewer notes that the measure is specified to be collected via administrative claims alone or using manual abstraction of paper or electronic health records. We think it is essential to keep in mind the word 'or' and the clause that follows it. The measure is specified to be collected via administrative claims alone or using manual abstraction of paper or electronic health records. It is up to the user to assess which mechanism of collection will produce results that are reliable and valid. We also agree that the validity of CPT code 96110 as evidence that a PSC was given would need to be established before using it (the CPT code) as evidence that a PSC had been given. If in any given system, a correspondence between 96110 and/or any other billing code and the PSC can be established (as it was in these clinics in Massachusetts), then using administrative data to code the presence of the psychosocial screen is a valid way to assess the presence of this quality indicator, as documented in our testing form. Should the Behavioral Health Standing Committee concur, we are happy to add such a clarification to our measure information form.

We appreciate the chance to reply to the comment by the American Medical Association. We believe that this comment expresses essentially the same concerns as those noted by the Federation of American Hospitals and that we have addressed the first point in our response to the FAH comments and that NQF staff will address the second issue about reliability and validity testing.

Member Expression of Support

Throughout the 16-week, continuous public commenting period, NQF members had the opportunity to express their support ('support' or 'do not support') for each measure submitted for endorsement consideration to inform the Committee's recommendations. Three NQF members provided their expression of support. Appendix C details the expression of support.

Removal of NQF Endorsement

Two measures previously endorsed by NQF have not been re-submitted, and endorsement has been removed.

Measure	Measure Description	Reason for Removal of Endorsement
1927 Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications	The percentage of individuals 25-64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication and who received a cardiovascular health screening during the measurement year.	The developer (NCQA) stated that this measure is not currently in use in the HEDIS measurement set, and therefore may not provide sufficient data to meet NQF's updated use/usability and validity standards.
1937 Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)	The percentage of discharges for individuals 18-64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: • The percentage of individuals who received follow-up within 30 days of discharge • The percentage of individuals who received follow-up within 7 days of discharge	The developer (NCQA) has an existing Follow-Up After Hospitalization measure for the general population, which is already endorsed through NQF and includes this sub-population.

Appendix A: CSAC Checklist

The table below lists the key considerations to inform the CSAC's review of the measures submitted for endorsement consideration.

Key Consideration	Yes/No	Notes
Were there any process concerns raised during the CDP project? If so, briefly explain.	Yes	An error was made during the Committee vote for measure #3332 during the February 6 measure evaluation meeting. The measure submission demonstrated inter-rater reliability and data element validity. The Committee voted on both validity and reliability but only the vote for validity was shown in the draft report posted for public comment. NQF staff have updated the draft report to include the voting results for both validity and reliability.
Did the Standing Committee receive requests for reconsideration? If so, briefly explain.	No	
Did the Standing Committee overturn any of the Scientific Methods Panel's ratings of Scientific Acceptability? If so, state the measure and why the measure was overturned.	No	
If a recommended measure is a related and/or competing measure, was a rationale provided for the Standing Committee's recommendation? If not, briefly explain.	N/A	

Key Consideration	Yes/No	Notes
Were any measurement gap areas addressed? If so, identify the areas.	Yes	Several gap areas were addressed, including: • Measures that encompass multiple settings to better push towards integrated behavioral health and physical health (3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs) • Measures specific to child and adolescent behavioral health needs (3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PCS-Tool))
Are there additional concerns that require CSAC discussion? If so, briefly explain.	No	

Appendix B: Measures Not Recommended for Endorsement

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

Legend: H = High; M = Moderate; L = Low; I = Insufficient

Measure	Voting Results	Standing Committee Rationale
3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (CMS)	**Evidence** **H-0**; **M-7**; **L-11**; **I-2** **Gap** H-0; M-0; L-0; I-0 **Reliability** H-0; M-0; L-0; I-0 **Validity** H-0; M-0; L-0; I-0 **Feasibility** H-0; M-0; L-0; I-0 **Usability and Use** *Use* Pass-0; No Pass-0 *Usability* H-0; M-0; L-0; I-0	The Committee expressed concern in regards to evidence for the measure-specific to exclusions, and missing exclusions such as hospitalized elderly patients who were previously on an antipsychotic for depression but did not have a diagnosis of the denominator exclusions of schizophrenia, Tourette's syndrome, bipolar disorder, and Huntington's Disease. The Committee also was concerned about the lack of clarity for the numerator exclusion of patients who are "threatening harm to self or others." In addition, the Committee was concerned that the evidence lacked benchmarks to determine what constitutes appropriate ordering of antipsychotics. The Committee did not recommend the measure for NQF endorsement because it did not pass criterion 1a Evidence to Support the Measure Focus.

Appendix C: NQF Member Expression of Support Results

Three of five measures under consideration received support from NQF members. Results for each measure are provided below

3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs (CMS)

Member Council	Support	Do Not Support	Total
Health Plan	1	0	1
Health Professional	1	0	1
Provider Organization	1	0	1

3313: Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (CMS)

Member Council	Support	Do Not Support	Total
Health Professional	1	0	1
Provider Organization	1	0	1

3315e: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting (CMS)

Member Council	Support	Do Not Support	Total
Health Professional	0	1	1
Provider Organization	0	1	1

3317: Medication Reconciliation on Admission (CMS)

Member Council	Support	Do Not Support	Total
Health Professional	1	0	1
Provider Organization	1	0	1

3332: Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) (Massachusetts General Hospital)

No member expressions of support were received for this measure.

Appendix D: Details of Measure Evaluation

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

Measures Recommended

3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

Description: Percentage of discharges from a detoxification episode for adult Medicaid Beneficiaries, age 18-64, that was followed by a treatment service for substance use disorder (including the prescription or receipt of a medication to treat a substance use disorder (pharmacotherapy) within 7 or 14 days after discharge. This measure is reported across all detoxification settings.

Numerator Statement: Discharges in the denominator who have an inpatient, intensive outpatient, partial hospitalization, outpatient visit, residential, or drug prescription or procedure within 7 or 14 days after discharge from a detoxification episode.

Denominator Statement: Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.

Exclusions: Not applicable. The measure does not have denominator exclusions.

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Population:Regional and State

Setting of Care: Inpatient/Hospital, Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

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STANDING COMMITTEE MEETING [01/24/2018]

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

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

1a. Evidence: **M-16**; **L-1**; **I-0**; 1b. Performance Gap: **H-12**; **M-5**; **L-0**; **I-0**

Rationale:

- The developer provided evidence that supported that continuity of care should occur within a short time after discharge from detoxification. The developer found 11 studies showing association of continuity with a range of better outcomes, such as reduction in readmission, less criminal justice involvement, lower mortality, and improved employment.
- The Committee noted that there is strong evidence linking to improved outcomes for individuals who receive detoxification services with follow-up care. Additionally, the

Committee agreed that this measure is important given the current opioid epidemic coupled with high rates of overdose post-detox.

- The Committee requested clarification from the developer regarding the types and timing of pharmacotherapy as it relates to the measure. The developer confirmed that all FDA-approved pharmacotherapies for substance use disorder (SUD) are included in the measure.
- The Committee questioned how the use of monthly treatment and extended release pharmacotherapy, such as naltrexone, might be included in the seven and 14-day timeframes given that the prescription is for 30-days. The developer stated that in their testing they looked at all prescriptions, regardless of the number of days. However, for prescriptions that are given in 30-day dosages, they still require seven or 14 day follow-up given both SAMHSA and ASAM guidelines.
- The Committee requested more information on the developer's decision to choose seven- and 14-day follow-up periods. The developer confirmed that the follow-up periods are consistent with SAMHSA and other relevant guidelines. In addition, based on feedback from numerous stakeholders and state agencies, it was suggested that seven days might not be feasible for some organizations, so the developer balanced seven days as clinically appropriate with 14 days as a feasible benchmark for state Medicaid.
- The Committee questioned why telehealth was not included in the measure and the developer confirmed that telehealth had not been an option when the measure was being tested, but agreed that it could be included in future versions of the measure.
- There were concerns from the Committee that same day follow-up visits for newly discharged individuals is not included in the measure. The developer agreed that same day visits are important, but stated that there are limitations in the Medicaid claims data used to calculate the measure making it difficult, if not impossible, to identify same day visits. The Committee hopes to see the inclusion of same day visits in a future iteration of this measure.

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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; 2c. For composite measures: Empirical Analysis Supporting Composite)

2a. Reliability: **H-2**; **M-14**; **L-1**; **I-0** 2b. Validity: **H-1**; **M-16**; **L-0**; **I-0**

<u>Rationale</u>:

- The Committee asked for clarification on whether or not primary care is included and the developer confirmed that it is.
- The Committee questioned whether the denominator includes individuals who may have received Naloxone (Narcan) in the emergency department (ED) as a detox event and the developer responded that it is not included unless the patient had some sort of additional follow-up within the seven to 14 days following discharge. The Committee had concerns that same day pharmacotherapy prescriptions did not meet the continuity of care criteria.
- The Committee questioned whether both primary and secondary diagnoses are included in the measure. The developer noted that they are allowing both primary and secondary diagnoses to count for follow-up visits because they recognize that a person may have a

co-occurring diagnosis, therefore it is important to count any documented visit of a substance use diagnosis.
- The developer stated that the high signal-to-noise reliability testing results indicate the measure can discern performance between states with high precision.
- The developer noted that the convergent validity results indicate lower odds (8.3% for those with continuity at 14 days) of readmission to detox or overdose treatment among those episodes with continuity of care.

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3. Feasibility: H-7; M-10; 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 there was enough data in the analysis to show the feasibility of the measure.
- The Committee raised concern that state Medicaid systems where mental health and substance use are "carved out," that some treatments (i.e., detox, overdose treatment, and substance use disorder counseling admissions) may not appear in the Medicaid claims data and therefore could impede the feasibility of the measure.
- The Committee noted that the data could easily be extracted from Medicaid claims data across all states and can be consistently implemented.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-17; Not Pass-0;** *4b. Usability:* **H-10; M-7; L-0; I-0**

Rationale:

- The Committee agreed that the intent of this measure is to foster improved continuity of care and that the measure has the potential to improve care for this population.
- While this is a new measure and not currently in use, the Committee anticipates it will be used by states to monitor and improve quality of care provided for Medicaid beneficiaries with alcohol and/or drug related use disorders.

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5. Related and Competing Measures

- This measure is related to NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET) and NQF #2605: Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence. The developer stated that both of these measures have been harmonized to the extent possible, thus, the Committee did not discuss harmonization.

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6. Standing Committee Recommendation for Endorsement: **Y-17**; **N-0**

7. Public and Member Comment

- Five comments were received on this measure during the post-evaluation commenting period. Two comments were in support of the Committee's decision to recommend the measure and another commenter encouraged the developer to incorporate telehealth into the next iteration of the measure. Another commenter suggested that modifications be made to the measure to ensure alignment, harmonization, and consistent terminology among similar measures. For example, use the term "medically supervised withdrawal" rather than "detox," use the DSM-5 terminology "alcohol use disorder" rather than "alcohol dependence," and include methadone and naltrexone in pharmacotherapy for opioid use disorder. Finally, one commenter noted concern regarding the performance measurement of emergency physicians, who are completely dependent on community resources, whether it be office-based providers or opioid treatment programs, and that it can sometimes be challenging to connect patients to such services, as they do not always exist.
    - Developer response: We agree that telehealth can increase access to treatment. We will take this suggestion into consideration during the next annual update opportunity.

      We appreciate the feedback, and will take the suggestion to revise "detox" to "medically supervised withdrawal" into consideration during the next annual update opportunity. The measure was tested in data that included ICD-9 codes and therefore we used "alcohol dependence" instead of the more current "alcohol use disorder." We will take this suggestion into consideration during the next annual update opportunity.

      The measure currently includes methadone and naltrexone in pharmacotherapy for opioid use disorder. These codes are in the value set that accompanied the NQF materials we submitted for endorsement.

      We agree there are many factors associated with receipt of follow-up care. The evidence suggests that patients who receive follow-up care after detoxification are less likely to experience a relapse in substance use or readmissions for another detoxification. The evidence also suggests that receipt of follow-up care for individuals who are newly prescribed antipsychotic medications is associated with better medication adherence, reduced medication side effects, and improved quality of life. We believe these measures present a valuable opportunity for the healthcare system to improve the quality of care delivered to individuals with substance use disorders and individuals newly prescribed antipsychotic medications.

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

9. Appeals

3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication

Description: Percentage of new antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older who have completed a follow-up visit with a provider with prescribing authority within four weeks (28 days) of prescription of an antipsychotic medication.

Numerator Statement: Antipsychotic prescriptions from the denominator prescribed to a beneficiary who completed a follow-up visit with a provider with prescribing authority within four weeks of prescription of an antipsychotic medication.

Denominator Statement: New antipsychotic prescriptions for Medicaid beneficiaries age 18 years and older.

Exclusions: • Medicaid beneficiaries with an acute inpatient admission during the four-week follow-up period after prescription of an antipsychotic medication

• Patients who expired within four weeks of new prescription date.

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Population: Regional and State

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims

Measure Steward: Centers for Medicare and Medicaid Services (CMS)

STANDING COMMITTEE MEETING [01/24/2018]

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

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

1a. Evidence: **H-2**; **M-15**; **L-0**; **I-0**; 1b. Performance Gap: **H-12**; **M-5**; **L-0**; **I-0**

Rationale:

- The developer presented four clinical guidelines in support of follow-up for individuals with new antipsychotic prescriptions. The Committee agreed that any type of health monitoring and follow-up is important for this target population.
- The Committee discussed the importance of including telemedicine as a follow-up method for the measure to improve access. The current specifications include telephone follow-up and the developer intends to include telemedicine codes in future specifications.
- There was some concern from the Committee that Medicaid claims do not identify the content of the follow-up visit and that a follow-up encounter may not be specific to antipsychotic use. Incentivizing follow-up care does not guarantee or promote quality care; however, the Committee agreed that follow-up is an important support of adherence and monitoring.

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

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **H-3**; **M-14**; **L-0**; **I-0** 2b. Validity: **H-17**; **M-0**; **L-0**; **I-0**

Rationale:

- The Committee asked for clarification on whether the follow-up was with the prescribing provider. The developer confirmed that follow-up is not limited to the prescribing provider; the measure supports integrated team based care.
- The Committee questioned how follow-up might be linked to the prescribing episode. The developer responded that follow-up was not linked to the prescribing event and inclusion in the measure does not require a psychiatric diagnosis code. This allows the measure to best capture all types of follow-up care.
- While the Committee agreed that the exclusions were clear, there was some concern about the inclusion of Compazine and its use outside of psychotic disorders.
- The measure testing had high signal-to-noise reliability across the states indicating the measure can distinguish between state-level performances with respect to healthcare quality.
- There was a high level of agreement among the expert panel members on systematic assessment of face validity: eight out of 11 agreed that the state-level performance scores can distinguish good from poor quality of care.

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3. Feasibility: H-13; M-4; L-0; I-0

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

Rationale:

- The Committee agreed that there was enough data in the analysis to show the feasibility of the measure.
- All required data elements are available electronically.

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4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-17; Not Pass-0** *4b. Usability:* **H-12; M-5; L-0; I-0**

Rationale:

- The Committee agreed that the intent of this measure is to foster improved continuity of care and that it has the potential to improve care for this population.
- The Committee agreed that while this is a new measure and not currently in use, they anticipate it will be used by states to monitor and improve quality of care provided for Medicaid beneficiaries with serious mental illness.

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5. Related and Competing Measures

- This measure is related to NQF #0108: Follow-Up care for Children Prescribed ADHD Medication (ADD). The measures focus on different populations and different medications, but have been harmonized to the extent possible with the same follow-up period and look-back period to establish a "new prescription".

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6. Standing Committee Recommendation for Endorsement: **Y-16**; **N-0**

7. Public and Member Comment

- Six comments were received on this measure during the post-evaluation commenting period. One commenter encouraged the developer to incorporate telehealth into the next iteration of the measure. Another commenter had concerns with the availability of prescribers and the variation between states and encouraged the developer to specify whether there should be risk-adjustment based upon provider density data or an exclusion related to the lack of provider availability. Finally, one commenter suggested expanding the measurement period to 30 days or 35 days (from 28) to account for use of long-acting injectable antipsychotics. There were further concerns that limiting the follow-up period may cause errors in the measurement and may have unintended consequences.
    - Developer response: The measure specifications currently include two codes for "phone visits." These codes are in the value set that accompanied the NQF materials we submitted for endorsement. At the next annual update opportunity, we will reevaluate the list of telehealth codes and consider incorporating additional telehealth codes in the measure's specifications.

      We agree that limited psychiatric prescribers can pose a barrier to follow-up care. This measure is intended to support a team-based, integrated approach to care and, as such, allows the follow-up visit to occur with any type of prescribing provider; the prescriber is not limited to a psychiatrist or other mental health specialists.

      We agree it is important to identify a follow-up time period that accurately measures performance and minimizes unintended consequences. This follow-up period aligns with recommendations from clinical guidelines, which range from two to four weeks following the initial prescription. The focus of this follow-up is to monitor side effects and assess the medication's effectiveness. Our clinical advisory workgroup panel recommended a four week follow-up time period.

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

9. Appeals

3317 Medication Reconciliation on Admission

Description: Percentage of patients for whom a designated Prior to Admission (PTA) medication list was generated by referencing one or more external sources of PTA medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization.

Numerator Statement: Number of patients for whom a designated PTA medication list was generated by referencing one or more external sources of medications and for which all PTA medications have a documented reconciliation action by the end of Day 2 of the hospitalization when the admission date is Day 0.

Denominator Statement: All patients admitted to an inpatient facility from home or a non-acute setting.

Exclusions: The measure applies two exclusion criteria to ensure that it is feasible to complete the medication reconciliation process on admission to the IPF:

1. Patients transferred from an acute care setting

2. Patient admissions with a length of stay less than or equal to 2 days

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Paper Medical Records

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [02/06/2018]

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

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

1a. Evidence: **H-2**; **M-19**; **L-0**; **I-0**; 1b. Performance Gap: **H-9**; **M-12**; **L-0**; **I-0;**

Rationale:

- To support the measure, the developer provided two systematic reviews of the evidence for hospital-based medication reconciliation.
- The performance gap assessed data from nine Inpatient Psychiatric Facilities (IPF) with 100 patient admissions—each produced average measure scores equaling 50%.
- Fifteen of the 16 studies included by the developer required an external source to be included in the medication reconciliation process–these sources also align with The Joint Commission's National Patient Safety Goal (NPSG.03.06.01) on medication safety that are relevant to the admission process. The developer noted the rationale behind maintaining external sources as a part of the intervention was to align the measure with evidence.
- The developer deliberately allowed for a wide range of "external sources" to promote ease of use in collecting the data element by including sources such as caregiver and/or patient proxy interviews, medication containers, and electronic prescribing network systems (e.g., Allscripts and Surescripts).

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

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **H-0**; **M-14**; **L-7**; **I-0** 2b. Validity: **H-0**; **M-20**; **L-0**; **I-0**

Rationale:

- Inter-rater reliability testing results indicated overall agreement of 87%; however, one of the data elements "external sources" had a low Kappa score of .18.
- Committee members stated concern for the low score and the burden associated with the amount of time (six-minutes) estimated to complete all of the components of the measure.
- The developer indicated that the concept of using external sources is a part of the measure and the practice is based on evidence and guidelines from other medication reconciliation programs.
- The developer noted that an anticipated result of implementing the measure would encourage IPF to standardize the "external source" data element. In addition, supporting education will be provided to facilities to assist in improving documentation practices, including a PTA form intended to reduce the time of an average chart abstraction by providing a list of all external sources that could potentially be used in the medication reconciliation process.
- The developer provided a systematic assessment of face validity. The assessment of face validity indicated that the measure is viewed as valid by 100% of voting TEP members.

3. Feasibility: H-1; M-14; L-7; 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 the measure is feasible for implementation. The Committee noted concern that the measure is specified to use manually chart-abstracted data from medical records, additional costs, and burden. The developer responded that the measure is specified as such because only 36% of sites attested to using an EHR system.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-20; Not Pass-0** *4b. Usability:* **H-2; M-19; L-0; I-0**

Rationale:

- This measure is currently not in use. The planned use is to include the measure in the CMS Inpatient Psychiatric Facility Quality Reporting Program.

5. Related and Competing Measures

- This measure relates to:
    - 0097 Medication Reconciliation Post-Discharge
    - 0293 Medication Information
    - 0553 Care for Older Adults (COA) – Medication Review
    - 0646 Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care of Any Other Site of Care)
    - 2988 Medication Reconciliation for Patients Receiving Care at Dialysis Facilities
- This measure has been harmonized to the extent possible with related measures by aligning timeframe specifications and data elements.
- There are no competing measures noted.

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

7. Public and Member Comment

- NQF received four comments for this measure during the post-evaluation commenting period. One commenter supported the measure's intent to improve patient safety through a comprehensive medication reconciliation process, but was concerned that while this measure contains elements that are essential to generating a comprehensive PTA medication list, the process is still subject to human error. A second commenter raised two concerns with the measures specifications, including that "external source" reliability should not be assumed and that the measure imparts significant burden due to the six minutes it takes to compute the measure scores. Two commenters also suggested that the measure be specified as an eMeasure.
    - Developer response: The Medication Reconciliation on Admission measure does not attempt to assess the accuracy of the medication information collected. The intent of this measure is to set a minimum standard by assessing whether an attempt has been made to collect PTA medications so that these can be reconciled in a timely manner and in a dedicated location in the medical record. While the measure requires a minimum of one external source of PTA medication information, such as an electronic prescribing network, providers are encouraged to consult as many sources as needed to compile the most accurate list of PTA medications.

      We anticipate that if this measure were to be implemented, the data elements could be captured in structured fields and the average abstraction time per record to collect the eight data elements is likely to decrease. Respecification of the measure to allow for electronic capture may be considered in the future to promote interoperability as more facilities adopt EHR systems.

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

9. Appeals

3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)

Description: Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

Numerator Statement: Number of patients with documentation that the PSC tool was administered as part of the well child visit.

Denominator Statement: Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

Exclusions: No exclusions.

Adjustment/Stratification: No risk adjustment or risk stratification

Level of Analysis: Clinician: Group/Practice, Population: Regional and State

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Electronic Health Records, Paper Medical Records

Measure Steward: Massachusetts General Hospital

STANDING COMMITTEE MEETING [02/06/2018]

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

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

1a. Evidence: **H-0**; **M-18**; **L-1**; **I-0**; 1b. Performance Gap: **H-13**; **M-6**; **L-0**; **I-0**

Rationale:

- The developer cited evidence from more than 180 studies over the past 30 years demonstrating the feasibility and acceptability of the PSC as a clinical and research assessment focused on diverse populations on a statewide scale. The developer also provided strong evidence that children who have a positive risk score on the PSC are more likely to be referred to and/or receive mental health services.
- Performance data provided by the developer show variability in statewide rates of mental health screening with formal tools for children by age. Statewide data broken down for children ages 3-17 years were higher (71.2%) than all children .5 to 20 years of age (62.8%).
- The Committee agreed this measure is a valuable screening tool because it spans a broad age range, multiple languages, and a broad range of problems.
- Committee members noted concern regarding the strength of the evidence for screening linked to improved outcomes. The developer cited a series of randomized controlled trials by Kolko, et al, suggesting screening with the PSC leads to better outcomes, specifically higher rates of follow-up for mental health conditions and lower symptom scores on average.
- Committee members supported the intent of the measure recognizing that less than 25% of children with mental health disorders receive treatment. The Committee noted that not screening could unintentionally lead to more harm.

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; 2c. For composite measures: Empirical Analysis Supporting Composite))

2a. Reliability: **M-20; L-0; I-**02b. Validity: **M-20**; **L-0**; **I-0**

<u>Rationale</u>:

- Data element validity testing was conducted with a Kappa score of 84; this indicates a very high level of reliability and validity. Inter-rater reliability was also assessed yielding 94% agreement.
- The Committee noted concern regarding the lack of specified timeframes in the numerator and/or denominator. The developer responded that the lack of a timeframe was intentional to allow for flexibility in reporting the measure and to better align the encounter with an outcome.
- During the post-comment web meeting, the Committee discussed concerns raised by commenters questioning the validity of the CPT code 96110 in the numerator. The Committee agreed that since the CPT code that is specified within the measure is not specific to the PSC, the claims version of the measure lacks validity. The Committee voted to rescind the initial recommendation for endorsement for the claims version of the measure and to move forward with recommending for endorsement the chart abstraction version. The developer agreed to this change and has resubmitted the measure specifications to reflect the removal of the administrative claims version.

3. Feasibility: H-12; M-8; 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 the measure is feasible for implementation. The measure is specified for several data sources, including claims, electronic health records, and paper medical records. All data elements are in defined fields and available in a combination of electronic sources.

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **Pass-20; Not Pass-0** *4b. Usability:* **H-12; M-9; L-0; I-0**

<u>Rationale</u>:

- According to the developer, this measure is publically reported in the Behavioral Health Screening Cumulative Quarterly Report. It is also used for professional certification and recognition programs and quality improvement with benchmarking.
- The Committee discussed the potential for “labeling” as an unintended consequence of the measure. The developer noted that Massachusetts Medicaid requires screening, and

with over 10 years experience and over a million screenings with the PSC, they have not seen a case of "labeling" or other related unintended consequences. The Committee ultimately determined that not screening would result in more harm.

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5. Related and Competing Measures

- This measure is related to 0712 Depression Utilization of the PHQ-9 Tool and has been harmonized to the extent possible.
- There are no competing measures noted.

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6. Standing Committee Recommendation for Endorsement: **Y-20**; **N-1**

7. Public and Member Comment

- Six comments on this measure were received during the post-evaluation commenting period. Five of the commenters shared general support for the measure. One comment noted adoption of the PSC in primary care practices in North Carolina where they track rates using claims data, and another commenter noted that the measure fills a gap in quality measurement for behavioral health. Another commenter recommended the measure be linked to a specific disease-associated rating scale and referral to treatment. Two commenters expressed concern with the capture of the numerator CPT code 96110 to identify use of the PSC in the measure as specified in the administrative claims version. Finally, two comments were received related to the evaluation of measure 3332 and the lack of clarity on the voting process during the measure evaluation meetings for the scientific acceptability criterion. Specifically, the commenters questioned why the data element validity testing satisfied the reliability requirement given the fact that the developer provided inter-rater reliability results in addition to data element validity.
    - Developer response: Although we appreciate the comment by the American Psychiatric Association Foundation and its general support for the PSC screening tool, we do not agree that adding a diagnosis specific screening tool as a second step to follow a positive screen on the PSC can be justified at this time. Since the proposal for NQF endorsement for "Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool)" is based heavily on the American Academy of Pediatrics recommendation for a single, general, first stage mental health screen as a part of all well child visits (and the EPSDT requirement for the same) we believe that adding a second stage to the required first stage of general screening would go beyond current guidelines and as well as the available evidence for positive outcomes based on such a step. If the PSC is endorsed by NQF as a single stage screen, it may be possible in the future to request additional endorsements for follow up assessments (as is now done with the PHQ-9) or second stage screens.

      We appreciate the chance to respond to the comment by the Federation of American Hospitals (FAH). Comment 6870 states that although FAH supports the overall intent of measure 3332, the FAH comment: 1) questions whether the measure truly meets the Scientific Acceptability criteria [as specified]; and 2)

expresses confusion about the process used to evaluate the measure. Since the process used to evaluate the measure pertains to NQF Measure Evaluation Criteria, we will defer to NQF to respond to this issue. With regard to the first part of the comment, the FAH reviewer notes that the measure is specified to be collected via administrative claims alone or using manual abstraction of paper or electronic health records. We think it is essential to keep in mind the word 'or' and the clause that follows it. The measure is specified to be collected via administrative claims alone or using manual abstraction of paper or electronic health records. It is up to the user to assess which mechanism of collection will produce results that are reliable and valid. We also agree that the validity of CPT code 96110 as evidence that a PSC was given would need to be established before using it (the CPT code) as evidence that a PSC had been given. If in any given system, a correspondence between 96110 and/or any other billing code and the PSC can be established (as it was in these clinics in Massachusetts), then using administrative data to code the presence of the psychosocial screen is a valid way to assess the presence of this quality indicator, as documented in our testing form. Should the Behavioral Health Standing Committee concur, we are happy to add such a clarification to our measure information form.

We appreciate the chance to reply to the comment by the American Medical Association. We believe that this comment expresses essentially the same concerns as those noted by the Federation of American Hospitals and that we have addressed the first point in our response to the FAH comments and that NQF staff will address the second issue about reliability and validity testing.

- NQF response: If a developer provides inter-rater reliability testing results and data element validity testing results for a measure, the Committee must vote on both reliability and validity. The Behavioral Health and Substance Use Standing Committee voted on both reliability and validity for this measure. However, in the draft report released for public comment, NQF staff incorrectly reported voting results for validity only.

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

9. Appeals

Measures Not Recommended

3315e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

Description: Proportion of inpatient hospitalizations for patients 65 years of age and older who receive an order for antipsychotic medication therapy.

Numerator Statement: Inpatient hospitalizations for patients who received an order for an antipsychotic medication during the inpatient encounter.

Denominator Statement: Denominator: Non-psychiatric inpatient hospitalizations for patients who are 65 and older.

Exclusions: Denominator Exclusions: Inpatient hospitalizations for patients with a diagnosis of schizophrenia, Tourette's syndrome, bipolar disorder, Huntington's disease during the encounter.

Adjustment/Stratification: No risk adjustment or risk stratification
Level of Analysis: Facility

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING [01/19/2018]

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

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

1a. Evidence: **H-0**; **M-7**; **L-11**; **I-2**; 1b. Performance Gap: **N/A**

Rationale:

- Some Committee members were concerned that the evidence provided was not directly linked to inappropriate inpatient encounter use.
- Additional research provided by the developer indicated antipsychotic exposure rates of non-psychiatric hospital admissions in six to nine percent of visits.
- The Committee questioned what a reasonable benchmark for this performance gap might be and agreed that the measure as specified lacked clear benchmark threshold rates to indicate quality of care and support accountability.
- The Committee was concerned by depression and pharmacotherapy-related inclusions and exclusions, highlighting multiple prior to admission scenarios that the measure might not adapt for including polypharmacy antipsychotics and the use of antipsychotics for treatment of depression.
- There was an additional concern that the definition of “danger to self or others” was too vague and that there may be an unintended consequence of increased restraint use as a result of the measure.
- The Committee encouraged the developer to adjust the measure based on their feedback and bring it back for evaluation in a future endorsement review cycle.

2. Scientific Acceptability of Measure Properties: N/A

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2c. For composite measures: Empirical Analysis Supporting Composite))

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

3. Feasibility: N/A

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

4. Use and Usability

4a. Use; 4a1. Accountability and transparency; 4a2. Feedback on the measure by those being measured and others; 4b. Usability; 4b1. Improvement; 4b2. The benefits to patients outweigh evidence of unintended negative consequences to patients)

4a. Use: **N/A** *4b. Usability:* **N/A**

5. Related and Competing Measures

- This measure is related to NQF #2111: Antipsychotic Use in Persons with Dementia and NQF #2933: Potentially Harmful Drug-Disease Interactions in the Elderly. The developer stated that both of these measures have been harmonized to the extent possible, thus, the Committee did not discuss harmonization.

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

7. Public and Member Comment

- Three comments were received on this measure during the post-evaluation commenting period and all agreed with the Committee's decision not to recommend this measure for endorsement. One commenter also suggested that patients with schizoaffective disorder and patients with documented psychotic symptoms (e.g., delusions and hallucinations) also be excluded from the denominator.
    - Developer response: Thank you for the feedback. We look forward to exploring potential exclusions, including patients with psychotic symptoms or schizoaffective disorder, during further measure development and testing.

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