NATIONAL QUALITY FORUM

Memo

October 21-22, 2019

To: Consensus Standards Approval Committee (CSAC)

From: Behavioral Health and Substance Use Standing Committee Project Team
Re: Spring 2019 Review Cycle

CSAC Action Required

The CSAC will review recommendations from the Behavioral Health and Substance Use Standing Committee for the spring 2019 review cycle and vote on whether to uphold the recommendations from the Committee.

This memo includes a summary of the project, measure recommendations, themes identified and responses to the public and member comments and the results from the NQF member expression of support. The following documents accompany this memo:

1. Behavioral Health and Substance Use Spring 2019 Year 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**. NQF staff has briefly summarized the theme(s) apparent in each comment received. The table lists 14 comments received during the post-meeting comment period and the NQF and Standing Committee responses.

Background

The Behavioral Health and Substance Use (BHSU) project aims to endorse measures of accountability for improving the delivery of behavioral health and substance use services and achieving better health outcomes for the U.S. population. The 23-member Standing Committee oversees NQF's portfolio of BHSU measures that includes measures for serious mental illnesses (e.g., schizophrenia, mania, major depression), dysthymia, anxiety, ADHD and other learning and behavioral problems, alcohol and illegal drug use, tobacco dependence, care coordination (between and within the spheres of psychiatric, substance use, and related physical illness), medication use, and patient care experience. This portfolio contains 46 measures: 38 process measures, seven outcome measures, and one composite measure.

Draft Report

The Behavioral Health and Substance Use draft report presents the results of the evaluation of six measures considered under the Consensus Development Process (CDP) in the Spring 2019 NQF evaluation cycle. Four are recommended for endorsement and two were not recommended.

The measures were evaluated against the 2018 version of the measure evaluation criteria.

	Maintenance	New	Total
Measures under consideration	6	0	6
Measures recommended for endorsement	4	0	4
Measures not recommended for endorsement	2	0	2
Reasons for not recommending	Importance - 2 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure - 0	Importance - 0 Scientific Acceptability - 0 Use - 0 Overall - 0 Competing Measure – 0	2

CSAC Action Required

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

Measures Recommended for Endorsement

- 0640 HBIPS-2 Hours of Physical Restraint Use (The Joint Commission)

Overall Suitability for Endorsement: Yes-14; No-2

- 0641 HBIPS-3 Hours of Seclusion Use (The Joint Commission)

Overall Suitability for Endorsement: Yes-14; No-2

- 3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) (National Committee for Quality Assurance)

Overall Suitability for Endorsement: Yes-13; No-1

- 3489 Follow-Up After Emergency Department Visit for Mental Illness (National Committee for Quality Assurance)

Overall Suitability for Endorsement: Yes-13; No-1

Measures Not Recommended for Endorsement

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

- 0560 HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications (The Joint Commission)
- 1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission)

Comments and Their Disposition

NQF received 14 comments from three organizations (including one member organization) and individuals 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 measures were forwarded to the respective developers, who were invited to respond.

The Standing Committee were given the opportunity to review all of the submitted comments) and developer responses. Staff facilitated this by sending the Comment spreadsheet to the Committee prior to the meeting and summarizing the most salient points of that spreadsheet during the meeting. Committee members focused their discussion on measures or topic areas with the most significant and recurring issues.

Measure-Specific Comments

0560 HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification

Measure 0560 received two comments, both suggesting that the measure needs specification revisions before it should be considered for maintenance endorsement. Commenters noted that specifications revisions should be developed that allow for the use of multiple antipsychotics under certain circumstances, and which more generally should be updated using updated evidence and new guidelines which are to emerge in fall 2019.

Committee Response

The comments are aligned with the Committee's decision not to recommend continued endorsement. The Committee reviewed these comments during its deliberations on the post-comment call. The Committee did not elect to reconsider any of their previous decisions and did not recommend continued endorsement of this measure.

Developer Response

Thank you for your comment.

At the present time the measure allows for the use of multiple antipsychotics for cases with the following justification:

1. The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy.
2. The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge.
3. The medical record contains documentation of augmentation of Clozapine.

Updates to the measure will be taken into consideration.

0640 HBIPS-2 Hours of physical restraint use and 0641 HBIPS-3 Hours of seclusion use

Four comments (two from each of the two commenter) were received regarding measures 0640 and 0641. These commenters supported continued endorsement, but one commenter suggested that risk-stratification methods should be used to account for performance differences related to differing case-mix.

Committee Response

The Committee reviewed these comments during its deliberations on the Post-Comment Call. The Committee accepted the developer's response regarding risk stratification, and one member specifically noted the NQF generally does not consider process measures as good candidates for such adjustment, especially related to social determinants. The Committee did not elect to reconsider any of their previous decisions and recommended continued endorsement of these two measures.

Developer Response

Thank you for your comments.

The use of seclusion and restraint should be limited to situations deemed to meet the threshold of imminent danger. The intent of the measure is to provide that when restraint and seclusion are applied, use is rigorously monitored and analyzed to prevent future use when possible.

The measure is currently written so that it will apply consistently across all accredited inpatient psychiatric care facilities. As a general practice, The Joint Commission does not risk adjust process measures. This measure is currently age stratified. Risk stratification for special populations could cause undue burden of data abstraction.

Although we do not routinely evaluate differences between free-standing inpatient psychiatric facilities and acute care hospital inpatient psychiatric units, we are able to evaluate these differences with the data collected on the measure.

The developer also thanks the commenters for their support of these measures.

3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and 3489 Follow-Up After Emergency Department Visit for Mental Illness

Five comments were received related to measures 3488 and 3489 from three commenters. One commenter simply expressed support for both measures. A second commenter expressed concern that these two measures were separated, rather than a single measure. The commenter also expressed support at the health plan level of analysis, but emphasized the importance of testing at more granular levels of analysis before the measure is used more broadly in other programs. Finally, a third commenter suggested that 3488 should allow for the inclusion of cases where only a secondary alcohol or other drug diagnosis is evident.

Committee Response

The Committee reviewed these comments during its deliberations on the Post-Comment Call. The Committee expressed interest in measure #3488 considering secondary diagnosis of SUD in the denominator in the future. One member specifically noted concrete instances when a secondary diagnosis of SUD likely reflects an issue of primary importance, such as cirrhosis or pancreatitis in the primary position and alcohol use disorder in the secondary position. Such scenarios logically support the future development of a measure that includes in the denominator some cases where SUD appears in a secondary diagnostic position. The Committee did not elect to reconsider any of their previous decisions and thus they recommended continued endorsement of these two measures.

Developer Response

Thank you for the comment. The two measures used to be one and recently separated into two to align with HEDIS where they are reported as two separate measures. Additionally, the measures have distinct denominator populations that need to be calculated separately, which also justifies having them as two separate measures. The denominator of NQF 3488 is those with a primary SUD diagnosis. The denominator of NQF's 3849 is those with a primary mental illness diagnosis. Given this, the level of effort required to calculate them as two separate measures is the same as calculating them as one with multiple indicators.

We agree that measures should be tested at the level of intended use. The measures (NQF 3488 and NQF 3849) were tested and are used as plan/state level measures. They are not emergency department level measures. The NQF 0576 (FUH) measure was tested at the IPF level before it was introduced into the IPFQR or QPP.

NCQA's Behavioral Health Measurement Advisory Panel and the Committee on Performance Measurement recommended the measure (3488) to require primary diagnosis of AOD for the denominator and numerator to make sure that the ED visit and the follow-up visits are for AOD and to be consistent between the requirement for the denominator and the numerator. Claims typically have no designation of "secondary" diagnosis, instead they have primary diagnosis and diagnosis in any other position. Our expert panels considered it would be non-specific to count non-primary AOD diagnosis in the measure denominator or numerator. Assuming the commenter means multiple ED visit by multiple visits, we want to note that the measure is episode-based. A member with multiple ED visits would be in the measure denominator multiple times and should receive follow-up care after each ED visit. The measure focuses on AOD and monitors AOD separately from ensuing consequences through requiring a primary AOD diagnosis in the denominator and numerator.

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Three comments were received regarding measure 1922 from three separate commenters. Two commenters suggested that the measure needs to be updated with follow-up response to screening results as a numerator requirement. A third comment suggested better connectivity to outcome-evidence supporting its deployment, thereby

highlighting a key Committee concern regarding this measure. The commenter also expressed that the measure continues to be important to monitor, but recommended the developer identify strategies to ensure the desired screening is taking place.

Committee Response

The Committee reviewed and discussed these comments as well as performance information provided by the developer during the Post-Comment Call. Some Committee members remained concerned that measure performance was high, greater than 90 percent without much variation. Committee members expressed interest in a future iteration of this measure that includes appropriate action taken based on positive screens. After Committee discussion, which included additional discourse with the developer who was on the line, the Committee re-voted on the performance gap criterion. The Committee did not pass the measure on the performance gap criterion and, therefore, did not recommended the measure for continued endorsement. This final decision was reached even as the developer noted that their performance distribution showed dozens of entities achieved less than 90 percent on the measure. Accordingly, the Committee seemed to hold fast to the decision that while this measure had previously been useful, it is now time to update so that it includes follow-up medical action beyond screening.

Developer Response

Thank you for your comment[s]. The evaluation of appropriate interventions will be taken into consideration for future measure development. Follow-up measures will [also] be taken into consideration for future measure development.

As a screening measure, the intent is to determine that an appropriate patient assessment was conducted in order to inform clinical and treatment decisions. The current measure specifications do include the detail of what is required in order to demonstrate that the desired screening has been conducted:

- Patient Strengths: Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Examples of patient strengths are provided in notes for abstraction.
- Psychological Trauma History: Traumatic life experiences are defined as those that result in responses to life stressors characterized by significant fear, anxiety, panic, terror, dissociation, feelings of complete powerless or strong emotions that have long term effects on behaviors and coping skills. Examples of psychological trauma are provided in notes for abstraction.
- Substance Use: Substance use is defined as the use of psychoactive or mood altering substances, i.e., prescription medications, over the counter medications, inhalants, organic substances, illegal substances and street drugs. The screening must include: the type, amount, frequency of use and any problems due to past use.
- Violence Risk to Others: includes threats of violence and/or actual commission of violence toward others. Some examples of violence risk to others include but are not limited to the following: thoughts of harm to others, intentional infliction of

harm on someone else by the patient, homicidal thoughts by the patient and thoughts of harming someone else by the patient.

Violence Risk to Self: includes ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. Some examples of violence to self-include but are not limited to: past suicide attempts by the patient, intentional cutting, burning, bruising or damaging of self by the patient, inappropriate substance use, suicidal thoughts in the past six months by the patient, specific suicidal plan in the past six months by the patient and past suicide attempts by anyone in patient's family.

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. One NQF member organization provided their expression of support. Appendix C details the expression of support.

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.	No	
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.	Yes	There were no competing measures. The related measures did not warrant further Committee discussion in regard to best-in-class.
Were any measurement gap areas addressed? If so, identify the areas.	Yes	The need for more outcome measures, or at least for process measures that go beyond the screening checklist phase of patient engagement.
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
0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification (The Joint Commission)	**Evidence** H-1; M-2; L-6; I-7 **Gap** N/A **Reliability** N/A **Validity** N/A **Feasibility** N/A **Usability and Use** *Use* N/A *Usability* N/A **Post Comment Call Vote:** N/A	The Standing Committee did not vote on a recommendation for endorsement because the measure did not pass the evidence criterion—a must-pass criterion. Committee discussion about this measure revealed concern that the evidence presented by the developer was dated and too general to support a measure that looks at antipsychotic use for indications outside of schizophrenia. There was also concern that the measure might discourage multiple antipsychotic use that may be indicated.

Measure	Voting Results	Standing Committee Rationale
1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission)	**Evidence** H-0; M-11; L-5 **Gap** H-0; M-9; L-7; I-0 **Reliability** M-13; L-3; I-0 **Validity** H- 0; M-11; L-4; I-1 **Feasibility** H-2; M-2; L-3; I-11 **Usability and Use** *Use* Pass-14; No Pass-2 *Usability* H-0; M-12; L-4; I-0 **Post Comment Call Vote:** **Performance Gap (Re-vote):** H-1; M-7; L-8; I-0	The principal reason the Committee did not pass this measure on performance gap is that they were concerned it was essentially "topped out" at just over 90 percent performance rates on average, and that it represents a simple process that is quite distant from a desired outcome. The Committee expressed interest in a future measure like this one if the numerator definition includes evidence-based treatment initiation events in response to positive screens.

Appendix C: NQF Member Expression of Support Results

One NQF members provided their expression of support. NQF members provided their expression of support for four measures under consideration. Results for each measure are provided below.

0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification (The Joint Commission)

Member Council	Support	Do Not Support	Total
QMRI	1	0	1

0640 HBIPS-2 Hours of physical restraint use (The Joint Commission)

Member Council	Support	Do Not Support	Total
QMRI	1	0	1

0641 HBIPS-3 Hours of seclusion use (The Joint Commission)

Member Council	Support	Do Not Support	Total
QMRI	1	0	1

1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission)

Member Council	Support	Do Not Support	Total
QMRI	1	0	1

Appendix D: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Recommended

0640 HBIPS-2 Hours of physical restraint use

Submission

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint.

Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

Denominator Statement: Number of psychiatric inpatient days

Denominator basis: per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

Exclusions: Total leave days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **M-14; L-2; I-0**. Performance Gap: **H-3; M-9; L-3; I-1**

Rationale:

- The evidence provided by the developer included a clinical practice guideline and systematic review, along with many additional citations.
- The Committee generally agreed that restraint use is still frequently used, the measure has had a positive impact, and there is room for improvement (i.e., for alternative conflict mitigation strategies for patients who become agitated or other challenge to control).
- Some of the data presented show a decrease in the median time in restraints from 2009 to 2018.
- Other data presented by the developer indicated that restraint use was increasing with time, but the developer argued that those unexpected trends were the result of confounding case-mix.

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

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

2a. Reliability: **M-13; L-3; I-0**; 2b. Validity: **H-2; M-12; L-2; I-0**

Rationale:

- The Committee accepted the data-element reliability testing (which showed perfect agreement pertaining to ~200 chart re-abstractions) and score level validity testing (which, as hypothesized, indicated a slight positive correlation with measure 0641 (seclusion) and no correlation with the other antipsychotic justify cation measure (arguably not a good comparator) were presented.
- When asked if they believed a more direct test-retest reliability experiment was necessary—for example with two time-keepers monitoring each restraint event—the developer responded that this was not feasible, but that they did visit several facilities to verify chart reviews, and there were procedures in place at each facility to get precise start and stop times for restraint use.

3. Feasibility: H-2; M-11; L-3; I-0

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

Rationale:

- The measure uses EHR or paper medical record data. One member commented that there is not additional burden as there are already strict requirements in place to keep track of time when patients are placed in seclusion.

4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-3; M-10; L-2; I-1**

<u>Rationale</u>:

- It was noted that there may be an unintentional consequence of increasing the use of as needed medication if trying to reduce restraint use. Stated another way, the Committee believes that seclusion, physical constraints, and chemical constraints (e.g., sedation), likely act as substitutes/complements for one another and future measures should consider that connectivity.
- The measure is publicly reported and used for accountability.

5. Related and Competing Measures

- This measure is related to measure 0687: Percent of Residents Who Were Physically Restrained (Long Stay).
    - The measure focus is the same, but the populations are different – psychiatric inpatients versus long stay care residents.
- The Committee discussed that this measure is also conceptually related to 0641 (seclusion) and expressed some interest in exploring how these measures work together or if they could be considered together in the future.

Standing Committee Recommendation for Endorsement: **Yes-14**; **No-2**

6. Public and Member Comment

- Four comments (two from each of the two commenters) were received regarding measures 0640 (restraints) and 0641 (seclusion). These commenters supported continued endorsement, but one commenter suggested that risk-stratification methods should be used to account for performance differences related to differing case-mix.
    - Developer Response: Thank you for your comments. The use of seclusion and restraint should be limited to situations deemed to meet the threshold of imminent danger. The intent of the measure is to provide that when restraint and seclusion are applied, use is rigorously monitored and analyzed to prevent future use when possible.

      The measure is currently written so that it will apply consistently across all accredited inpatient psychiatric care facilities. As a general practice, The Joint Commission does not risk adjust process measures. This measure is currently age stratified. Risk stratification for special populations could cause undue burden of data abstraction.

Although we do not routinely evaluate differences between free-standing inpatient psychiatric facilities and acute care hospital inpatient psychiatric units, we are able to evaluate these differences with the data collected on the measure.

The developer also thanks the commenters for their support of these measures.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

0641 HBIPS-3 Hours of seclusion use

Submission

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

Denominator Statement: Number of psychiatric inpatient days

Denominator basis per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

Exclusions: Total leave days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **M-12; L-4; I-0**. Performance Gap: **H-2; M-12; L-2; I-0**

Rationale:

- The developer cites the same evidence as used for the previous endorsement and provides a logic model linking decreased seclusion use to decreased patient and staff injuries, shorter lengths of stays and decreased costs. Though at least one member believed the evidence that directly links decreased seclusion use to these outcomes is not very strong.
- At least one member shared that the measure has helped drive change in the culture on inpatient units towards the use of seclusion. Another member believed the evidence for seclusion use was less straightforward than restraint use (e.g., seclusion might be a way to prevent restraint and may be more appropriate in some cases; or seclusion might be desired by, rather than imposed upon, the patient)
- Performance data showed that mean rates varied between 2009-2018 while median rates decreased, with some outliers present. Data also suggested disparities by race, age, and gender.

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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)

2a. Reliability: **M-13; L-3; I-0**; 2b. Validity: **H-1; M-14; L-1; I-0**

Rationale:

- The Committee accepted the data element reliability testing results (n=190 patient cases; 9 observations for the numerator elements). The Committee also accepted the validity testing which showed a significant slight positive correlation with measure 0640 (restraints).
- The Committee briefly discussed that the developer presented face validity results from hospital representatives which were favorable.
- One Committee member also asked for the developer to clarify their “target analysis.” That analysis creates a benchmark and allows hospitals to see how they are performing

relative to others. That target analysis was used to support the presence of a performance gap in a subset of identified hospitals.

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3. Feasibility: H-1; M-12; L-3; I-0

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

Rationale:

- The Committee did not have many comments on feasibility but noted that this measure is a human- recorded measure and that some psychiatric facilities rely on paper rather than more automated electronic records.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-2; M-12; L-1; I-1**

Rationale:

- The measure is used for public reporting and accountability.
- The Committee did not raise any concerns about usability not already discussed for measure 0640.

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5. Related and Competing Measures

- No related or competing measures were noted by the developer.
- The Committee noted this measure (seclusion) and 0640 (restraints) are conceptually related. The committee expressed interested in how these measures may work together but they are currently harmonized to the extent possible. One Committee member was interested in how measures might in the future be engineered to consider de-escalation strategies more generally.

Standing Committee Recommendation for Endorsement: **Yes-14**; **No-2**

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6. Public and Member Comment

- Four comments (two from each of the two commenters) were received regarding measures 0640 (restraint) and 0641 (seclusion). These commenters supported continued endorsement, but one commenter suggested that risk-stratification methods should be used to account for performance differences related to differing case-mix.
    - Developer Response: Developer Response: Thank you for your comments. The use of seclusion and restraint should be limited to situations deemed to meet the threshold of imminent danger. The intent of the measure is to provide that

when restraint and seclusion are applied, use is rigorously monitored and analyzed to prevent future use when possible.

The measure is currently written so that it will apply consistently across all accredited inpatient psychiatric care facilities. As a general practice, The Joint Commission does not risk adjust process measures. This measure is currently age stratified. Risk stratification for special populations could cause undue burden of data abstraction.

Although we do not routinely evaluate differences between free-standing inpatient psychiatric facilities and acute care hospital inpatient psychiatric units, we are able to evaluate these differences with the data collected on the measure.

The developer also thanks the commenters for their support of these measures.

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7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Submission

Description: The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Numerator Statement: The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.
- 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

Denominator Statement: Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

Exclusions: Patients in hospice.

Adjustment/Stratification: This measure is stratified by age:

- Age 13 to 17 years
- Age 18 and older
- Total (sum of the age stratifications)

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims. This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **H-4; M-10; L-0; I-0**. Performance Gap: **H-8; M-6; L-0; I-0**

Rationale:

- Published clinical guidelines and literature link ongoing treatment of patients with substance abuse, including follow-up care after an acute episode of the illness such as an ED visit, to improved patient outcomes such as reduce risk of subsequent ED visits.
- Data indicate a performance gap with very low performance overall and performance variation across payer types and age groups. Average 30-day follow-up performance across all ages is 12 percent for Medicare plans, 18 percent for Medicaid plans, and 14 percent for commercial plans.
- The Committee agreed the measure provides healthcare organizations a way to monitor quality of care for vulnerable populations.
- There was a minor concern that patients visiting the ED multiple times are only counted once, and then removed from the denominator.
- The Committee expressed interest in denominator events where SUD is the secondary rather than the primary diagnosis. The developer explained that for the present they aimed to restrict focus to the most certain diagnostic cases (i.e., to the primary diagnosis exclusively).
- The Committee supported that a visit with any provider that records SUD as the primary diagnosis is counted in the numerator (e.g., a primary care provider attending to SUD would be considered a true qualifying event).
- At least one member expressed support for the inclusion of telehealth as appropriate follow-up. Members concerned that a simple survey of a patient, even an online survey,

might be inappropriately counted as a bona fide follow-up event were assuaged by the developer who noted that only two-way communications (e.g., survey plus a response from provider) were counted as such, even as that two-way exchange could be asynchronous (e.g., via email).

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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)

2a. Reliability: **H-2; M-12; L-0; I-0**; 2b. Validity: **H-2; M-12; L-0; I-0**

<u>Rationale</u>:

- Signal to noise score-level reliability testing results indicated moderate/high reliability across age groups and payer types (reliability statistic 0.81-0.98).
- Validity testing at the score level indicated a strong positive correlation between this measure and 3489: Follow-Up After Emergency Department Visit for Mental Illness across all payer types (validity statistics from 0.42 to 0.57, all statistically significant).
- Correlations for within measure 7-day and 30-day rates were strong (>0.94, all statistically significant).
- The Committee accepted the measure's scientific acceptability without concern.

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3. Feasibility: H-6; M-7; L-1; I-0

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

<u>Rationale</u>:

- The measure uses claims data and the committee did not express any feasibility concerns.

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4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-13; No Pass-1** 4b. Usability: **H-3; M-10; L-1; I-0**

<u>Rationale</u>:

- The measure is used in multiple national reporting programs such as the Medicaid Core Set, demonstration programs to certify a community's behavioral clinics, and HEDIS reporting by all product lines to NCQA.
- The Committee agreed the measure is usable. One member expressed that in the future measures should consider the quality of transition and follow-up care (e.g., communication at hand-off, integration of primary and specialty care, appropriateness of level of care assigned).

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5. Related and Competing Measures

- This measure is related to the following measures:

  - 0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
  - 3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
  - 3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
  - 0576: Follow-Up After Hospitalization for Mental Illness (FUH)
  - 3489: Follow-Up After Emergency Department Visit for Mental Illness
- The Committee did not note any immediate harmonization opportunities, however generally encouraged a more holistic approach to measuring continuity of care, follow-up, and care coordination for various conditions and populations.

Standing Committee Recommendation for Endorsement: **Yes-13**; **No-1**

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6. Public and Member Comment

- Five comments were received related to measures 3488 (Follow-up to SUD ED admission) and 3489 (Follow-up to mental illness ED admission) from three commenters. One commenter simply expressed support for both measures. A second commenter expressed concern that these two measures were separated, rather than a single measure. The commenter also expressed support at the health plan level of analysis but emphasized the importance of testing at more granular levels of analysis before the measure is used more broadly in other programs. Finally, a third commenter suggested that 3488 should allow for the inclusion of cases where only a secondary alcohol or other drug diagnosis is evident.
  - Developer Response: Thank you for the comment. The two measures used to be one and recently separated into two to align with HEDIS where they are reported as two separate measures. Additionally, the measures have distinct denominator populations that need to be calculated separately, which also justifies having them as two separate measures. The denominator of NQF 3488 is those with a primary SUD diagnosis. The denominator of NQF's 3849 is those with a primary mental illness diagnosis. Given this, the level of effort required to calculate them as two separate measures is the same as calculating them as one with multiple indicators.

    We agree that measures should be tested at the level of intended use. The measures (NQF 3488 and NQF 3849) were tested and are used as plan/state level measures. They are not emergency department level measures. The NQF 0576 (FUH) measure was tested at the IPF level before it was introduced into the IPFQR or QPP.

    NCQA's Behavioral Health Measurement Advisory Panel and the Committee on Performance Measurement recommended the measure (3488) to require

primary diagnosis of AOD for the denominator and numerator to make sure that the ED visit and the follow-up visits are for AOD and to be consistent between the requirement for the denominator and the numerator. Claims typically have no designation of "secondary" diagnosis, instead they have primary diagnosis and diagnosis in any other position. Our expert panels considered it would be non-specific to count non-primary AOD diagnosis in the measure denominator or numerator. Assuming the commenter means multiple ED visit by multiple visits, we want to note that the measure is episode-based. A member with multiple ED visits would be in the measure denominator multiple times and should receive follow-up care after each ED visit. The measure focuses on AOD and monitors AOD separately from ensuing consequences through requiring a primary AOD diagnosis in the denominator and numerator.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

3489 Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Submission

Description: The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Numerator Statement: The numerator consists of two rates:

- 30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- 7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Denominator Statement: Emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.

Exclusions: Patients in hospice.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **H-4; M-10; L- 0; I-0** Performance Gap: **H-7; M-7; L-0; I-0**

Rationale:

- The evidence is primarily based on review of four guidelines. The Committee discussed that the measure targets broader processes than those specified in the guidelines, but they still agreed that follow-up from a mental illness related ED visit is important.
- For 2016 and 2017, the 30-day follow up varied from 60% with commercial coverage to 47% with Medicare. The 7-day rates varied from 46% commercial to 31%, respectively.

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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)

2a. Reliability: **H-2; M-11; L-1; I-0** 2b. Validity: **H-2; M-12; L-0; I-0**

Rationale:

- Signal to noise reliability tested showed high reliability (statistics exceeded 0.91).
- Validity testing at the score level indicated a strong positive correlation between this measure and 3489: Follow-Up After Emergency Department Visit for Mental Illness across all payer types (validity statistics from 0.42 to 0.57, all statistically significant).
- Correlation between the 7- and 30- days rates was high (r >0.92), as expected.
- The Committee accepted the measure's scientific acceptability without concern.

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3. Feasibility: H-5; M-8; L-1; I-0

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

Rationale:

- The measure is feasible as it uses claims data that are readily available and captured without burden.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-13; No Pass-1**; 4b. Usability: **H-4; M-10; L-0; I-0**

Rationale:

- The measure is used in multiple national reporting programs such as the Medicaid Core Set, demonstration programs to certify a community's behavioral clinics, and HEDIS reporting by all product lines to NCQA.
- One Committee member noted that the two years of data presented did not show an upward trend. The developer responded that the measure is relatively new, and it is not uncommon across HEDIS measures to see the rates fluctuate during the first few years of deployment. Improvement is otherwise expected with time.
- The Committee discussed that a lack of resources in many areas impact the ability of EDs to connect patients with follow-up care, but this measure is specified and tested at the health plan level of analysis (e.g., health plans are held responsible based on this measure).

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5. Related and Competing Measures

- This measure is related to the following measures:
    - 0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
    - 3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
    - 3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
    - 0576: Follow-Up After Hospitalization for Mental Illness (FUH)
    - 3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- The Committee did not note any immediate harmonization opportunities, however generally encouraged a more holistic approach to measuring continuity of care, follow-up, and care coordination for various conditions and populations.

Standing Committee Recommendation for Endorsement: **Y-13; N-1**

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6. Public and Member Comment

- Five comments were received related to measures 3488 (…for SUD) and 3489 (… for mental illness) from three commenters. One commenter simply expressed support for both measures. A second commenter expressed concern that these two measures were separated, rather than a single measure. The commenter also expressed support at the health plan level of analysis but emphasized the importance of testing at more granular levels of analysis before the measure is used more broadly in other programs. Finally, a third commenter suggested that 3488 should allow for the inclusion of cases where only

a secondary alcohol or other drug diagnosis is evident, with no similar suggestion was made for 3489.

- Developer Response: Thank you for the comment. The two measures used to be one and recently separated into two to align with HEDIS where they are reported as two separate measures. Additionally, the measures have distinct denominator populations that need to be calculated separately, which also justifies having them as two separate measures. The denominator of NQF 3488 is those with a primary SUD diagnosis. The denominator of NQF's 3849 is those with a primary mental illness diagnosis. Given this, the level of effort required to calculate them as two separate measures is the same as calculating them as one with multiple indicators.

  We agree that measures should be tested at the level of intended use. The measures (NQF 3488 and NQF 3849) were tested and are used as plan/state level measures. They are not emergency department level measures. The NQF 0576 (FUH) measure was tested at the IPF level before it was introduced into the IPFQR or QPP.

  NCQA's Behavioral Health Measurement Advisory Panel and the Committee on Performance Measurement recommended the measure (3488) to require primary diagnosis of AOD for the denominator and numerator to make sure that the ED visit and the follow-up visits are for AOD and to be consistent between the requirement for the denominator and the numerator. Claims typically have no designation of "secondary" diagnosis, instead they have primary diagnosis and diagnosis in any other position. Our expert panels considered it would be non-specific to count non-primary AOD diagnosis in the measure denominator or numerator. Assuming the commenter means multiple ED visit by multiple visits, we want to note that the measure is episode-based. A member with multiple ED visits would be in the measure denominator multiple times and should receive follow-up care after each ED visit. The measure focuses on AOD and monitors AOD separately from ensuing consequences through requiring a primary AOD diagnosis in the denominator and numerator.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

Measures Not Recommended

0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Submission

Description: The proportion of patients, age greater than and equal to 1 year, discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

Denominator Statement: Psychiatric inpatient discharges

Exclusions:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients with a length of stay less than or equal to 3 days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

1. Importance to Measure and Report: The measure does not meet the Importance criteria (1a. Evidence, 1b. Performance Gap)

1a. Evidence: **H-1; M-2; L-6; I-7**

Rationale:

- The developer cited evidence used to inform the 2004 American Psychiatric Association (APA) Practice guideline for the treatment of patients with schizophrenia, which included a meta-analysis of various RCTs and observational studies comparing polypharmacy to monotherapy. The developer stated that a literature search did not yield new guidelines or significant research that would warrant a measure change.
- Several Committee members noted the growing controversy in the field about the use of multiple antipsychotics (which is sometimes indicated) and expressed that the evidence presented was dated.
- In response, the developer noted that the measure is based on current guidelines, though new APA guidelines are anticipated in September 2019. The developer also argued that the measure neither supports or discourages polypharmacy, but only requires that one of three evidence-based justifications be proffered if it is used.
- At least one Committee member voiced support for these justifications and the measure as it was presented. Other Committee members expressed concern that the evidence presented did not fully consider the possibility that the measure may discourage polypharmacy when it is indicated. Committee members also held to their concern that the evidence presented was specific to schizophrenia even as the measure specifications were not similarly restricted to the use of antipsychotics for that single indication.
- The Committee recommended that a more rigorous environmental scan be conducted and suggested the measure may need to be updated accordingly. Ultimately the measure did not meet pass Evidence (a must-pass criterion), therefore discussion and voting on the remaining criteria did not continue.

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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)

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

Rationale: N/A

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3. Feasibility: H-2; M-2; L-3; I-11

(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: N/A

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-N/A; No Pass-N/A**; 4b. Usability: **N/A**

Rationale: N/A

5. Related and Competing Measures

- **N/A**

6. Public and Member Comment

- Measure 0560 received two comments, both suggesting that the measure needs specification revisions before it should be considered for maintenance endorsement. Commenters wrote that revisions should be developed that allow for the use of multiple antipsychotics under certain circumstances, and which more generally should be updated using new guidelines which are anticipated soon.
    - Developer Response: Thank you for your comment. At the present time the measure allows for the use of multiple antipsychotics for cases with the following justification:
        - The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy.
        - The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge.
        - The medical record contains documentation of augmentation of Clozapine.

      Updates to the measure will be taken into consideration.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths complete

Submission

Description: The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.

Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

Denominator Statement: Psychiatric inpatient discharges

Exclusions:

- Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions
- Patients with a Length of Stay = or less than 3 days or = or greater than 365 days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

1. Importance to Measure and Report: Did not pass performance gap

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

1a. Evidence: **H-0; M-11; L-5; I-0**; 1b. Performance Gap: **H-0; M-9; L-7; I-0**

Performance Gap (Re-vote): H-1; M-7; L-8; I-0

Rationale:

- Updated 2016 American Psychiatric Association (APA) practice guidelines are used to support the measure. Multiple members suggested that the measure application lacked a sufficient link to desired outcomes, while another felt deployment of this measure continued to be of obvious importance.
- Committee members asked the developer to address the concern that the three-day period allowed for such screening was too long, especially to ascertain substance use or violence threats for a newly admitted patient. In response to this three-day window question, the developer said that this period of review was explicitly noted as a maximum time rather than an optimal time.
- Some Committee members expressed concern that the measure may have "topped out" as performance rates have increased from 87 percent in 2009 to 93.7 percent in 2018,

and no disparities were presented. In 2018 the 20th percentile was 92 percent, and the 70th percentile was 99 percent. At least one member believed performance could still be closer to 100 percent.

- The developer shared that they were aware of inter-facility differences and noted that rates are not the same for free standing facilities versus acute hospital unit or military/government facilities. They also noted that over 70 of the facilities tested were performing at or below 83 percent on this measure.
- A Committee member asked about which hospitals used paper records versus electronic record, but the developer responded that they don't have a way to determine that information. This question attempted to explore whether or not electronic record keeping enhanced fulfillment of such a measure.
- The Committee expressed strong interest in the measure if it included assessment of proper follow-up to positive screens. Some Committee members expressed interest in approving this measure if the developer would promise to re-specify it in the future to include such follow-up requirements. As such, the Committee was reminded by staff that for this particular cycle they needed to make a recommendation on the measure "as specified", which means absent any follow-up component.
- At least one member stated that the measure had likely served its purpose, but that now it was time to retire it in favor of metrics that more directly assess follow-up action and outcomes. Other members note that despite high performance rates overall, differences in performance rates may persist in facility subsets which mark addressable gaps.
- One Committee member asked if there were any existing follow-up measures related to the screenings (of SUD, violence, trauma, patient strengths) assessed by this measure. The only response to this question came from staff which said that they were aware of only SUD follow-up measures, but none related to the other screening dimensions composing this measure.
- During this post-comment meeting, one Committee member asked if there might be some way to retire the measure for ongoing use, but still retain it in some database or other format such that it may be revived for U.S. or international use given the utility it has thus far served. In response staff note that the report would reflect that suggestion, and that NQF maintains the freely available Quality Positioning System (QPS) database which catalogues and retains descriptions of formerly endorsed measures.

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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)

2a. Reliability: **M-13; L-3; I-0**; 2b. Validity: **H- 0; M-11; L-4; I-1**

<u>Rationale</u>:

- The data element reliability testing was done using a sample of 191 patient records. There was a very high level of agreement along each of the data elements in the numerator and denominator of > 98%, based on a simple repeat review of medical charts.

- Validity testing presented by the developer included the absence of significant correlations between this measure and measures of hours of restraint and seclusion use (measures 0640 and 0641) describe above, and a small, significant correlation between this measure and appropriate justification of multiple antipsychotic use (r=0.14, p=0.0002; measure 0560). This validity presentation, however, was regarded by some Committee members as reflecting only that various screening was occurring rather than that more specific risk screening was happening. Some Committee members thus believed the comparative standard used was a poor indicator of true risk/strength screening targeted by this measure.

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3. Feasibility: H-2; M-2; L-3; I-11

(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 elements are generated during the care process and defined in health record data.
- The Committee acknowledged the measure has been widely used since 2011.

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4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-14; No Pass-2**; 4b. Usability: **H-0; M-12; L-4; I-0**

Rationale:

- This measure is used in the Joint Commission's Hospital Accreditation program and publicly reported in ORYX Performance Measure Reporting Program.

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5. Related and Competing Measures

- This measure is related but not competing with the following measures:
  - 0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
  - 1365e: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
  - 2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
  - 2599: Alcohol Screening and Follow-up for People with Serious Mental Illness
  - 2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
- The measures are currently harmonized to the extent possible. The developer noted differences in level of analysis, diagnosis specificity, and the aspects and focus of the screenings across these measures.

Standing Committee Recommendation for Endorsement: Yes-9; No-7 (Consensus not reached)

Rationale:

As a 60 percent vote in the high to moderate range is required for the measure to pass, the measure remains "consensus not reached" at 8/16=50 percent, and thus it fails this "must pass" criteria and will be sent to Consensus Standards Approval Committee (CSAC) as one that is *not* recommended for ongoing endorsement.

The principal reason the Committee rejected this measure is that they were concerned it was essentially "topped out" at just over 90 percent performance rates on average, and also that it represents a simple process measure that is quite distant from a desired outcome. The Committee's ambivalence about the measure is reflected in the vote which was 50 percent high to moderate and 50 percent low regarding the performance gap criteria. Accordingly, the Committee expressed interest in a future measure like this one if the numerator definition includes evidence-based treatment initiation events in response to positive screens across each of the four domains addressed. Moreover, the Committee was reassured to know that even if the measure ultimately fails to receive maintenance endorsement, it will yet be stored with definitions in NQF's Quality Positioning System Database.

6. Public and Member Comment

- Three comments were received regarding measure 1922 from three separate commenters. Two commenters suggested that the measure needs to be updated with follow-up response to screening results as a numerator requirement. A third comment suggested better connectivity to outcome-evidence supporting its deployment, thereby supporting a key Committee concern regarding this measure. The commenter also expressed that the measure continues to be important to monitor, but recommended the developer identify strategies to ensure the desired screening is taking place.
    - Developer Response: Thank you for your comment[s]. The evaluation of appropriate interventions will be taken into consideration for future measure development. Follow-up measures will [also] be taken into consideration for future measure development.
        - As a screening measure, the intent is to determine that an appropriate patient assessment was conducted in order to inform clinical and treatment decisions. The current measure specifications do include the detail of what is required in order to demonstrate that the desired screening has been conducted.
        - Patient Strengths: Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Examples of patient strengths are provided in notes for abstraction.
        - Psychological Trauma History: Traumatic life experiences are defined as those that result in responses to life stressors characterized by significant fear, anxiety, panic, terror, dissociation, feelings of complete powerless or strong emotions that have long term effects on behaviors and coping skills. Examples of psychological trauma are provided in notes for abstraction.

- Substance Use: Substance use is defined as the use of psychoactive or mood altering substances, i.e., prescription medications, over the counter medications, inhalants, organic substances, illegal substances and street drugs. The screening must include: the type, amount, frequency of use and any problems due to past use.
- Violence Risk to Others: includes threats of violence and/or actual commission of violence toward others. Some examples of violence risk to others include but are not limited to the following: thoughts of harm to others, intentional infliction of harm on someone else by the patient, homicidal thoughts by the patient and thoughts of harming someone else by the patient.
- Violence Risk to Self: includes ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. Some examples of violence to self-include but are not limited to: past suicide attempts by the patient, intentional cutting, burning, bruising or damaging of self by the patient, inappropriate substance use, suicidal thoughts in the past six months by the patient, specific suicidal plan in the past six months by the patient and past suicide attempts by anyone in patient's family.

NATIONAL QUALITY FORUM

Behavioral Health and Substance Use Spring 2019 Review Cycle

CSAC Review and Endorsement

October 21-22, 2019

Behavioral Health and Substance Use Measure Portfolio

- 46 endorsed measures
  - 38 process/structure measures
  - 7 outcome and resource use measures
  - 1 composite measures

	Process	Outcome/Resource Use	Composite
Alcohol and Drug Use	5	0	1
Care Coordination	2	0	0
Depression	5	4	0
Medication Use	10	0	0
Experience of Care	2	0	0
Tobacco	5	0	0
Physical Health	9	3	0
Total	38	7	1

Standing Committee Recommendations

- 4 maintenance measures recommended for endorsement
  - ***0640*** *HBIPS-2 Hours of Physical Restraint Use*
  - ***0641*** *HBIPS-3 Hours of Seclusion Use*
  - ***3488*** *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)*
  - ***3489*** *Follow-Up After Emergency Department Visit for Mental Illness*

- 2 maintenance measures not recommended for endorsement
  - ***0560*** *HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications*
  - ***1922*** *HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed*

- No Spring 2019 measures were reviewed by the Scientific Methods Panel (SMP)

Public and Member Comment and Member Expressions of Support

- 14 comments received
  - *All supportive of the measures under review*

- Four of six measures under consideration received support from one NQF member organization.

Themes regarding non-recommended measures

- 0560 HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications
  - *Evidence for connection to better outcomes weak*
    - » Polypharmacy sometimes indicated
    - » New guidelines anticipated

- 1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed
  - *Gap no long evident, topped-out (>92% performance on average)*
    - » Distal process measure
      - *Response to positive screen as numerator event could enhance*
    - » Measure has fulfilled its use (specification still a resource)

Themes regarding recommended measures

- **0640** HBIPS-2 Hours of Physical Restraint Use & **0641** HBIPS-3 Hours of Seclusion Use
  - *Risk-adjustment suggestion by one commenter*
    - » Developer and Committee noted that process measures often are not risk-adjusted, but age- and facility-type strata are available in the data

- **3488** Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) & **3489** Follow-Up After Emergency Department Visit for Mental Illness
  - *Newly devolved from a combined measure*
  - *Commenter and Committee interest in seeing that the denominator of the SUD allow for inclusion of secondary diagnoses (e.g., Cirrhiosis and alcohol use disorder).*

Timeline and Next Steps

Meeting	Date/Time
CSAC Review	October 21-22, 2019
Appeals Period	October 30 – November 28, 2019

Questions?

- Project team:
  - *Michael Abrams, MPH, PhD, Senior Director*
  - *Nicolette Mehas, PharmD, Director*
  - *Desmirra Quinnonez, Project Analyst*
  - *Hannah Bui, MPH, Project Analyst*

- Project webpage: http://www.qualityforum.org/Behavioral_Health_and_Substance_Use.aspx

- Project email address: behavioralhealth@qualityforum.org

Behavioral Health and Substance Use, Spring 2019 Review Cycle: CDP Report

DRAFT REPORT FOR CSAC REVIEW

October 21-22, 2019

NATIONAL QUALITY FORUM

This report is funded by the Department of Health and Human Services under contract HHSM-500-2017-00060I Task Order HHSM-500-T0001.

Contents

Behavioral Health and Substance Use, Spring 2019 Cycle

DRAFT REPORT

Executive Summary

This report summarizes the most recent measurement evaluation and deliberation activities of the National Quality Forum's (NQF) Behavioral Health and Substance Use (BHSU) Standing Committee. It corresponds to measures reviewed during the spring 2019 measure review cycle. This report follows directly from several recent reports including one that is just concluding for fall of 2018. As such, this current report shares background materials with prior reports, but otherwise is updated to reflect new Committee activities and more general evolutions in the BHSU field.

Behavioral health—including psychiatric illness (mental illness) and substance use disorders (SUDs) (e.g., tobacco and opioid abuse and dependence)—continues to be an important organizational construct (unified by brain-based etiology and behavioral symptomology) of healthcare across the globe. The most comprehensive annual report of behavioral health prevalence data in the U.S. is the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). Results from the 2017 NSDUH indicated that in the U.S. 19.7 million persons (age ≥12 years) suffered from an apparent SUD (not including tobacco dependence), and 46.6 million persons (age ≥18 years) suffered from a mental illness. These numbers jointly suggest that substantive behavioral health disease was evident in at least 56 million adolescent and adult Americans in 2017, or roughly 21 percent of the maturing/mature population. This 1 in 5 rate is consistent with other epidemiologic studies that have previously revealed the prevalence of behavioral health conditions in the U.S.

The NSDUH from 2017 further reveals an important concern about behavioral healthcare in this country: only 12.5 percent of persons with SUDs reported treatment during that year, and only 43.6 percent of those with any mental illness reported receiving care for that condition.[1] This gap between marked behavioral health pathology and treatment alone should give one pause about the quality of the U.S. healthcare system regarding such issues, and it certainly represents an unmet or untapped need. This unfulfilled need persists even as behavioral health disease burden is high in the U.S. and even as good treatments exist.

Specifically, 2015 data that quantified age-standardized disability adjusted life years (DALYs) showed that mental and substance use disorders yield more years lost to suboptimal health per 100,000 persons in the U.S. (3,355 DALYs) than any other major disease category including cancers (3,131 DALYs), circulatory diseases (3,065 DALYs), injuries (2,419 DALYs), and endocrine (kidney) diseases (1,827 DALYs).[2] Recent work in behavioral health has described effective psychosocial or psychopharmaceutical therapies for depression, opioid addiction, anxiety, schizophrenia, and bipolar disorder.[3–10] However, this same and related work also demonstrates ongoing challenges in the prevention, diagnosis, and treatment of behavioral health disorders—illnesses that are typically chronic, cycling, and difficult to diagnose precisely because they do not correlate with salient biologic markers. As such, quality of care in behavioral health remains one of the great challenges in healthcare.

Recent examples from the scientific literature that point to the unique challenges facing BHSU care are numerous. One described that undiagnosed healthcare cases often involve hidden psychiatric illness which only becomes evident upon closer inspection.[11] Another found that tobacco use has recently flattened (rather than declined) because of the introduction of the e-cigarette,[12,13] evidence that specific substances and vehicles of chronic dependence change over time. A third study reported that stigma (i.e., discrimination) continues to be significant treatment barrier for several illnesses, especially mental health and substance use disorders,[14] And finally, one recent study found that persons who use inpatient services—an intensive and costly level of healthcare—typically have psychiatric or substance use disorders, while only about 17 percent of those diagnoses are addressed directly with treatment.[15]

The review and evaluation of behavioral health measures has long been a priority of NQF with endorsement for mental health and substance use disorder measures going back at least a decade. At present, there are 46 NQF-endorsed behavioral health measures. The background and description of NQF's most recent BHSU Standing Committee meeting as well as previous meetings are available on NQF's project webpage. This Committee oversees the measurement portfolio used to advance accountability and quality in the delivery of behavioral health and substance use services. The Committee's most recent decision making meeting is detailed in this report, and it includes the evaluation and voting results of measures including the use of physical restraint and seclusion, follow-up after emergency department visit for alcohol and other illegal drug use or dependence and mental illness, as well as the discharge of patients on multiple antipsychotic medications and the screening for violence risk, substance use, psychological trauma history, and patient strengths completed upon admission.

For this project, the Standing Committee evaluated six measures undergoing maintenance review according to NQF's standard evaluation criteria. Four measures were recommended for endorsement, two measures were not recommended for endorsement. The Standing Committee recommended the following four measures:

- 0640 HBIPS-2 Hours of Physical Restraint Use
- 0641 HBIPS-3 Hours of Seclusion Use
- 3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)
- 3489 Follow-Up After Emergency Department Visit for Mental Illness

The Committee did not recommend the following measure:

- 0560 HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications
- 1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Brief summaries of all six measures considered during this measurement cycle are included in the body of the report; detailed summaries of the Committee's discussion and ratings of the criteria for each measure are in Appendix A.

Beyond the six measures considered for endorsement, the Committee also discussed a measure that the Scientific Methods Panel (SMP) rejected because the developer did not use ICD-10 codes for testing (only ICD-9), it did not include proper level of testing, and there were concerns about some of the definitions in the measure specifications. The Committee expressed appreciation for the SMP review, and was also pleased to be reassured that the SMP focuses on quantitative/statistical issues thereby deferring content review to each respective Standing Committee.

Finally, during this most recent review cycle, the Committee briefly discussed measure gap areas including burn-out of professionals, which was noted during the previous cycle and which is also now included as a condition category in the International Classification of Diseases version 11 (ICD-11) coding scheme.[16] In reviewing the latest ICD-11, NQF staff further noted for the Committee several behavioral health changes to the ICD-11.

Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of—or suffering from—mental (i.e., emotional and/or cognitive issues) or addictive disorders—challenges broadly ranging from mood and anxiety disorders, to learning disabilities and substance abuse or dependence (including tobacco dependence). In the United States, over 56 million adolescents and adults suffer from a discernable behavioral health disorder (roughly 1 in 5),[17] and this includes over 11 million persons with the most serious forms of mental illness (schizophrenia, bipolar disorder, major depression), and a similar number of persons (substantially overlapping with the 11 million) who suffer simultaneously from a mental illness and an SUD. Behavioral disorders cause considerable pain and dysfunction in the U.S. population, so much so that it represents the leading cause of death and disability when compared to other major illness clusters including cancers, circulatory disease (heart disease, stroke, arteriosclerosis), injuries, and kidney disease.[2]

Opioid overdose deaths have recently become a particular concern in the U.S., and data compiled by the U.S. Centers for Disease Control and Prevention placed such deaths at over 47,000 in 2017 alone.[17] U.S. suicides in 2016 approach that number,[18] and deaths attributable to alcohol use (overdose, accidents, cirrhosis, cancers) numbered approximately 88,000 per 2006-2010 data, thus making alcohol use the third most common cause of preventable mortality behind tobacco use (first) and poor diet and physical inactivity (second).[19] Finally, mental illness strongly correlates with premature death by an average of 8 years for all mental illnesses and 25 years for the most serious forms.[20] The causes for this premature mortality are multifactorial including tobacco use, suicide, poor self-advocacy, and risk of victimization, but a least one recent study found that 95 percent of these premature deaths are from medical causes.

Despite the deep challenges posed by behavioral health illnesses—they are typically cycling, chronic, and serious—there exist many evidence-based approaches to prevent such illnesses and to treat persons and families impacted by them.[21–23] Applications of these strategies are neither easy nor universal; however, they are made challenging by the complexity and uncertainty of the underlying pathology and by stigma that shrouds a category of diseases which often negatively impacts one's social functioning.[24–27] Accordingly, quality measurement and quality improvement tools are essential to behavioral health—extraordinarily so compared to most other aspects of health.

NQF Portfolio of Performance Measures for Behavioral Health and Substance Use Conditions

The Behavioral Health and Substance Use Standing Committee (Appendix C) oversees NQF's portfolio of Behavioral Health and Substance Use measures (Appendix B) that includes measures for serious mental illnesses (e.g., schizophrenia, mania, major depression), dysthymia, anxiety, ADHD and other learning and behavioral problems, alcohol and illegal drug use, tobacco dependence, care coordination (between and within the spheres of psychiatric, substance use, and related physical illness), medication use, and patient care experience. This portfolio contains 46 measures: 38 process measures, seven outcome and resource use measures, and one composite measure (see table below).

Table 1. NQF Behavioral Health and Substance Use Portfolio of Measures

	Process	Outcome/Resource Use	Composite
Alcohol and Drug Use	5	0	1
Care Coordination	2	0	0
Depression	5	4	0
Medication Use	10	0	0
Experience of Care	2	0	0
Tobacco	5	0	0
Physical Health	9	3	0
Total	38	7	1

Additional behavioral health measures have been assigned to other portfolios. Examples include patient experience measures (Patient Experience and Function project); measures focused on antipsychotics, screening for drugs of abuse in psychosis, and tobacco use (Pediatrics/Patient Safety projects); measures related to pharmacotherapy for opioid use disorder (Patient Safety project); unplanned readmissions following psychiatric hospitalization (All-Cause Admissions and Readmissions project); and smoking prevalence (Prevention and Population Health project).

Portfolio Gaps Discussion

After completion of the measure reviews for this cycle, the Committee engaged in a brief discussion regarding the composition of NQF's current BHSU measurement portfolio. This discourse gave the Committee an opportunity to discuss their latest perspectives and desires regarding measurement science as it pertains to the U.S. behavioral health and substance use disorder prevention and treatment enterprise. Accordingly, this part of the Committee's proceedings is a touchstone for policymakers and measure developers to obtain ideas regarding the frontier of quality measurement as it pertains to diseases ranging from schizophrenia and depression, to alcohol and other drug use disorders, including opioid addiction.

To support this discussion, NQF staff first provided an overview of the portfolio gaps identified by the Committee during previous meetings spanning 2016-2018. Points described during that review included the Committee's expressed interest in seeing more measures that address the following issues: opioid

use disorder, criminal justice issues, patient-reported outcomes, tailored treatments that specifically consider stage of illness and readiness for change, recovery measures that address long-term outcomes, social determinants (e.g., housing, employment), care coordination issues, cost of care issues, and functional outcomes.

During this closing discussion, Committee members emphasized the following issues: serious mental illness (SMI) should be considered as a special population or a disparities population; more patient-reported "experience" measures should be developed (in addition to patient-reported outcomes); and more effort should be dedicated to considering if measures crystalize into standards of care (i.e., whether they become, as intended, broadly utilized).

Committee members also discussed the addition of professional burn-out to ICD-11, and staff presented additional information about behavioral health additions to that international reporting standard. One Committee member involved in formal ICD-11 discussions outside of NQF noted that the new standard is about five years from full use, but in the meantime, it aims to facilitate more automated record keeping and analytics, and further includes some important innovations that permit linking of patient safety information to other records. NQF staff noted that ICD-11 advanced from ICD-10 by appending several novel brain-based illness changes such as creating new diagnostic categories for hording and gambling, reclassifying stroke as neurologic rather than circulatory, and permitting the use of the attention deficit hyperactivity disorder (ADHD) diagnosis across ages.[16]

During the gaps discussion, one Committee member asked how such discourse at the Standing Committee level interacted with other quality improvement activities at NQF such as the NQF Measure Incubator®. While NQF staff emphasized the existence of a firewall between measure endorsement and the NQF Incubator®, staff also explained that the key gaps identified by Standing Committees are indeed practical information for other activities at NQF including the NQF Measure Incubator® and measure application, framework, and broad quality improvement initiatives.

Behavioral Health and Substance Use Measure Evaluation

On June 19 and 26, 2019 the Behavioral Health and Standing Committee evaluated six measures undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 2. Behavioral Health and Substance Use Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	6	0	6
Measures recommended for endorsement	4	0	4
Measures where consensus is not yet reached	1	0	1
Measures not recommended for endorsement	1	0	1
Reasons for not recommending	Importance – 1	Importance – 0	1

	Maintenance	New	Total
	Scientific Acceptability – 0 Use – 0 Overall Suitability – 0 Competing Measure – 0	Scientific Acceptability – 0 Overall Suitability – 0 Competing Measure –0	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on April 24, 2019 and will close on August 26, 2019. As of June 5, no comments were submitted prior to the measure evaluation meetings (Appendix F).

Overarching Issues

During the Standing Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure.

Need for Stronger Validity Assessments

During the discussion of multiple measures, the Standing Committee discussed the need for validity assessments to be strengthened. While the Committee recognized that it is difficult to perform the strongest types of validity assessment (e.g., correlating a measure with improved patient outcomes in an RCT), they also believed NQF's validity requirements sometimes lead to testing methods and results from which it is difficult to determine a measure's true validity. It was raised that in some cases, developers must use the data available to them to do a correlation analysis with another measure (which may or may not be appropriately selected as a comparator) that often results in a weak correlation. Related to measure 1922, for example, the immediate next step in the logic model provided links screenings to changes in a patient's treatment plan. The Committee suggested one could look at the relationship between the measure and the treatment plan or other "outcomes" in the inpatient setting. This may provide more information related to validity and could be gathered in the inpatient setting.

Defining "Topped Out" Performance

At least one Committee member expressed that NQF should consider convening methodologists and other experts to standardize how performance gap is assessed, especially when performance rates appear to be high and/or leveling off. Another Committee member shared that this is complex and difficult to standardize and should be discussed on a case by case basis, as considerations about opportunity for improvement vary based on the specifics of an individual measure.

Connecting Standing Committee Activities to Other Quality Improvement Actions Within and Outside of NQF

While a firewall exists between NQF's measure endorsement process and NQF's Measure Incubator, Committee members expressed interest in connecting their measure adjudication efforts with other activities at NQF such as the incubator, measurement applications, and other quality improvement projects. They also were interested in evaluating the impact of measures on downstream assessment of which measure targets ultimately become formalized as standards of practice.

Summary of Measure Evaluation

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

0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification (The Joint Commission): Not Recommended

Description: The proportion of patients, age greater than and equal to 1 year, discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification. **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Paper Medical Records

The Committee did not vote on a recommendation for endorsement because this maintenance measure did not pass the evidence criterion—a "must-pass" criterion. Committee discussion about this measure revealed concern that the evidence presented by the developer was dated and too general to support a measure that looks at antipsychotic use for indications outside of schizophrenia. There was also concern that the measure might discourage multiple antipsychotic use that may be useful. Two specific studies[28,29] were cited during the discussion as examples demonstrating that while monotherapy is generally regarded as the best first-line approach, evidence indicates that polypharmacy may be superior in some instances. Accordingly, the Committee was concerned that the current measure might work against the best option for some patients and acknowledged the growing controversy in practice related to the appropriateness of multiple antipsychotics for certain patients.

0640 HBIPS-2 Hours of physical restraint use (The Joint Commission): Recommended

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint. **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Paper Medical Records

The Standing Committee recommended the measure for continued endorsement. Generally, the Committee expressed sentiments in favor of the measure as impactful in changing the way restraints are used, though there was some discussion about whether lower restraint use represents higher quality care. Regarding performance gap, the Committee heard and discussed that there are some inconsistent findings: sometimes the elderly and minorities are characterized as high risk for restraint use, but other studies show young white males are restrained most. Physical restraint use appeared to be relatively rare (<1 percent) per the developer's data, and one member of the Committee suggested that there may be no further room for improvement across most facilities. The developer and Committee discussion clarified that the data showed approximately 36,000 occurrences of restraint use in 2018, suggesting that the method is still prominent. Regarding reliability, the developer checked charts against their study records and found 100 percent concordance based on 191 records. Discussion of validity testing noted a "moderate" correlation (r=0.216) was observed between restraint use and seclusion use (measure 0641). The Committee agreed that the measure is feasible and usable, though at least one

member questioned whether decreased seclusion rates might correlate with increased and potentially inappropriate use of chemical restraints (e.g., sedatives).

Discourse surrounding this restraint measure (0640) and the seclusion measure (0641) described below overlapped because both of these strategies are uniquely dramatic and controversial given their distinct potential to work against the value of patient-oriented care. Moreover, the Committee expressed concern that such strategies may be substituted with chemical constraints (e.g., sedatives).

0641 HBIPS-3 Hours of seclusion use (The Joint Commission): Recommended

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion. **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Paper Medical Records

This maintenance measure, originally endorsed in 2010, was recommended by the Standing Committee for continued endorsement. The Committee discussion regarding this measure was similar to that for the restraint measure (0640). The discussion noted disparities data that supported a performance gap. Some concern was expressed that the measure may have "topped out," as much change in restraint and seclusion practices has already occurred in recent years. Reliability was noted as limited to 190 chart re-abstractions (as was the case with the restraint measure). Validity was predicated upon the same empirical correlation described for restraints, and face validity was noted as well based on responses from 36 hospital-based representatives—31 of which reported the measure to be very good or good with regards to its validity.

At least one Committee member expressed concern, but also accepted, that validity assessments submitted with NQF measures rarely include randomized studies that establish a link between a measure and complex, long-term quality outcomes (e.g., qualify of life years after symptoms first emerged). Another Committee member received confirmation from the developer that part of its validity presentation involved a target analysis, which allows users to assess or benchmark their relative performance against other hospitals reporting to The Joint Commission. One Committee member suggested seclusion, physical restraints, and chemical sedation should all be considered in relation to one another as practices that may generally reflect undesirable outcomes. Overall, most Committee members agreed that the measure has been used to drive changes in seclusion practices and is usable and relatively straightforward to capture. During the related measures discussion, one Committee member was interested in how measures might capture de-escalation options, and it was noted that seclusions and restraint approaches are related processes.

1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed (The Joint Commission): Consensus Not Reached

Description: The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths. **Measure Type**: Process; **Level of Analysis**: Facility, Other; **Setting of Care**: Inpatient/Hospital; **Data Source**: Electronic Health Records, Paper Medical Records

This measure was first endorsed in 2014 and assesses whether psychiatric inpatients are screened on five basic criteria.

During the initial Spring 2019 measure evaluation web meeting, Committee members did not vote on an overall recommendation for endorsement because prior "must pass" voting did not reach consensus on performance gap. Supporting that ambivalent vote, some Committee members expressed concerns with the evidence, performance gap, and validity testing associated with the measure. While one member shared that the measure was not convincingly linked to outcomes, another believed that it was obvious this screening is important to perform and has the potential for high impact.

Committee members agree that the focus of the screening is important for psychiatric inpatients. There was discussion about the three-day window to screen, which some members believed may be too long. In response to this concern the developer noted that three days was the maximum window post-admission, thereby allowing earlier evaluations immediately following an admission. Some Committee members suggested that the measure may have "topped out" as performance rates have increased from 87 percent in 2009 to 93.7 percent in 2018, and no disparities were presented, though another member believed performance could be closer to 100 percent. The developer shared that they were aware of inter-facility differences and noted that rates are not the same for free standing facilities versus acute care hospital units or military/government facilities.

Validity testing presented by the developer included a small, but significant correlation between this measure and appropriate justification of multiple antipsychotic use. This validity presentation, however, was regarded by some Committee members as reflecting only that some screening was occurring rather than that more specific risk screening was achieved. The Committee accepted the data element reliability testing presented and agreed that the measure was feasible and usable, as it has been in use since 2011. The Joint Commission currently uses it for hospital accreditation; it is reported in the ORYX Performance Measurement Reporting Program.

Given that a 60 percent voting consensus was not reached on performance during the initial meeting, this specific question was revisited in a follow-up meeting on September 16, 2019. During that meeting, NQF offered the Committee a reminder description of the measure along with a description of previous concerns the Committee expressed, and of public comments about this measure received after the draft report was web-posted. That renewed discourse hit that same areas as before. Specifically, some Committee members continued to be concerned that the measure was close enough to 100 percent performance rates across providers to suggest it had "topped-out" regarding its usefulness as a quality measure. Moreover, although the Committee had previously passed the measure on evidence (i.e., the demonstrated link between screening and desired outcomes), they continued to express concern that screening, per se, is an insufficient indicator of good quality care.

During the renewed Committee discussion, more than a single member expressed interest in retaining the measure in some form as a useful historic measure, but also as a potential measure for other countries to utilize if they had yet to achieve high rates. In response to the comment, NQF staff stated that the NQF-maintained Quality Positioning System retains a full and searchable record of formerly endorsed measures.

At least one Committee member also asked if there was a specific threshold for performance which could be used to define a measure as "topped-out". Staff noted there is no defined threshold, and thus it remains the Committee's judgement on a case-by-case basis. One Committee member also asked when the developers could submit a revision of the measure, and staff noted that they could do so up to two times per year, given NQF's current review calendar. In response to this discourse, the developer stated that even the most recent years of data suggest that over 70 programs were performing at or below 83%, thereby indicating room for improvement in some venues. The developer also noted that NQF's calendar was not the limiting factor for revising and resubmitting a measure; instead, it was that updating and retesting a measure requires months to years of effort.

In the wake of the renewed discourse from September 16, 2019, the Committee reached only a 50% (8 of 16) consensus in the high (1 vote) to moderate (7 votes) range supporting the premise that there is a sufficient performance gap for this measure. As such and by NQF rules, the measure failed to achieve an endorsement recommendation from the Standing Committee

3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (National Committee for Quality Assurance): Recommended

Description: The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:
- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims

The Committee recommended the measure for continued endorsement. This measure is a maintenance measure because it was previously measure 2605 *Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*, which combined mental health and substance use disorder (SUD) emergency department (ED) follow-up visits. In addition to two updated guidelines provided as evidence, the developer noted in their introduction that absence of follow-up care from a SUD ED event increased one's risk of readmission by six times. The Committee found that this measure supports the connection of patients to outpatient care after ED use and rates indicate a significant opportunity for improvement.

The performance gap was substantial as data across ages and Medicare and Medicaid programs indicated that less than 20 percent of the qualifying ED discharges that are followed-up; moreover, those with the added risk of co-occurring psychiatric illness had even lower rates of follow-up. Committee members expressed support for the inclusion of SUD follow-up services delivered by primary care providers and inclusion of telehealth services.

Validation for this measure was demonstrated by comparing it to the mental illness follow-up measure (3489) and by comparing the 7- and 30-day follow-up measures rates to each other. The Committee found these validation approaches reasonable. Some concern was discussed that the current measure

was competing with measure 0004 *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*, but the developer assuaged that concern by noting the current measure is unique to ED venues and near-term follow-up. One Committee member expressed moderate concern that this measure does not include follow-up treatments outside of the traditional medical sphere (e.g., 12-step programs). The Committee agreed that this measure is feasible and meaningful to measure.

3489 Follow-Up After Emergency Department Visit for Mental Illness (National Committee for Quality Assurance): Recommended

Description: The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:
- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). **Measure Type**: Process; **Level of Analysis**: Health Plan; **Setting of Care**: Outpatient Services; **Data Source**: Claims

This process measure was recommended for continued endorsement. This measure is a maintenance measure because it was previously measure 2605 *Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence*, which combined mental health and substance use disorder (SUD) emergency department (ED) follow-up visits. The Committee expressed some concern that the measure is based on a very general definition of follow-up, but the gap evident for delivery of even this "low bar" service was said to be important to improve as fewer than 60 percent of the entities studied completed such follow-up activities within 30 days of an emergency department (ED) event. This measure was updated to include telehealth as a numerator qualifying event. Signal-to-noise reliability testing supported the reproducibility of the measure to differentiate between tested entities. Score-level reliability testing showed a moderate correlation with the related measure 3488 and that the 7- and 30-day rates are highly correlated. Though the Committee articulated some concern that the two years of data presented did not demonstrate improvement trends, the developer said that such variability is not uncommon for newly deployed measures. The Committee discussed the responsibility of the ED for this measure, discussion which seemed to converge on the expectation that EDs, per se, have limited responsibility, but health plans are instead held responsible for performance on this measure. The Committee agreed that this measure, similar to 3488, is feasible, and the results can be used to improve the quality of care and timely connection to outpatient care for individuals with mental illness.

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

Measures Recommended

0640 HBIPS-2 Hours of physical restraint use

Submission | Specifications

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

Numerator Statement: The total number of hours that all psychiatric inpatients were maintained in physical restraint.

Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

Denominator Statement: Number of psychiatric inpatient days

Denominator basis: per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

Exclusions: Total leave days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **M-14; L-2; I-0**. Performance Gap: **H-3; M-9; L-3; I-1**

Rationale:

- The evidence provided by the developer included a clinical practice guideline and systematic review, along with many additional citations.
- The Committee generally agreed that restraint use is still frequently used, the measure has had a positive impact, and there is room for improvement (i.e., for alternative conflict mitigation strategies for patients who become agitated or other challenge to control).
- Some of the data presented show a decrease in the median time in restraints from 2009 to 2018.
- Other data presented by the developer indicated that restraint use was increasing with time, but the developer argued that those unexpected trends were the result of confounding case-mix.

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

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

2a. Reliability: **M-13; L-3; I-0**; 2b. Validity: **H-2; M-12; L-2; I-0**

Rationale:

- The Committee accepted the data-element reliability testing (which showed perfect agreement pertaining to ~200 chart re-abstractions) and score level validity testing (which, as hypothesized, indicated a slight positive correlation with measure 0641 (seclusion) and no correlation with the other antipsychotic justify cation measure (arguably not a good comparator) were presented.
- When asked if they believed a more direct test-retest reliability experiment was necessary—for example with two time-keepers monitoring each restraint event—the developer responded that this was not feasible, but that they did visit several facilities to verify chart reviews, and there were procedures in place at each facility to get precise start and stop times for restraint use.

3. Feasibility: H-2; M-11; L-3; I-0

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

Rationale:

- The measure uses EHR or paper medical record data. One member commented that there is not additional burden as there are already strict requirements in place to keep track of time when patients are placed in seclusion.

4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-3; M-10; L-2; I-1**

Rationale:

- It was noted that there may be an unintentional consequence of increasing the use of as needed medication if trying to reduce restraint use. Stated another way, the Committee believes that seclusion, physical constraints, and chemical constraints (e.g., sedation), likely act as substitutes/complements for one another and future measures should consider that connectivity.
- The measure is publicly reported and used for accountability.

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5. Related and Competing Measures

- This measure is related to measure 0687: Percent of Residents Who Were Physically Restrained (Long Stay).
    - The measure focus is the same, but the populations are different – psychiatric inpatients versus long stay care residents.
- The Committee discussed that this measure is also conceptually related to 0641 (seclusion) and expressed some interest in exploring how these measures work together or if they could be considered together in the future.

Standing Committee Recommendation for Endorsement: **Yes-14**; **No-2**

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6. Public and Member Comment

- Four comments (two from each of the two commenters) were received regarding measures 0640 (restraints) and 0641 (seclusion). These commenters supported continued endorsement, but one commenter suggested that risk-stratification methods should be used to account for performance differences related to differing case-mix.
    - Developer Response: Thank you for your comments. The use of seclusion and restraint should be limited to situations deemed to meet the threshold of imminent danger. The intent of the measure is to provide that when restraint and seclusion are applied, use is rigorously monitored and analyzed to prevent future use when possible.

      The measure is currently written so that it will apply consistently across all accredited inpatient psychiatric care facilities. As a general practice, The Joint Commission does not risk adjust process measures. This measure is currently age stratified. Risk stratification for special populations could cause undue burden of data abstraction.

      Although we do not routinely evaluate differences between free-standing inpatient psychiatric facilities and acute care hospital inpatient psychiatric units, we are able to evaluate these differences with the data collected on the measure.

      The developer also thanks the commenters for their support of these measures.

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7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

0641 HBIPS-3 Hours of seclusion use

Submission | Specifications

Description: The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

Numerator Statement: The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

Denominator Statement: Number of psychiatric inpatient days

Denominator basis per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

Exclusions: Total leave days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **M-12; L-4; I-0**. Performance Gap: **H-2; M-12; L-2; I-0**

Rationale:

- The developer cites the same evidence as used for the previous endorsement and provides a logic model linking decreased seclusion use to decreased patient and staff injuries, shorter lengths of stays and decreased costs. Though at least one member believed the evidence that directly links decreased seclusion use to these outcomes is not very strong.
- At least one member shared that the measure has helped drive change in the culture on inpatient units towards the use of seclusion. Another member believed the evidence for seclusion use was less straightforward than restraint use (e.g., seclusion might be a way to prevent restraint and may be more appropriate in some cases; or seclusion might be desired by, rather than imposed upon, the patient)
- Performance data showed that mean rates varied between 2009-2018 while median rates decreased, with some outliers present. Data also suggested disparities by race, age, and gender.

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

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

2a. Reliability: **M-13; L-3; I-0**; 2b. Validity: **H-1; M-14; L-1; I-0**

Rationale:

- The Committee accepted the data element reliability testing results (n=190 patient cases; 9 observations for the numerator elements). The Committee also accepted the validity testing which showed a significant slight positive correlation with measure 0640 (restraints).
- The Committee briefly discussed that the developer presented face validity results from hospital representatives which were favorable.
- One Committee member also asked for the developer to clarify their "target analysis." That analysis creates a benchmark and allows hospitals to see how they are performing relative to others. That target analysis was used to support the presence of a performance gap in a subset of identified hospitals.

3. Feasibility: H-1; M-12; L-3; I-0

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

Rationale:

- The Committee did not have many comments on feasibility but noted that this measure is a human- recorded measure and that some psychiatric facilities rely on paper rather than more automated electronic records.

4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-16; No Pass-0**; 4b. Usability: **H-2; M-12; L-1; I-1**

Rationale:

- The measure is used for public reporting and accountability.
- The Committee did not raise any concerns about usability not already discussed for measure 0640.

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5. Related and Competing Measures

- No related or competing measures were noted by the developer.
- The Committee noted this measure (seclusion) and 0640 (restraints) are conceptually related. The committee expressed interested in how these measures may work together but they are currently harmonized to the extent possible. One Committee member was interested in how measures might in the future be engineered to consider de-escalation strategies more generally.

Standing Committee Recommendation for Endorsement: **Yes-14**; **No-2**

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6. Public and Member Comment

- Four comments (two from each of the two commenters) were received regarding measures 0640 (restraint) and 0641 (seclusion). These commenters supported continued endorsement, but one commenter suggested that risk-stratification methods should be used to account for performance differences related to differing case-mix.
    - Developer Response: Developer Response: Thank you for your comments. The use of seclusion and restraint should be limited to situations deemed to meet the threshold of imminent danger. The intent of the measure is to provide that when restraint and seclusion are applied, use is rigorously monitored and analyzed to prevent future use when possible.

      The measure is currently written so that it will apply consistently across all accredited inpatient psychiatric care facilities. As a general practice, The Joint Commission does not risk adjust process measures. This measure is currently age stratified. Risk stratification for special populations could cause undue burden of data abstraction.

      Although we do not routinely evaluate differences between free-standing inpatient psychiatric facilities and acute care hospital inpatient psychiatric units, we are able to evaluate these differences with the data collected on the measure.

      The developer also thanks the commenters for their support of these measures.

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7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)

Submission | Specifications

Description: The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Numerator Statement: The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.
- 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

Denominator Statement: Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

Exclusions: Patients in hospice.

Adjustment/Stratification: This measure is stratified by age:

- Age 13 to 17 years
- Age 18 and older
- Total (sum of the age stratifications)

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims. This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **H-4; M-10; L-0; I-0**. Performance Gap: **H-8; M-6; L-0; I-0**

Rationale:

- Published clinical guidelines and literature link ongoing treatment of patients with substance abuse, including follow-up care after an acute episode of the illness such as an ED visit, to improved patient outcomes such as reduce risk of subsequent ED visits.
- Data indicate a performance gap with very low performance overall and performance variation across payer types and age groups. Average 30-day follow-up performance across all ages is 12 percent for Medicare plans, 18 percent for Medicaid plans, and 14 percent for commercial plans.
- The Committee agreed the measure provides healthcare organizations a way to monitor quality of care for vulnerable populations.
- There was a minor concern that patients visiting the ED multiple times are only counted once, and then removed from the denominator.
- The Committee expressed interest in denominator events where SUD is the secondary rather than the primary diagnosis. The developer explained that for the present they aimed to restrict focus to the most certain diagnostic cases (i.e., to the primary diagnosis exclusively).
- The Committee supported that a visit with any provider that records SUD as the primary diagnosis is counted in the numerator (e.g., a primary care provider attending to SUD would be considered a true qualifying event).
- At least one member expressed support for the inclusion of telehealth as appropriate follow-up. Members concerned that a simple survey of a patient, even an online survey, might be inappropriately counted as a bona fide follow-up event were assuaged by the developer who noted that only two-way communications (e.g., survey plus a response from provider) were counted as such, even as that two-way exchange could be asynchronous (e.g., via email).

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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)

2a. Reliability: **H-2; M-12; L-0; I-0**; 2b. Validity: **H-2; M-12; L-0; I-0**

Rationale:

- Signal to noise score-level reliability testing results indicated moderate/high reliability across age groups and payer types (reliability statistic 0.81-0.98).
- Validity testing at the score level indicated a strong positive correlation between this measure and 3489: Follow-Up After Emergency Department Visit for Mental Illness across all payer types (validity statistics from 0.42 to 0.57, all statistically significant).
- Correlations for within measure 7-day and 30-day rates were strong (>0.94, all statistically significant).
- The Committee accepted the measure's scientific acceptability without concern.

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3. Feasibility: H-6; M-7; L-1; I-0

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

Rationale:

- The measure uses claims data and the committee did not express any feasibility concerns.

4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-13; No Pass-1** 4b. Usability: **H-3; M-10; L-1; I-0**

Rationale:

- The measure is used in multiple national reporting programs such as the Medicaid Core Set, demonstration programs to certify a community's behavioral clinics, and HEDIS reporting by all product lines to NCQA.
- The Committee agreed the measure is usable. One member expressed that in the future measures should consider the quality of transition and follow-up care (e.g., communication at hand-off, integration of primary and specialty care, appropriateness of level of care assigned).

5. Related and Competing Measures

- This measure is related to the following measures:
    - 0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
    - 3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
    - 3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
    - 0576: Follow-Up After Hospitalization for Mental Illness (FUH)
    - 3489: Follow-Up After Emergency Department Visit for Mental Illness
- The Committee did not note any immediate harmonization opportunities, however generally encouraged a more holistic approach to measuring continuity of care, follow-up, and care coordination for various conditions and populations.

Standing Committee Recommendation for Endorsement: **Yes-13**; **No-1**

6. Public and Member Comment

- Five comments were received related to measures 3488 (Follow-up to SUD ED admission) and 3489 (Follow-up to mental illness ED admission) from three commenters. One commenter simply expressed support for both measures. A second commenter expressed concern that these two measures were separated, rather than a single measure. The commenter also expressed support at the health plan level of analysis but emphasized the importance of testing at more granular levels of analysis before the measure is used more broadly in other programs. Finally, a third commenter suggested that 3488 should allow for the inclusion of cases where only a secondary alcohol or other drug diagnosis is evident.
    - Developer Response: Thank you for the comment. The two measures used to be one and recently separated into two to align with HEDIS where they are reported as two separate measures. Additionally, the measures have distinct denominator populations

that need to be calculated separately, which also justifies having them as two separate measures. The denominator of NQF 3488 is those with a primary SUD diagnosis. The denominator of NQF's 3849 is those with a primary mental illness diagnosis. Given this, the level of effort required to calculate them as two separate measures is the same as calculating them as one with multiple indicators.

We agree that measures should be tested at the level of intended use. The measures (NQF 3488 and NQF 3849) were tested and are used as plan/state level measures. They are not emergency department level measures. The NQF 0576 (FUH) measure was tested at the IPF level before it was introduced into the IPFQR or QPP.

NCQA's Behavioral Health Measurement Advisory Panel and the Committee on Performance Measurement recommended the measure (3488) to require primary diagnosis of AOD for the denominator and numerator to make sure that the ED visit and the follow-up visits are for AOD and to be consistent between the requirement for the denominator and the numerator. Claims typically have no designation of "secondary" diagnosis, instead they have primary diagnosis and diagnosis in any other position. Our expert panels considered it would be non-specific to count non-primary AOD diagnosis in the measure denominator or numerator. Assuming the commenter means multiple ED visit by multiple visits, we want to note that the measure is episode-based. A member with multiple ED visits would be in the measure denominator multiple times and should receive follow-up care after each ED visit. The measure focuses on AOD and monitors AOD separately from ensuing consequences through requiring a primary AOD diagnosis in the denominator and numerator.

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7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

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8. Appeals

3489 Follow-Up After Emergency Department Visit for Mental Illness (FUM)

Submission | Specifications

Description: The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Numerator Statement: The numerator consists of two rates:

- 30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
- 7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

Denominator Statement: Emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.

Exclusions: Patients in hospice.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 06/19/2019

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

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

1a. Evidence: **H-4; M-10; L- 0; I-0** Performance Gap: **H-7; M-7; L-0; I-0**

Rationale:

- The evidence is primarily based on review of four guidelines. The Committee discussed that the measure targets broader processes than those specified in the guidelines, but they still agreed that follow-up from a mental illness related ED visit is important.
- For 2016 and 2017, the 30-day follow up varied from 60% with commercial coverage to 47% with Medicare. The 7-day rates varied from 46% commercial to 31%, respectively.

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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)

2a. Reliability: **H-2; M-11; L-1; I-0** 2b. Validity: **H-2; M-12; L-0; I-0**

Rationale:

- Signal to noise reliability tested showed high reliability (statistics exceeded 0.91).
- Validity testing at the score level indicated a strong positive correlation between this measure and 3489: Follow-Up After Emergency Department Visit for Mental Illness across all payer types (validity statistics from 0.42 to 0.57, all statistically significant).
- Correlation between the 7- and 30- days rates was high (r >0.92), as expected.
- The Committee accepted the measure's scientific acceptability without concern.

3. Feasibility: H-5; M-8; L-1; I-0

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

Rationale:

- The measure is feasible as it uses claims data that are readily available and captured without burden.

4. Usability and Use: The maintenance measure meets the Use subcriterion

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-13; No Pass-1**; 4b. Usability: **H-4; M-10; L-0; I-0**

Rationale:

- The measure is used in multiple national reporting programs such as the Medicaid Core Set, demonstration programs to certify a community's behavioral clinics, and HEDIS reporting by all product lines to NCQA.
- One Committee member noted that the two years of data presented did not show an upward trend. The developer responded that the measure is relatively new, and it is not uncommon across HEDIS measures to see the rates fluctuate during the first few years of deployment. Improvement is otherwise expected with time.
- The Committee discussed that a lack of resources in many areas impact the ability of EDs to connect patients with follow-up care, but this measure is specified and tested at the health plan level of analysis (e.g., health plans are held responsible based on this measure).

5. Related and Competing Measures

- This measure is related to the following measures:
    - 0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
    - 3312: Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
    - 3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
    - 0576: Follow-Up After Hospitalization for Mental Illness (FUH)
    - 3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
- The Committee did not note any immediate harmonization opportunities, however generally encouraged a more holistic approach to measuring continuity of care, follow-up, and care coordination for various conditions and populations.

Standing Committee Recommendation for Endorsement: **Y-13; N-1**

6. Public and Member Comment

- Five comments were received related to measures 3488 (…for SUD) and 3489 (… for mental illness) from three commenters. One commenter simply expressed support for both measures. A second commenter expressed concern that these two measures were separated, rather than a single measure. The commenter also expressed support at the health plan level of analysis but emphasized the importance of testing at more granular levels of analysis before the measure is used more broadly in other programs. Finally, a third commenter suggested that 3488 should allow for the inclusion of cases where only a secondary alcohol or other drug diagnosis is evident, with no similar suggestion was made for 3489.
    - Developer Response: Thank you for the comment. The two measures used to be one and recently separated into two to align with HEDIS where they are reported as two separate measures. Additionally, the measures have distinct denominator populations that need to be calculated separately, which also justifies having them as two separate measures. The denominator of NQF 3488 is those with a primary SUD diagnosis. The denominator of NQF's 3849 is those with a primary mental illness diagnosis. Given this, the level of effort required to calculate them as two separate measures is the same as calculating them as one with multiple indicators.

      We agree that measures should be tested at the level of intended use. The measures (NQF 3488 and NQF 3849) were tested and are used as plan/state level measures. They are not emergency department level measures. The NQF 0576 (FUH) measure was tested at the IPF level before it was introduced into the IPFQR or QPP.

      NCQA's Behavioral Health Measurement Advisory Panel and the Committee on Performance Measurement recommended the measure (3488) to require primary diagnosis of AOD for the denominator and numerator to make sure that the ED visit and the follow-up visits are for AOD and to be consistent between the requirement for the denominator and the numerator. Claims typically have no designation of "secondary" diagnosis, instead they have primary diagnosis and diagnosis in any other position. Our expert panels considered it would be non-specific to count non-primary AOD diagnosis in the measure denominator or numerator. Assuming the commenter means multiple ED visit by multiple visits, we want to note that the measure is episode-based. A member with multiple ED visits would be in the measure denominator multiple times and should receive follow-up care after each ED visit. The measure focuses on AOD and monitors AOD separately from ensuing consequences through requiring a primary AOD diagnosis in the denominator and numerator.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

Measures Not Recommended

0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Submission

Description: The proportion of patients, age greater than and equal to 1 year, discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

Numerator Statement: Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

Denominator Statement: Psychiatric inpatient discharges

Exclusions:

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients with a length of stay less than or equal to 3 days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

1. Importance to Measure and Report: The measure does not meet the Importance criteria

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

1a. Evidence: **H-1; M-2; L-6; I-7**

Rationale:

- The developer cited evidence used to inform the 2004 American Psychiatric Association (APA) Practice guideline for the treatment of patients with schizophrenia, which included a meta-analysis of various RCTs and observational studies comparing polypharmacy to monotherapy. The developer stated that a literature search did not yield new guidelines or significant research that would warrant a measure change.
- Several Committee members noted the growing controversy in the field about the use of multiple antipsychotics (which is sometimes indicated) and expressed that the evidence presented was dated.
- In response, the developer noted that the measure is based on current guidelines, though new APA guidelines are anticipated in September 2019. The developer also argued that the measure neither supports or discourages polypharmacy, but only requires that one of three evidence-based justifications be proffered if it is used.
- At least one Committee member voiced support for these justifications and the measure as it was presented. Other Committee members expressed concern that the evidence presented did not fully consider the possibility that the measure may discourage polypharmacy when it is indicated. Committee members also held to their concern that the evidence presented was specific to schizophrenia even as the measure specifications were not similarly restricted to the use of antipsychotics for that single indication.
- The Committee recommended that a more rigorous environmental scan be conducted and suggested the measure may need to be updated accordingly. Ultimately the measure did not meet pass Evidence (a must-pass criterion), therefore discussion and voting on the remaining criteria did not continue.

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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)

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

<u>Rationale</u>: N/A

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3. Feasibility: H-2; M-2; L-3; I-11

(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>: N/A

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4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-N/A; No Pass-N/A**; 4b. Usability: **N/A**

<u>Rationale</u>: N/A

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5. Related and Competing Measures

- **N/A**

6. Public and Member Comment

- Measure 0560 received two comments, both suggesting that the measure needs specification revisions before it should be considered for maintenance endorsement. Commenters wrote that revisions should be developed that allow for the use of multiple antipsychotics under certain circumstances, and which more generally should be updated using new guidelines which are anticipated soon.
    - Developer Response: Thank you for your comment. At the present time the measure allows for the use of multiple antipsychotics for cases with the following justification:
        - The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy.
        - The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge.
        - The medical record contains documentation of augmentation of Clozapine.

      Updates to the measure will be taken into consideration.

7. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Yes-X; No-X

8. Appeals

1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths complete

Submission | Specifications

Description: The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.

Numerator Statement: Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

Denominator Statement: Psychiatric inpatient discharges

Exclusions:

- Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions
- Patients with a Length of Stay = or less than 3 days or = or greater than 365 days

Adjustment/Stratification: The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years

- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years
- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

Level of Analysis: Facility, Other

Setting of Care: Inpatient/Hospital

Type of Measure: Process

Data Source: Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

Measure Steward: The Joint Commission

STANDING COMMITTEE MEETING 06/19/2019

1. Importance to Measure and Report: Did not pass performance gap

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

1a. Evidence: **H-0; M-11; L-5; I-0**; 1b. Performance Gap: **H-0; M-9; L-7; I-0**

Performance Gap (Re-vote): H-1; M-7; L-8; I-0

Rationale:

- Updated 2016 American Psychiatric Association (APA) practice guidelines are used to support the measure. Multiple members suggested that the measure application lacked a sufficient link to desired outcomes, while another felt deployment of this measure continued to be of obvious importance.
- Committee members asked the developer to address the concern that the three-day period allowed for such screening was too long, especially to ascertain substance use or violence threats for a newly admitted patient. In response to this three-day window question, the developer said that this period of review was explicitly noted as a maximum time rather than an optimal time.
- Some Committee members expressed concern that the measure may have "topped out" as performance rates have increased from 87 percent in 2009 to 93.7 percent in 2018, and no disparities were presented. In 2018 the 20th percentile was 92 percent, and the 70th percentile was 99 percent. At least one member believed performance could still be closer to 100 percent.
- The developer shared that they were aware of inter-facility differences and noted that rates are not the same for free standing facilities versus acute hospital unit or military/government facilities. They also noted that over 70 of the facilities tested were performing at or below 83 percent on this measure.
- A Committee member asked about which hospitals used paper records versus electronic record, but the developer responded that they don't have a way to determine that information. This

question attempted to explore whether or not electronic record keeping enhanced fulfillment of such a measure.

- The Committee expressed strong interest in the measure if it included assessment of proper follow-up to positive screens. Some Committee members expressed interest in approving this measure if the developer would promise to re-specify it in the future to include such follow-up requirements. As such, the Committee was reminded by staff that for this particular cycle they needed to make a recommendation on the measure "as specified", which means absent any follow-up component.
- At least one member stated that the measure had likely served its purpose, but that now it was time to retire it in favor of metrics that more directly assess follow-up action and outcomes. Other members note that despite high performance rates overall, differences in performance rates may persist in facility subsets which mark addressable gaps.
- One Committee member asked if there were any existing follow-up measures related to the screenings (of SUD, violence, trauma, patient strengths) assessed by this measure. The only response to this question came from staff which said that they were aware of only SUD follow-up measures, but none related to the other screening dimensions composing this measure.
- During this post-comment meeting, one Committee member asked if there might be some way to retire the measure for ongoing use, but still retain it in some database or other format such that it may be revived for U.S. or international use given the utility it has thus far served. In response staff note that the report would reflect that suggestion, and that NQF maintains the freely available Quality Positioning System (QPS) database which catalogues and retains descriptions of formerly endorsed measures.

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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)

2a. Reliability: **M-13; L-3; I-0**; 2b. Validity: **H- 0; M-11; L-4; I-1**

<u>Rationale</u>:

- The data element reliability testing was done using a sample of 191 patient records. There was a very high level of agreement along each of the data elements in the numerator and denominator of > 98%, based on a simple repeat review of medical charts.
- Validity testing presented by the developer included the absence of significant correlations between this measure and measures of hours of restraint and seclusion use (measures 0640 and 0641) describe above, and a small, significant correlation between this measure and appropriate justification of multiple antipsychotic use (r=0.14, p=0.0002; measure 0560). This validity presentation, however, was regarded by some Committee members as reflecting only that various screening was occurring rather than that more specific risk screening was happening. Some Committee members thus believed the comparative standard used was a poor indicator of true risk/strength screening targeted by this measure.

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3. Feasibility: H-2; M-2; L-3; I-11

(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 elements are generated during the care process and defined in health record data.
- The Committee acknowledged the measure has been widely used since 2011.

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4. Usability and Use: <u>The maintenance measure meets the Use subcriterion</u>

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Pass-14; No Pass-2**; 4b. Usability: **H-0; M-12; L-4; I-0**

<u>Rationale</u>:

- This measure is used in the Joint Commission's Hospital Accreditation program and publicly reported in ORYX Performance Measure Reporting Program.

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5. Related and Competing Measures

- This measure is related but not competing with the following measures:
    - 0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
    - 1365e: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
    - 2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
    - 2599: Alcohol Screening and Follow-up for People with Serious Mental Illness
    - 2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
- The measures are currently harmonized to the extent possible. The developer noted differences in level of analysis, diagnosis specificity, and the aspects and focus of the screenings across these measures.

Standing Committee Recommendation for Endorsement: Yes-9; No-7 (Consensus not reached)

<u>Rationale</u>:

- As a 60 percent vote in the high to moderate range is required for the measure to pass, the measure remains "consensus not reached" at 8/16=50 percent, and thus it fails this "must pass" criteria and will be sent to Consensus Standards Approval Committee (CSAC) as one that is *not* recommended for ongoing endorsement.
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6. Public and Member Comment

- Three comments were received regarding measure 1922 from three separate commenters. Two commenters suggested that the measure needs to be updated with follow-up response to screening results as a numerator requirement. A third comment suggested better connectivity to outcome-evidence supporting its deployment, thereby supporting a key Committee concern regarding this measure. The commenter also expressed that the measure continues to be important to monitor, but recommended the developer identify strategies to ensure the desired screening is taking place.
    - Developer Response: Thank you for your comment[s]. The evaluation of appropriate interventions will be taken into consideration for future measure development. Follow-up measures will [also] be taken into consideration for future measure development.

- As a screening measure, the intent is to determine that an appropriate patient assessment was conducted in order to inform clinical and treatment decisions. The current measure specifications do include the detail of what is required in order to demonstrate that the desired screening has been conducted.
- Patient Strengths: Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Examples of patient strengths are provided in notes for abstraction.
- Psychological Trauma History: Traumatic life experiences are defined as those that result in responses to life stressors characterized by significant fear, anxiety, panic, terror, dissociation, feelings of complete powerless or strong emotions that have long term effects on behaviors and coping skills. Examples of psychological trauma are provided in notes for abstraction.
- Substance Use: Substance use is defined as the use of psychoactive or mood altering substances, i.e., prescription medications, over the counter medications, inhalants, organic substances, illegal substances and street drugs. The screening must include: the type, amount, frequency of use and any problems due to past use.
- Violence Risk to Others: includes threats of violence and/or actual commission of violence toward others. Some examples of violence risk to others include but are not limited to the following: thoughts of harm to others, intentional infliction of harm on someone else by the patient, homicidal thoughts by the patient and thoughts of harming someone else by the patient.
- Violence Risk to Self: includes ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. Some examples of violence to self-include but are not limited to: past suicide attempts by the patient, intentional cutting, burning, bruising or damaging of self by the patient, inappropriate substance use, suicidal thoughts in the past six months by the patient, specific suicidal plan in the past six months by the patient and past suicide attempts by anyone in patient's family.

Appendix B: Behavioral Health and Substance Use Portfolio—Use in Federal Programs[a]

NQF #	Title	Federal Programs: Finalized or Implemented as of July 10, 2019
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2015)
0004e	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Finalized 2018)
0027	Medical Assistance With Smoking and Tobacco Use Cessation	Medicaid (Implemented 2018) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016)
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicare Shared Savings Program (MSSP) (Implemented 2012)
0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Million Hearts (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0104	Adult Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS) (Implemented 2016)
0104e	Adult Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0105	Antidepressant Medication Management (AMM)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016) Medicaid (Implemented 2013)
0105e	Antidepressant Medication Management (AMM) (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicaid (Implemented 2018) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2016)

[a] Per CMS Measures Inventory Tool as of 07/12/2019

NQF #	Title	Federal Programs: Finalized or Implemented as of July 10, 2019
0108e	Follow-Up Care for Children Prescribed ADHD Medication (ADD) (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0418	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Medicaid (Implemented 2018)
0418e	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0560	HBIPS-5 Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification	Hospital Compare (Implemented 2013) Inpatient Psychiatric Quality Reporting (Implemented 2013)
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015) Qualified Health Plan (QHP) Quality Rating System (QRS) (Implemented 2015) Medicaid (Implemented 2013)
0640	HBIPS-2 Hours of physical restraint use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0641	HBIPS-3 Hours of seclusion use	Hospital Compare (Implemented 2013) Inpatient Psychiatric Facility Quality Reporting (Implemented 2013)
0710e	Depression Remission at Twelve Months (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
0711	Depression Remission at Six Months	Merit-Based Incentive Payment System (MIPS) Program (Finalized 2016)
0712e	Depression Utilization of the PHQ-9 Tool (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Merit-based Incentive Payment System (MIPS) (Finalized 2016)
1365e	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment (eMeasure)	Merit-based Incentive Payment System (MIPS) (Implemented 2018) Medicaid Promoting Interoperability Program (Implemented 2019)

NQF #	Title	Federal Programs: Finalized or Implemented as of July 10, 2019
1651	TOB-1 Tobacco Use Screening	Hospital Compare (Implemented 2016) Inpatient Psychiatric Facility Quality Reporting (Implemented 2016; to be removed 2019)
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Hospital Compare (Implemented 2016) Inpatient Psychiatric Hospital Facility Reporting (Implemented 2016)
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	Hospital Compare (Implemented 2017) Inpatient Psychiatric Hospital Facility Reporting (Implemented 2017)
1661	SUB-1 Alcohol Use Screening	Hospital Compare (Implemented 2015) Inpatient Psychiatric Facility Quality Reporting (Implemented 2015; to be removed 2019)
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	Hospital Compare (Implemented 2017) Inpatient Psychiatric Facility Quality Reporting (Implemented 2017)
1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	Inpatient Psychiatric Facility Quality Reporting (Implemented 2017)
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Merit-based Incentive Payment System (MIPS) (Finalized 2016) Medicaid (Implemented 2013)
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Medicaid (Implemented 2018)
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Merit-based Incentive Payment System (MIPS) (Finalized 2016)

NQF #	Title	Federal Programs: Finalized or Implemented as of July 10, 2019
2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Medicaid (Implemented 2018)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Medicaid (Implemented 2017)
3175	Continuity of Pharmacotherapy for Opioid Use Disorder	Merit-Based Incentive Payment System (MIPS) Program (Finalized 2018)

Appendix C: Behavioral Health and Substance Use Standing Committee and NQF Staff

STANDING COMMITTEE

Peter Briss, MD, MPH (Co-Chair)
Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Chamblee, Georgia

Harold Pincus, MD (Co-Chair)
Irving Institute for Clinical and Translational Research at Columbia University
New York, New York

Mady Chalk, PhD, MSW
The Chalk Group
Washington, District of Columbia

David Einzig, MD
Children's Hospital And Clinics Of Minnesota
Saint Paul, Minnesota

Julie Goldstein Grumet, PhD
Education Development Center/Suicide Prevention Resource Center/National Action Alliance for Suicide Prevention
Washington, District of Columbia

Charles Gross, PhD
Behavioral and Physical Health Integration, Anthem, Inc.
Hanover, Maryland

Constance Horgan, ScD
Institute for Behavioral Health, The Heller School for Social Policy and Management, Brandeis University
Waltham, Massachusetts

Lisa Jensen, DNP, APRN
Specialty Care Services, Veteran's Health Administration
North Salt Lake, Utah

Dolores (Dodi) Kelleher, MS, DMH
D Kelleher Consulting
Alameda, California

Kraig Knudsen, PhD
Bureau of Research and Evaluation, Ohio Department of Mental Health and Addiction Services
Columbus, Ohio

Michael R. Lardieri, LCSW
Northwell Health, Behavioral Health Services Line
Glen Oaks, New York

Tami Mark, PhD, MBA
RTI International
Bethesda, Maryland

Raquel Mazon Jeffers, MPH, MIA
The Nicholson Foundation
Hopewell, New Jersey

Bernadette Melnyk, PhD, RN, CPNP/FAANP, FNAP, FAAN
The Ohio State University
Columbus, Ohio

Laurence Miller, MD
University of Arkansas for Medical Sciences
Little Rock, Arkansas

Brooke Parish, MD
Blue Cross Blue Shield of New Mexico
Albuquerque, New Mexico

David Pating, MD
Kaiser Permanente
San Francisco, California

Vanita Pindolia, PharmD, MBA
Henry Ford Health System
Detroit, Michigan

Lisa Shea, MD, DFAPA
Lifespan
Providence, Rhode Island

Andrew Sperling, JD
National Alliance on Mental Illness
Arlington, Virginia

Jeffery Susman, MD
Northeast Ohio Medical University
Rootstown, Ohio

Michael Trangle, MD
HealthPartners Medical Group
Minnetonka, Minnesota

Bonnie Zima, MD, MPH
University of California, Los Angeles (UCLA) Semel Institute for Neuroscience and Human Behavior
Los Angeles, California

Leslie S. Zun, MD, MBA
Sinai Health System
Chicago, Illinois

NQF STAFF

Elisa Munthali, MPH
Senior Vice President, Quality Measurement

Michael Abrams, MPH, PhD
Senior Director

Nicolette Mehas, PharmD
Director

Desmirra Quinnonez
Project Manager

Hannah Bui, MPH
Project Analyst

Appendix D: Measure Specifications

Measures Recommended

0640 HBIPS-2 Hours of physical restraint use

STEWARD

The Joint Commission

DESCRIPTION

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

TYPE

Process

DATA SOURCE

Electronic Health Records, Paper Medical Records. Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

LEVEL

Facility, Other

SETTING

Inpatient/Hospital

NUMERATOR STATEMENT

The total number of hours that all psychiatric inpatients were maintained in physical restraint.

Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

NUMERATOR DETAILS

Three data elements are used to calculate the numerator:

1. Event Date* - The month, day and year of the event.

2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion

3. Minutes of Physical Restraint - The total minutes recorded in the medical record that a patient was maintained in Event Type 1 (physical restraint(s)) for the associated Event Date. Allowable values 1-1440 minutes

*The data elements Event Date and Event Type are used for both HBIPS-2 (Hours of Physical Restraint Use) and HBIPS-3: Hours of Seclusion Use).

Patients are eligible for the numerator population when a physical restraint event occurs.

A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. This definition is noted in the data element Minutes of Physical Restraint included with the submission.

DENOMINATOR STATEMENT

Number of psychiatric inpatient days

Denominator basis: per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

DENOMINATOR DETAILS

Seven data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.

2. Birthdate - The month, day and year the patient was born.

3. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.

4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month.

7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month.

* The distinction between Medicare and Non-Medicare was added to account for the adoption of the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program

Populations: All psychiatric inpatient days.

EXCLUSIONS

Total leave days

EXCLUSION DETAILS

• Patients who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The measure is stratified by the following age groups:

• Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years

• Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years

• Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years

• Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

TYPE SCORE

Ratio better quality = lower score

ALGORITHM

1. Run all cases that are included in the Initial Patient Population for HBIPS-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure.

2. Check Event Type

a. If Event Type equals 2, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-2a) and will not be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure

b. If Event Type equals 1, continue processing and proceed to Minutes of Physical Restraint.

3. Check Minutes of Physical Restraint

a. If Minutes of Physical Restraint is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-2a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

b. If Minutes of Physical Restraint equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

c. If Minutes of Physical Restraint equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

4. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals U, Set the Measure Category Assignment for the strata measures (HBIPS-2b through HBIPS-2e) = ´U´. Stop processing.

b. If Overall Rate Category Assignment equals E, X or Y, continue processing and proceed to Patient Age at Time of Event.

5. Initialize the Measure Category Assignment for each strata measure (b-e) = ´B´. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-2a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-2a) Measure Category Assignment.

6. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-2b = Measure Category Assignment for measure HBIPS-2a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event.

7. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-2c = Measure b. Category Assignment for measure HBIPS-2a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event.

8. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-2d = Measure Category Assignment for measure HBIPS-2a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-2e = Measure Category Assignment for measure HBIPS-2a. Stop processing

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0641 HBIPS-3 Hours of seclusion use

STEWARD

The Joint Commission

DESCRIPTION

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion.

TYPE

Process

DATA SOURCE

Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

LEVEL

Facility, Other

SETTING

Inpatient/Hospital

NUMERATOR STATEMENT

The total number of hours that all psychiatric inpatients were held in seclusion

Numerator Basis: The numerator evaluates the number of hours of seclusion; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

NUMERATOR DETAILS

Three data elements are used to calculate the numerator:

1. Event Date*- The month, day and year of the event.

2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion

3. Minutes of Seclusion - The total minutes recorded in the medical record that a patient was held in Event Type 2 (seclusion) for the associated Event Date. Allowable values 1-1440 minutes

*The data elements Event Date and Event Type are used for both HBIPS-2: (Hours of Physical Restraint Use) and HBIPS-3 (Hours of Seclusion Use).

Patients are eligible for the numerator population when a seclusion event occurs.

Seclusion is the involuntary confinement of a patient alone in a room or an area where the patient is physically prevented from leaving. This definition is noted in the data element Minutes of Seclusion included with the submission.

DENOMINATOR STATEMENT

Number of psychiatric inpatient days

Denominator basis per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a

smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

DENOMINATOR DETAILS

Seven data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.

2. Birthdate - The month, day and year the patient was born.

3. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.

4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month.

7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month.

* The distinction between Medicare and Non-Medicare was added to account for the adoption of the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program

Populations: All psychiatric inpatient days.

EXCLUSIONS

Total leave days

EXCLUSION DETAILS

- Patients who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

The measure is stratified by the following age groups:

- Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years
- Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years
- Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years

- Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

TYPE SCORE

Ratio better quality = lower score

ALGORITHM

1. Run all cases that are included in the Initial Patient Population for HBIPS-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure.
2. Check Event Type

a. If Event Type equals 1, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-3a) and will not be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

b. If Event Type equals 2, continue processing and proceed to Minutes of Seclusion.

3. Check Minutes of Seclusion

a. If Minutes of Seclusion is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-3a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

b. If Minutes of Seclusion equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-3a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

c. If Minutes of Seclusion equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-3a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

4. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals U, Set the Measure Category Assignment for the strata measures (HBIPS-3b through HBIPS-3e) = ´U´. Stop processing.

b. If Overall Rate Category Assignment equals E, X or Y, continue processing and proceed to Patient Age at Time of Event.

5. Initialize the Measure Category Assignment for each strata measure (b-e) = ´B´. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-3a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-3a) Measure Category Assignment.
6. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-3b = Measure Category Assignment for measure HBIPS-3a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event.

7. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-3c = Measure Category Assignment for measure HBIPS-3a. Stop processing.
b. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event.

8. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-3d = Measure Category Assignment for measure HBIPS-3a. Stop processing.
b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-3e = Measure Category Assignment for measure HBIPS-3a. Stop processing.

9. Measure Calculation for Aggregated Denominator. Denominator: For the overall measure and each strata measure calculate the denominator rate by aggregating the Psychiatric Inpatient Days and Leave Days. Number of Denominator Cases for the overall measure = (Psychiatric Inpatient Days – Leave Days), for all patients for the reporting month. Number of Denominator Cases for each strata measure = (Psychiatric Inpatient Days – Leave Days), for all patients with a Patient Age (Reporting Date - Birthdate) appropriate for the strata for the reporting month where Reporting Date is the last date of the reporting month that the census data is being reported. Performance Measurement Systems can refer to the Joint Commission's ORYX Technical Implementation Guide for information concerning the aggregation of HCO level data, including the Observed Rate and Population Size for this measure. 109255| 118672| 143087| 141015| 106080| 148676| 138035| 110874

3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

- 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

NUMERATOR DETAILS

30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

DENOMINATOR STATEMENT

Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

DENOMINATOR DETAILS

Age: 13 years and older as of the date of the ED visit

Benefit: Medical and chemical dependency.

Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.

Continuous Enrollment: Date of emergency department visit through 30 days after the ED visit

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

EXCLUSIONS

Patients in hospice.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

This measure is stratified by age:

- Age 13 to 17 years
- Age 18 and older
- Total (sum of the age stratifications)

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug abuse or dependence. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A).

Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A).

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3489 Follow-Up After Emergency Department Visit for Mental Illness

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

TYPE

Process

DATA SOURCE

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set

(HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

LEVEL

Health Plan

SETTING

Outpatient Services

NUMERATOR STATEMENT

The numerator consists of two rates:

- 30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- 7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

NUMERATOR DETAILS

30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

DENOMINATOR STATEMENT

Emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.

DENOMINATOR DETAILS

Age: 6 years and older as of the date of the ED visit

Benefit: Medical and mental health.

Continuous Enrollment: Date of emergency department visit through 30 days the ED visit

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1 then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

EXCLUSIONS

Patients in hospice.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

Not applicable.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A).

Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A).

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Appendix E1: Related and Competing Measures (tabular format)

Comparison of NQF 0560, 1879, 2801, 3205

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
Steward	The Joint Commission	Centers for Medicare and Medicaid Services	National Committee for Quality Assurance	Centers for Medicare & Medicaid Services
Description	The proportion of patients, age greater than and equal to 1 year, discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.	Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).	Percentage of children and adolescents 1–17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment.	This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years.
Type	Process	Process	Process	Process
Data Source	Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. No data collection instrument provided Attachment HBIPS_Code_Tables_Med_-636794264289743033.xlsx	Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used: • Denominator tables to determine individual enrollment • Prescription drug benefit (Part D) coverage tables • Beneficiary file • Institutional claims (Part A) • Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment) • Prescription drug benefit (Part D) claims • Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables • National Plan and Provider Enumeration System (NPPES) database No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx	Claims This measure is part of the Healthcare Effectiveness Data and Information Set (HEDIS). As part of HEDIS, the measure pulls from administrative claims collected in the course of providing care to health plan members. NCQA collects the HEDIS data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. The measure has also been tested at the state level and could be reported by states if added to a relevant program. No data collection instrument provided Attachment 2801_APP_Value_Sets.xlsx	Claims Medicare administrative data from Parts A, B, and D claims. No data collection instrument provided Attachment Med_Continuation_Data_Dictionary_180816.xlsx
Level	Facility, Other	Clinician : Group/Practice, Health Plan, Population : Regional and State	Health Plan, Integrated Delivery System, Population : Regional and State	Facility
Setting	Inpatient/Hospital	Outpatient Services	Inpatient/Hospital, Outpatient Services	Inpatient/Hospital
Numerator Statement	Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.	Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.	Children and adolescents from the denominator who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic.	The numerator for this measure includes: 1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge 2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge 3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
Numerator Details	One data element is used to calculate the numerator: Appropriate Justification for Multiple Antipsychotic Medications - Documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications. Allowable values: 1. The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy. 2. The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge. 3. The medical record contains documentation of augmentation of Clozapine. 4. The medical record contains documentation of a justification other than those listed in Allowable Values 1-3. 5. The medical record does not contain documentation supporting the reason for being discharged on two or more antipsychotic medications OR unable to determine from medical record documentation. Patients are eligible for the numerator population when they are discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.	The numerator is defined as individuals with a PDC of 0.8 or greater. The PDC is calculated as follows: PDC NUMERATOR The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. PDC DENOMINATOR The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.	The Psychosocial Care Value Set contains claims codes for behavioral health acute inpatient and outpatient encounters, including psychotherapy for patients, families, and/or groups; psychophysiological therapy; hypnotherapy; activity therapy, such as music, dance, or art; training and educational services related to the care and treatment of mental health issues; community and rehabilitations programs; and crisis interventions. These services align with a recent Institute of Medicine (IOM) report*, which defined psychosocial interventions for mental health and substance use disorders as "interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of reducing symptoms of these disorders and improving functioning or well-being." The IOM notes these interventions include psychotherapies, vocational rehabilitation and peer support services, and that they can utilize different formats, including individual, family, or group therapy. DEFINITIONS IPSD: The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History. Negative Medication History: A period of 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions. *Intitute of Medicine. Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders, Board on Health Sciences Policy. England MJ, Butler AS and Gonazlez ML, eds. Psychosocial Interventions for Mental and Substance Use Disorders: a Framework for Establishing Evidence-Based Standards. 2015. National Academies Press; Washington, DC (Prepublication copy).	The following are the evidence-based medications by class for the treatment of MDD, schizophrenia, and bipolar disorder. The route of administration includes all oral formulations and the long-acting (depot) injectable of the medications listed in this section, except where noted. Active ingredients for the oral medications listed are limited to oral, buccal, sublingual, and translingual formulations only. Obsolete drug products are excluded from NDCs with an inactive date more than three years prior to the beginning of the measurement period. MEDICATIONS FOR TREATMENT OF MDD Monoamine Oxidase Inhibitors -isocarboxazid -phenelzine -selegiline (transdermal patch) -tranylcypromine Selective Serotonin Reuptake Inhibitors (SSRI) -citalopram -escitalopram -fluoxetine -fluvoxamine -paroxetine -sertraline Serotonin Modulators -nefazodone -trazodone -vilazodone -vortioxetine Serotonin Norepinephrine Reuptake Inhibitors (SNRI) -desvenlafaxine -duloxetine -levomilnacipran -venlafaxine Tricyclic and Tetracyclic Antidepressants -amitriptyline -amoxapine -clomipramine -desipramine -doxepin -imipramine -maprotiline -nortriptyline -protriptyline -trimipramine Other Antidepressants

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
				-bupropion -mirtazapine Psychotherapeutic Combinations -amitriptyline-chlordiazepoxide -amitriptyline-perphenazine -fluoxetine-olanzapine MEDICATIONS FOR TREATMENT OF SCHIZOPHRENIA First-generation Antipsychotics -chlorpromazine -fluphenazine -haloperidol -haloperidol lactate -loxapine succinate -molindone -perphenazine -pimozide -prochlorperazine -thioridazine -thiothixene -trifluoperazine Second-generation (Atypical) Antipsychotics -aripiprazole -asenapine -brexpiprazole -cariprazine -clozapine -iloperidone -lurasidone -olanzapine -paliperidone -quetiapine -risperidone -ziprasidone Psychotherapeutic Combinations -amitriptyline-perphenazine -fluoxetine-olanzapine Long-Acting (Depot) Injectable Antipsychotics -fluphenazine decanoate -haloperidol decanoate -aripiprazole -aripiprazole lauroxil -olanzapine pamoate -paliperidone palmitate (1-month extended-release injection)

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
				-paliperidone palmitate (3-month extended-release injection) -risperidone microspheres MEDICATIONS FOR TREATMENT OF BIPOLAR DISORDER Anticonvulsants -carbamazepine -divalproex sodium -lamotrigine -valproic acid First-generation Antipsychotics -chlorpromazine -fluphenazine -haloperidol -haloperidol lactate -loxapine succinate -molindone -perphenazine -pimozide -prochlorperazine -thioridazine -thiothixene -trifluoperazine Second-generation (Atypical) Antipsychotics -aripiprazole -asenapine -brexpiprazole -cariprazine -clozapine -iloperidone -lurasidone -olanzapine -paliperidone -quetiapine -risperidone -ziprasidone Lithium Salts -lithium -lithium carbonate -lithium citrate Psychotherapeutic Combinations -fluoxetine-olanzapine Long-acting (depot) Injectable Antipsychotics -fluphenazine decanoate -haloperidol decanoate

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
				-aripiprazole -aripiprazole lauroxil -olanzapine pamoate -paliperidone palmitate (1-month extended-release injection) -paliperidone palmitate (3-month extended-release injection) -risperidone microspheres
Denominator Statement	Psychiatric inpatient discharges	Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).	Children and adolescents who had a new prescription of an antipsychotic medication for which they do not have a U.S Food and Drug Administration primary indication.	The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.
Denominator Details	Included populations: Patients with ICD-10-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 (See S.2b.) discharged on two or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0- Antipsychotic Medications). Nine data elements are used to calculate the denominator: 1. Admission Date - The month, day and year of admission to acute inpatient care. 2. Birthdate - The month, day and year the patient was born. 3. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay. 4. Discharge Disposition- The patient's discharge disposition. Allowable values: 1. Home, 2. Hospice – Home, 3. Hospice – Health Care Facility, 4. Acute Care Facility, 5. Other Health Care Facility, 6. Expired, 7. Left Against Medical Advice/AMA, 8 Not Documented or Unable to Determine (UTD). 5. ICD-10-CM Other Diagnosis Codes- The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization. 6. ICD-10-CM Principal Diagnosis Code- The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization. 7. Number of Antipsychotic Medications Prescribed at Discharge- The number of routinely scheduled antipsychotic medications prescribed to the patient at discharge as	Target population meets the following conditions: 1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period; 2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and, 3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period. IDENTIFICATION OF SCHIZOPHRENIA Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have: At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period. CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia. Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis ICD-9-CM: 295.xx ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9	Exclude children and adolescents in hospice. Children and adolescents age 1-17 as of December 31 of the measurement year (January 1 – December 31) who had a new prescription for an antipsychotic medication (antipsychotic Medications List; Antipsychotic Combination Medications List) during the intake period (January 1 through December 1 of the measurement year). Miscellaneous antipsychotic agents: Aripiprazole; Asenapine; Brexpiprazole; Cariprazine; Clozapine; Haloperidol; Iloperidone; Loxapine; Lurisadone; Molindone; Olanzapine; Paliperidone; Pimozide; Quetiapine; Quetiapine fumarate; Risperidone; Ziprasidone Phenothiazine antipsychotics: Cholpromazine; Fluphenazine; Perphenazine; Prochloperazine; Thioridazine; Trifluoperazine Thioxanthenes: Thiothixene Long-acting injections: Aripiprazole; Fluphenazine decanoate; Haloperidol Decanoate; Olanzapine; Paliperidone palmitate; Risperidone Antipsychotic Combinations Medications List Psychotherapeutic combinations: Fluoxetine-olanzapine; Perphenazine-amitriptyline	The denominator for this measure includes patients discharged from an IPF: 1. With a principal diagnosis of MDD, schizophrenia, or bipolar disorder (ICD codes provided below). 2. 18 years of age or older at admission. 3. Enrolled in Medicare fee-for-service Part A and Part B during the index admission and Parts A, B, and D at least 30-days post-discharge. 4. Alive at discharge and alive during the follow-up period. 5. With a discharge status code indicating that they were discharged to home or home health care. ICD-10-CM codes to identify MDD, schizophrenia, and bipolar disorder: MDD F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.9 Schizophrenia F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9 Bipolar disorder F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.81, F32.89

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
	documented in the medical record. Allowable values: 0-99, UTD (Unable to determine) 8. Patient Status at Discharge - Documentation in the medical record of the patient's status at the time the patient left the hospital-based inpatient psychiatric care setting. Allowable values: 1 The medical record contains documentation that the patient was discharged from the inpatient psychiatric care setting under these circumstances: • Patient is leaving the psychiatric unit within the acute care hospital AND the hospital facility completely. • Patient is leaving the freestanding inpatient psychiatric facility completely. 2 The medical record contains documentation of one of the following: • The patient eloped and was discharged • The patient failed to return from leave and was discharged • The patient has not yet been discharged from the hospital • The patient was transferred/discharged from the inpatient psychiatric unit in an acute care setting to another level of care, (i.e. medical unit), and subsequently discharged from that level of care 3 Unable to determine from medical record documentation. 9. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No. Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting who were discharged on two or more routinely scheduled antipsychotic medications on Table 10.0.	CODES USED TO IDENTIFY ENCOUNTER TYPE: Codes used to identify encounters are under tab NQF_1879_Encounter_types. Table 2.1: Outpatient Setting Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510 HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015 UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72 Table 2.2: Emergency Department Setting CPT: 99281-99285 UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 23 Table 2.3: Non-Acute Inpatient Setting CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337 HCPCS: H0017-H0019, T2048 UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291 WITH POS: 31, 32, 56 Table 2.4: Acute Inpatient Setting		

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
		UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987 OR CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291 WITH POS: 21, 51 IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION: Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period. TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS The following are oral formulations only. Typical Antipsychotic Medications: chlorpromazine fluphenazine haloperidol loxapine molindone perphenazine prochlorperazine thioridazine thiothixene trifluoperazine Atypical Antipsychotic Medications: aripiprazole asenapine brexpiprazole cariprazine clozapine iloperidone		

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
		lurasidone olanzapine paliperidone quetiapine quetiapine fumarate (Seroquel) risperidone ziprasidone Antipsychotic Combinations: perphenazine-amitriptyline TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below. Typical Antipsychotic Medications: fluphenazine decanoate (J2680) haloperidol decanoate (J1631) Atypical Antipsychotic Medications: aripiprazole (J0401) aripiprazole lauroxil (Aristada) olanzapine pamoate (J2358) paliperidone palmitate (J2426) risperidone microspheres (J2794) Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B: fluphenazine decanoate (J2680) – 28 days' supply haloperidol decanoate (J1631) – 28 days' supply aripiprazole (J0401) – 28 days' supply aripiprazole lauroxil (Aristada) - 28 days' supply olanzapine pamoate (J2358) – 28 days' supply paliperidone palmitate (J2426) – 28 days' supply risperidone microspheres (J2794) – 14 days' supply		
Exclusions	• Patients who expired • Patients with an unplanned departure resulting in discharge due to elopement • Patients with an unplanned departure resulting in discharge due to failing to return from leave • Patients with a length of stay less than or equal to 3 days	Individuals with any diagnosis of dementia during the measurement period.	Patients in hospice. Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration indication and are thus clinically appropriate: schizophrenia, bipolar disorder, psychotic disorder, autism, tic disorders.	The denominator for this measure excludes discharged patients who: 1. Received ECT during the inpatient stay or follow-up period. 2. Received TMS during the inpatient stay or follow-up period. 3. Were pregnant during the inpatient stay. 4. Had a secondary diagnosis of delirium. 5. Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia.

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
Exclusion Details	• Patients who expired are identified by the data element Discharge Disposition. • Patients with an unplanned departure resulting in discharge due to elopement, failing to return from leave are identified by the data element Patient Status at Discharge. • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is equal to or less than 3 days the patient is excluded.	Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia Table 5: Codes Used to Identify Dementia ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82 ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Exclude children and adolescents for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year (January 1 – December 31) meet criteria: Children and adolescents who have at least one acute inpatient encounter with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations meet criteria: -BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set. -BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set. -BH Stand Alone Acute Inpatient Value Set with Other Psychotic Disorders Value Set. -BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Psychotic Disorders Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – BH Acute Inpatient Value Set with Telehealth POS Value Set with Schizophrenia Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – BH Acute Inpatient Value Set with Telehealth POS Value Set with Bipolar Disorder Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – BH Acute Inpatient Value Set with Telehealth POS Value Set with Other Psychotic Disorders Value Set, with or without a telehealth modifier (Telehealth Modifier Value	1. ECT During Inpatient Stay or Follow-Up Period Rationale: Some patients who receive ECT during the inpatient stay or follow-up period may have failed pharmacotherapy and would not fill an evidence-based prescription post-discharge. Source: Identified from Part A and Part B claims data if treatment occurred on a date between the admission date and 30 days post-discharge. 2. TMS During Inpatient Stay or Follow-Up Period Rationale: Some patients who receive TMS during the inpatient stay or follow-up period may have failed pharmacotherapy and would not fill an evidence-based prescription post-discharge. Source: Identified from Part A and Part B claims data if treatment occurred on a date between the admission date and 30 days post-discharge. 3. Pregnant During Inpatient Stay Rationale: Some of the evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder are contraindicated during pregnancy. Source: Identified from Part A claims data from the index admission. 4. Secondary Diagnosis of Delirium Rationale: Some of the evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder are contraindicated for patients with delirium. Source: Identified from Part A claims data from the index admission. 5. Principal Diagnosis of Schizophrenia with Secondary Diagnosis of Dementia Rationale: APA Practice guidelines suggest caution in the use of antipsychotics in dementia patients so not all dementia patients would fill an evidence-based medication (antipsychotic) following discharge for schizophrenia. Source: Identified from Part A claims data from the index admission.

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			Set). • At least two Children and adolescents who have at least two visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations with or without a telehealth modifier (Telehealth Modifier Value Set), meet criteria: - – BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set. – BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set. – BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set. – BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set. – BH Stand Alone Outpatient/PH/IOP Value Set with Other Psychotic Disorders Value Set. – BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Psychotic Disorders Value Set. - BH Outpatient/PH/IOP Value Set with Telehealth POS Value Set with Schizophrenia Value Set. - BH Outpatient/PH/IOP Value Set with Telehealth POS Value Set with Bipolar Disorder Value Set. -BH Outpatient/PH/IOP Value Set with Telehealth POS Value Set with Other Psychotic Disorders Value Set. See attachment for all value sets (S.2b).	
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years	Depending on the operational use of the measure, measure results can be stratified by: • State • Physician Group* • Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years	Report three age stratifications and a total rate: 1–5 years. 6–11 years. 12–17 years. Total (sum of the age stratifications).	The measure is not stratified.

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	• Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years • Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years • Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years	• Race/Ethnicity • Dual Eligibility *See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.		
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	1. Run cases that are included in the Initial Patient Population for HBIPS-1,5 and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure. 2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 3. Check Length of Stay a. If Length of Stay is less than or equal 3 days, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. If Length of Stay is greater than 3 days, continue processing and proceed to Discharge Status. 4. Check Discharge Disposition a. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Discharge Disposition equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. C. Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, continue processing and proceed to Psychiatric Care Setting. 5. Check Psychiatric Care Setting	Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D. Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months). CREATE DENOMINATOR: 1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period. 2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period. 3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only). 4. Of those individuals identified in Step 3, keep individuals who had: At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period; OR Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period. 5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the	Step 1: Determine the eligible population, or the denominator, by identifying the number of children and adolescents in the specified age range who were dispensed an antipsychotic medication (Table APP-A) during the intake period (January 1 – December 1). Step 2: Exclude those who did not have a negative medication history and who have a diagnosis for which antipsychotic medications are clinically appropriate (see S.10). Step 3: Determine the numerator by identifying the number of children and adolescents in the eligible population who had documentation of psychosocial care in the 121-day period from 90 days prior through 30 days after the new prescription of an antipsychotic. Step 4: Divide the numerator by the denominator to calculate the rate.	Denominator: 1. Pull all IPF discharges from the Part A data. 2. Include IPF discharges for patients who were at least 18 years of age at admission. 3. Identify interim claims having the same beneficiary, provider, admission dates or having an admission date within 1 day of the discharge date of the previous claim and having a discharge status code of “Still patient.” Collapse or combine the interim claims into one hospital stay using the admission date from the earliest claim and the discharge date from the latest claim. The data values from the latest claim are used for the newly combined hospital stay. 4. De-duplicate the IPF inpatient discharges dataset by Patient ID, Sex, Provider ID, Admission Date, and Discharge Date. 5. Remove the IPF inpatient discharges for patients who do not have Part A and Part B coverage at admission, during the entire stay, at discharge, and during the 30 days post-discharge. 6. Remove the IPF inpatient discharges that do not have a principal diagnosis of MDD, bipolar disorder, or schizophrenia using value sets containing ICD-10 codes for each of the disease conditions. 7. Remove the IPF inpatient discharges for patients who expired during the hospital stay or within 30 days of discharge. 8. Remove the IPF inpatient discharges for patients who do not have Part D coverage during the 30 days post-discharge. 9. Remove the IPF inpatient discharges for patients who were not discharged to home or home health. 10. Exclude IPF inpatient discharges with a secondary diagnosis of pregnancy or delirium. 11. Exclude IPF inpatient discharges having schizophrenia as the principal diagnosis with a secondary diagnosis of dementia. 12. Exclude IPF inpatient discharges with ECT or TMS during the hospital stay or within 30 days post-discharge. Numerator: 1. Pull all Part D claims for the evidence-based medications used for the treatment of MDD, schizophrenia, and bipolar disorder.

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	a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Cat Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. If Psychiatric Care Setting is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. c. If Psychiatric Care Setting equals Yes, the case will proceed to Patient Status at Discharge. 6. Check Patient Status at Discharge a. If Patient Status at Discharge is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Patient Status at Discharge equals 2, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. c. If Patient Status at Discharge equals 1 or 3, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge. 7. Check Number of Antipsychotic Medications Prescribed at Discharge a. If Number of Antipsychotic Medications Prescribed at Discharge is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Number of Antipsychotic Medications Prescribed at Discharge is less than or equal 1, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize	measurement period. Attach the generic name and the drug ID to the dataset. 6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period. 7. Exclude those individuals with a diagnosis of dementia during the measurement period. Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications. CREATE NUMERATOR: For the individuals in the denominator, calculate the PDC for each individual according to the following methods: 1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period. 2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply. a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply. b. Calculate the number of days covered by antipsychotic drug therapy per individual. i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended. iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date. 3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1. An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the		2. Pull all Part A and Part B claims for antipsychotic long-acting injectables (LAIs) and add them to the Part D medication claims for schizophrenia and bipolar disorder. 3. Compare the medication claims to the denominator file of eligible IPF inpatient discharges and remove any claims that occur more than 2 days prior to the discharge date. 4. Determine which claims occur within the follow-up period (2 days prior to discharge through 30 days post-discharge) for each of the 3 disease conditions. 5. Total the denominator cases having at least one medication claim corresponding to the disease condition during the follow-up period.

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	the Measure Category Assignment for each strata measure. c. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2 or equal UTD, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge. 8. Check Number of Antipsychotic Medications Prescribed at Discharge a. If Number of Antipsychotic Medications Prescribed at Discharge equals UTD, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-5a) and will be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. b. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2, the case will proceed to Appropriate Justification for Multiple Antipsychotic Medications. 9. Check Appropriate Justification for Multiple Antipsychotic Medications a. If Appropriate Justification for Multiple Antipsychotic Medications is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure. b. If Appropriate Justification for Multiple Antipsychotic Medications equals 4 or 5, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-5a) and will be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure. c. If Appropriate Justification for Multiple Antipsychotic Medications equals 1, 2 or 3, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-5a) and will be in the numerator population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.	URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf. 4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator. PHYSICIAN GROUP ATTRIBUTION: Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not. I. Identify Physician and Medical Groups 1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters). 2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables. 3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty. 4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP). 5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.) a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year. b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code. c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of		

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	10. Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-5a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-5a) Measure Category Assignment. 11. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B, Set the Measure Category Assignment for the strata measures (HBIPS-5b through HBIPS-5e) = 'B'. Stop processing. b. If Overall Rate Category Assignment equals D or E or X, continue processing and proceed to Patient Age at Discharge. 12. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-5b = Measure Category Assignment for measure HBIPS-5a. Stop processing. b. If is greater than or equal 13 years, continue processing and proceed to Patient Age at Discharge. 13. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-5c = Measure Category Assignment for measure HBIPS-5a. Stop processing. b. If Patient Age at Discharge is greater than or equal 18 years, continue processing and proceed to Patient Age at Discharge. 14. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-5d = Measure Category Assignment for measure HBIPS-5a. Stop processing. b. If Patient Age at Discharge is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-5e = Measure Category Assignment for measure HBIPS-5a. Stop processing.	012345678, 012345678, 123456789, 987654321, or 87654321. 6. Identify TINs that are not solo practices. a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year. b. Count unique NPIs per TIN. c. Keep only those TINs having two or more providers. d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321. 7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices). 8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs. 9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants. a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty. b. The specialty with the maximum count is assigned to the medical group. II. Identify Individual Sample and Claims 10. Create individual sample. a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year. b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following: • A = working-age individual/spouse with an employer group health plan (EGHP) • B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP • G = working disabled for any month of the year c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C. d. Exclude individuals who enter the Medicare hospice at any point during the measurement year. e. Exclude individuals who died during the measurement year. 11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.		

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		a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245. b. Exclude claims with no npi_prfrmg. 12. Attach medical group TIN to claims by NPI. III. Patient Attribution 13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure. a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields. b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9. 14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims. 15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim. 16. Attach the medical group TIN to the denominator and numerator files by individual. Provider Specialties and Specialty Codes Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below: 01—General practice* 02—General surgery 03—Allergy/immunology 04—Otolaryngology 05—Anesthesiology 06—Cardiology 07—Dermatology 08—Family practice* 09—Interventional pain management 10—Gastroenterology 11—Internal medicine* 12—Osteopathic manipulative therapy 13—Neurology 14—Neurosurgery 16—Obstetrics/gynecology*		

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		18—Ophthalmology 20—Orthopedic surgery 22—Pathology 24—Plastic and reconstructive surgery 25—Physical medicine and rehabilitation 26—Psychiatry* 28—Colorectal surgery 29—Pulmonary disease 30—Diagnostic radiology 33—Thoracic surgery 34—Urology 37—Nuclear medicine 38—Geriatric medicine* 39—Nephrology 39—Pediatric medicine 40—Hand surgery 44—Infectious disease 46—Endocrinology 50—Nurse practitioner* 66—Rheumatology 70—Multi-specialty clinic or group practice* 72—Pain management 76—Peripheral vascular disease 77—Vascular surgery 78—Cardiac surgery 79—Addiction medicine 81—Critical care (intensivists) 82—Hematology 83—Hematology/oncology 84—Preventive medicine* 85—Maxillofacial surgery 86—Neuropsychiatry* 90—Medical oncology 91—Surgical oncology 92—Radiation oncology 93—Emergency medicine 94—Interventional radiology 97—Physician assistant* 98—Gynecologist/oncologist 99—Unknown physician specialty Other—NA *Provider specialty codes specific to this measure 119011| 120823| 140881| 123834| 141592| 141015| 142428		

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
Submission items	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable 5b.1 If competing, why superior or rationale for additive value: Not applicable	5.1 Identified measures: 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category 0542 : Adherence to Chronic Medications 0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease 0544 : Use and Adherence to Antipsychotics among members with Schizophrenia 0545 : Adherence to Statins for Individuals with Diabetes Mellitus 0569 : ADHERENCE TO STATINS 1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure. 5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64. During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia). Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer	5.1 Identified measures: 2337 : Antipsychotic Use in Children Under 5 Years Old 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: This new measure assesses receipt of psychosocial care among children and adolescents who are prescribed antipsychotics without a primary indication. Both measures address use of antipsychotics. However, 2337 assesses if children under 5 are prescribed an antipsychotic. Our Psychosocial Care measure assesses children of a broader age range (up to age 18) who are currently on antipsychotics but do not have a primary indication. Our measure also addresses a different focus: whether these children received first-line psychosocial care. 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable because there are no related measures. 5b.1 If competing, why superior or rationale for additive value: Not applicable because there are no competing measures.

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
		endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below. VALIDITY The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below. Adherence to Antipsychotic Medications for Individuals with Schizophrenia Method Measure Rate Comparison of MPR and PDC Method Measure Rate MPR 74.4% PDC 70.0% Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data. Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns: Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any		

	0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia	2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	3205 Medication Continuation Following Inpatient Psychiatric Discharge
		antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of "0" is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia. Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure 0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients." The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.) EFFICIENCY Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544. The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI's (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for beneficiaries in Florida and Rhode Island validated this concern and indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.		

Comparison of NQF 0640 and 0687

	0640 HBIPS-2 Hours of physical restraint use	0687 Percent of Residents Who Were Physically Restrained (Long Stay)
Steward	The Joint Commission	Centers for Medicare & Medicaid Services
Description	The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.	The measure reports the percentage of all long-stay residents who were physically restrained daily during the 7 days prior to the target MDS 3.0 assessment (OBRA, PPS or discharge) during their episode of nursing home care ending in the target quarter (3-month period). Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care.
Type	Process	Process
Data Source	Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. No data collection instrument provided Attachment HBIPS_Code_Tables-636794265307530611.xlsx	Electronic Health Record (Only) Nursing Home Minimum Data Set 3.0 Available in attached appendix at A.1 No data dictionary
Level	Facility, Other	Facility
Setting	Inpatient/Hospital	Nursing Home / SNF
Numerator Statement	The total number of hours that all psychiatric inpatients were maintained in physical restraint. Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.	The numerator is the number of long-stay residents with a selected target Minimum Data Set (MDS) assessment (assessments may be OBRA, PPS or discharge) who have experienced daily physical restraint usage during the 7 days prior to the selected assessment, as indicated by MDS 3.0, Section P, Item P0100, subitems B (P0100B – Trunk restraint used in bed), C (P0100C – Limb restraint used in bed), E (P0100E – Trunk restraint used in chair or out of bed), F (P0100F – Limb restraints used in chair or out of bed), or G (P0100G – Chair prevents rising).
Numerator Details	Three data elements are used to calculate the numerator: 1. Event Date* - The month, day and year of the event. 2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion 3. Minutes of Physical Restraint - The total minutes recorded in the medical record that a patient was maintained in Event Type 1 (physical restraint(s)) for the associated Event Date. Allowable values 1-1440 minutes *The data elements Event Date and Event Type are used for both HBIPS-2 (Hours of Physical Restraint Use) and HBIPS-3: Hours of Seclusion Use). Patients are eligible for the numerator population when a physical restraint event occurs. A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. This definition is noted in the data element Minutes of Physical Restraint included with the submission.	Residents are counted if they are long-stay residents, defined as residents whose cumulative length of stay is 101 days or more. Residents who return to the nursing home following a hospital discharge may not have their stay count within the episode of care reset to zero. Residents are counted if any of the following items on the target assessment are coded as "2", meaning that the physical restraint was used daily during the 7 days prior to the assessment: P0100B- Trunk restraint used in bed, P0100C-Limb restraint used in bed, P0100E- Trunk restraint used in chair or out of bed, P0100F-Limb restraint used in chair or out of bed, or P0100G-Chair prevents rising. Target assessments may be an OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, or 90-day assessments (A0310B = 01, 02, 03, 04, 05) or discharge assessment with or without return anticipated (A0310F = 10, 11).
Denominator Statement	Number of psychiatric inpatient days Denominator basis: per 1,000 hours To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.	The denominator is the total number of all long-stay residents in the nursing facility who have a target OBRA, PPS or discharge MDS 3.0 assessment during the selected quarter and who do not meet the exclusion criteria.
Denominator Details	Seven data elements are used to calculate the denominator: 1. Admission Date – The month, day and year of admission to acute inpatient care. 2. Birthdate - The month, day and year the patient was born. 3. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.	Residents are counted if they are long-stay residents defined as residents whose length of stay is 101 days or more. Residents who return to the nursing home following a hospital discharge may not have their day count within the episode of care reset to zero. The population includes all long-stay residents with a target MDS 3.0 , except those with exclusions. . Target assessments may be an OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, or 90-day assessments (A0310B = 01, 02, 03, 04, 05) or discharge assessment with or without return anticipated (A0310F = 10, 11).

	0640 HBIPS-2 Hours of physical restraint use	0687 Percent of Residents Who Were Physically Restrained (Long Stay)
	4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status). 5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status). 6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month. 7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month. * The distinction between Medicare and Non-Medicare was added to account for the adoption of the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program Populations: All psychiatric inpatient days.	
Exclusions	Total leave days	A resident is excluded from the denominator if there is missing data in any of the responses to the relevant questions in the MDS (P0100B= -, or P0100C= -, or P0100E= -, or P0100F= -, or P0100G= -). If the facility sample includes fewer than 30 residents, then the facility is excluded from public reporting.
Exclusion Details	• Patients who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.	The assessment is excluded if the resident is not in the numerator and there are missing values for any of the items in the numerator, i.e., P0100B = [-], Trunk restraint used in bed; P0100C = [-], Limb restraint used in bed; P0100E =[-], Trunk restraint used in chair or out of bed; P0100F =[-], Limb restraint used in chair or out of bed; or P0100G =[-], Chair prevents rising. If the facility sample includes fewer than 30 residents, then the facility is excluded from public reporting.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	The measure is stratified by the following age groups: • Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years • Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years • Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years • Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years	This is not applicable.
Type Score	Ratio better quality = lower score	Rate/proportion better quality = lower score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure. 2. Check Event Type a. If Event Type equals 2, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-2a) and will not be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure b. If Event Type equals 1, continue processing and proceed to Minutes of Physical Restraint. 3. Check Minutes of Physical Restraint a. If Minutes of Physical Restraint is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-2a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. b. If Minutes of Physical Restraint equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure. c. If Minutes of Physical Restraint equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.	Step 1: Identify the total number of long-stay residents who have a target assessment (OBRA, PPS, or discharge) during the quarter and who did not meet the exclusion criteria (i.e., they are not missing data on use of any type of physical restraint). Step 2: Starting with the set of residents identified in Step 1, determine the number of long-stay residents who have a target MDS assessment (OBRA, PPS, or discharge) reporting daily incidence of physical restraint use during the 7 days prior to the target assessment. Step 3: Divide the result of Step 2 by the result of Step 1.

	0640 HBIPS-2 Hours of physical restraint use	0687 Percent of Residents Who Were Physically Restrained (Long Stay)
	4. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals U, Set the Measure Category Assignment for the strata measures (HBIPS-2b through HBIPS-2e) = ´U´. Stop processing. b. If Overall Rate Category Assignment equals E, X or Y, continue processing and proceed to Patient Age at Time of Event. 5. Initialize the Measure Category Assignment for each strata measure (b-e) = ´B´. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-2a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-2a) Measure Category Assignment. 6. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-2b = Measure Category Assignment for measure HBIPS-2a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event. 7. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-2c = Measure b. Category Assignment for measure HBIPS-2a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event. 8. Check Patient Age at Time of Event a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-2d = Measure Category Assignment for measure HBIPS-2a. Stop processing. b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-2e = Measure Category Assignment for measure HBIPS-2a. Stop processing	
Submission items	5.1 Identified measures: 0687 : Percent of Residents Who Were Physically Restrained (Long Stay) 0203 : Restraint prevalence (vest and limb) 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 203 excludes patients under 18 years of age, only evaluates vest or limb restraint use and is based on a survey conducted at selected time intervals. Measure 0687 evaluates the percent of all patients in a long term care setting who had a vest or limb restraint applied during the reporting period. HBIPS-2 evaluates the total time all patients > 1 year of age in a psychiatric care setting were maintained in all forms of physical restraint for the reporting period. 5b.1 If competing, why superior or rationale for additive value: Not Applicable	5.1 Identified measures: 0640 : HBIPS-2 Hours of physical restraint use 0203 : Restraint prevalence (vest and limb) 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: NQF # 0203 Physical restraint (vest and limb only). While this measure has a similar focus, it is for use in acute care and uses a different definition of restraints. NQF # 0640 HBIPS-2 Hours of physical restraint use. This measure also has as similar focus but is for use in hospital-based inpatient psychiatric setting and is based on patient days. Detailed data on days of restraint use is not currently available on the MDS. The measure #0687 is specified to capture daily restraint use over the 7 days preceding the resident's assessment. 5b.1 If competing, why superior or rationale for additive value: This is not applicable. There are no competing measures.

Comparison of NQF 1922, 0104e, 1365e, 2152, 2599, 2806

	1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	0104eAdult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
Steward	The Joint Commission	PCPI	PCPI Foundation	PCPI Foundation	National Committee for Quality Assurance	Seattle Children's Research Institute
Description	The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.	Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user. Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).	Percentage of children/adolescents age =5 to =19 years-old seen in the emergency department with psychotic symptoms who are screened for alcohol or drugs of abuse
Type	Process	Process	Process	Process	Process	Process
Data Source	Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed. No data collection instrument provided Attachment HBIPS_Code_Tables-636794265723952869.xlsx	Electronic Health Records Not Applicable No data collection instrument provided Attachment 0104_MDD_SuicideRisk_ValueSets_2017September29.xlsx	Electronic Health Records Not Applicable No data collection instrument provided Attachment 1365_CMS177_Child_Adolescent_MDD_Value_Sets_05042018.xlsx	Registry Data Not applicable. No data collection instrument provided No data dictionary	Claims, Electronic Health Records, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients. No data collection instrument provided Attachment 2599_Alcohol_Screening_for_People_With_Mental_Illness_Value_Set-636583545268612951-636769175260262857.xlsx	Claims, Other, Paper Medical Records The data collection tool is publicly available on the website in S.1. and also attached in the Appendix materials. Title: “Medical Record Measure Electronic Abstraction and Scoring Tool” under “Mental Health Measures” Available at measure-specific web page URL identified in S.1 Attachment PSYCHOSIS_ICD9_and_ICD10_Codes_for_Denominator_Identification_SUBMITTED-635803493103736421.xlsx
Level	Facility, Other	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Clinician : Group/Practice, Clinician : Individual	Health Plan	Facility
Setting	Inpatient/Hospital	Emergency Department and Services, Other, Outpatient Services Behavioral Health Day Treatment	Outpatient Services	Home Care, Outpatient Services	Outpatient Services	Emergency Department and Services, Inpatient/Hospital

	1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	0104eAdult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
Numerator Statement	Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	Patient visits with an assessment for suicide risk	Patients who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user	Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.	Eligible patients with documentation of drug and alcohol screening using urine drug or serum alcohol tests.
Numerator Details	Five data elements are used to calculate the numerator: 1. Patient Strengths - Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening. 2. Psychological Trauma History - Documentation in the medical record that an admission screening for a psychological trauma history was performed within the first three days of admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening. 3. Substance Use - Documentation in the medical record that an admission screening for substance use and alcohol use which occurred over the past twelve (12) months was performed within the first three days of admission. The screening must include: the type, amount, frequency of use and any problems due to past use. Allowable values: Yes, No/UTD, or X unable to complete admission screening. 4. Violence Risk to Others - Documentation in the medical record that an admission screening for violence risk to others over the past six months was performed within the first three days of admission. Violence Risk to Others includes: threats of violence and/or actual commission of violence toward others. Documentation should include	Time Period for Data Collection: At every visit where a new diagnosis or recurrent episode of Major Depressive Disorder is identified [initial evaluation during the episode] Definition: Suicide risk assessment - Must include questions about the following: 1) Suicidal ideation 2) Patient's intent of initiating a suicide attempt AND, if either is present, 3) Patient plans for a suicide attempt 4) Whether the patient has means for completing suicide GUIDANCE: Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept “Intervention, Performed: Suicide Risk Assessment” included in the numerator logic in the attached HQMF in field S.2a. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	Time Period for Data Collection: At each visit for major depressive disorder during the measurement period. HQMF eCQM developed and is included in this submission. We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification. NUMERATOR DEFINITION: The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. 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. NUMERATOR GUIDANCE: A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period. Use of a standardized tool or instrument to assess suicide risk will	Time Period for Data Collection: At least once during the 24 month period. Definitions: Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include: • AUDIT Screening Instrument (score >= 8) • AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women) • Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2) Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking. NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624. For Registry: Report Quality Data Code:	Alcohol Use Screening ADMINISTRATIVE: Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. MEDICAL RECORD: Patients who had systematic screening for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year. Systematic Screening A systematic screening method is defined as: Asking the patient about their weekly use (alcoholic drinks per week), or Asking the patient about their per occasion use (alcoholic drinks per drinking day) or Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or Using another standardized tool Unhealthy Alcohol Use Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks	Patients passing the quality measure are identified during medical record abstraction using the guidelines below. The item numbers match the “Medical Records Abstraction Tool Guidelines” under “Mental Health Measures”provided on the website in S.1. This language is also in the “Medical Records Electronic Abstraction and Scoring Tool” on the website. 11. Urine Drug Screening /Serum Alcohol Screening – [Module: Psychosis, ED care] This item applies to children and adolescents presenting with psychotic symptoms who were admitted to the marker ED. Indicate if the patient had a urine drug screen and/or serum alcohol screen while in the ED. The alcohol test will be a separate test from the drug tests. The drug test must be comprehensive in that it tests for multiple types of illicit drugs. Do NOT give credit for tests that include results of just a single drug. Drug screens commonly include tests for benzodiazepines, barbiturates, methamphetamine, cocaine, methadone, opiates, tetrahydrocannabinol, etc.

	1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	0104eAdult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
	violence risk within the 6 months prior to admission AND any lifetime risk of violence to others beyond the 6 months prior to admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening. 5. Violence Risk to Self - Documentation in the medical record that an admission screening for violence risk to self over the past six months was performed within the first three days of admission. Violence Risk to Self includes: ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening. Patients are eligible for the numerator population when the allowable value equals “yes” for all five data elements: Patient Strengths, Psychological Trauma History, Substance Use, Violence Risk to Others and Violence Risk to Self as defined above.		meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic in the HQMF eCQM attached in field S.2a.	G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling OR G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method	per week or >4 drinks per occasion for men =65 years of age. Follow-Up ADMINISTRATIVE: Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users. MEDICAL RECORD: Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count). Counseling Counseling may include at least one of the following: Feedback on alcohol use and harms Identification of high risk situations for drinking and coping strategies Increase the motivation to reduce drinking Development of a personal plan to reduce drinking	
Denominator Statement	Psychiatric inpatient discharges	All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)	All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period	All patients 18 years of age or older as of December 31 of the measurement year with at least one inpatient visit or two outpatient visits for schizophrenia or bipolar I disorder, or at least one inpatient visit for major depression during the measurement year.	Patients aged =5 to =19 years-old seen in the emergency department with psychotic symptoms.
Denominator Details	Included Populations: • Patients with ICD-10-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 (See S.2b.)	Time Period for Data Collection: 12 consecutive months Guidance: This measure is an episode-of-care measure and should be reported for	Time Period for Data Collection: 12 consecutive months. HQMF eCQM developed and is included in this submission.	Time Period for Data Collection: 12 consecutive months For Registry: Patients aged >= 18 years AND	Age: 18 years and older Benefit: Medical Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement	Cases are identified from hospital administrative data. Patients aged =5-=19 years-old Patients have at least one of the following ICD9 codes for psychosis, as

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	(See S.2b for attached code table) Six data elements are used to calculate the denominator: 1. Admission Date – The month, day and year of admission to acute inpatient care. 2. Birthdate - The month, day and year the patient was born. 3. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay. 4. ICD-10-CM Other Diagnosis Codes- The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization. 5. ICD-10-CM Principal Diagnosis Code- The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization. 6. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.	each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population. It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (ie, at the initial evaluation). For the purposes of this measure, an episode of MDD would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence. The measure description outlined in the header for this measure states, 'patients aged 18 years and older' while the logic statement states, '>= 17 year(s) at: "Measurement Period"'. The logic statement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older. HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.	We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification. DENOMINATOR DEFINITION: None DENOMINATOR GUIDANCE: This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment.	At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 2 OR At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439 WITHOUT Telehealth Modifier: GQ, GT, 95, POS 02	year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled). Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior: At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations: BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set - Major Depression Value Set At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria: BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses:	a primary or secondary diagnosis: 291.3, 291.5, 292.11, 292.12, 293.81, 293.82, 295.30, 295.31, 295.32, 295.33, 295.34, 295.40, 295.41, 295.42, 294.43, 295.44, 295.70, 295.71, 295.72, 295.73, 295.74, 295.90, 295.91, 295.92, 295.93, 295.94, 296.24, 296.44, 297.1, 297.2, 297.3, 298.X These codes were chosen by Members of the COE4CCN Mental Health Working Group (see Ad.1) co-chaired by Psychiatric Health Services Researchers Drs. Michael Murphy and Bonnie Zima.

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					- Schizophrenia Value Set - Bipolar Disorder Value Set ED Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH ED Value Set with BH ED POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses: - Schizophrenia Value Set - Bipolar Disorder Value Set	
Exclusions	• Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions • Patients with a Length of Stay = or less than 3 days or = or greater than 365 days	None	None	Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)	Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).	No patients were excluded from the target population.
Exclusion Details	• Patients for whom screening cannot be completed due to the patient's inability or unwillingness to answer assessment questions within the first three days of admission OR patients with a previous admission to the psychiatric unit during a single hospitalization. • Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is less than 3 days or greater than 365 days, the patient is excluded.	Not Applicable	N/A	Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter. Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are	Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).	N/A

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				not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For Registry: Report Quality Data Code: G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)		
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	The measure is stratified by the following age groups:	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put	Consistent with CMS' Measures Management System Blueprint and recent national recommendations put	Not applicable.	N/A

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	• Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years • Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years • Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years • Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years	forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.	forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.	forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.		
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Ratio better quality = higher score
Algorithm	1. Run all cases that are included in the Initial Patient Population for HBIPS Discharge and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure 2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date. 3. Check Length of Stay a. If Length of Stay is less than or equal to 3 days or greater than or equal to 365 days, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. b. If Length of Stay is greater than 3 days and less than 365 days, continue processing and proceed to Psychiatric Care Setting. 4. Check Psychiatric Care Setting a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing. b. If Psychiatric Care Setting equals Yes, continue processing. 5. Initialize Missing Counter to equal zero. Initialize No Screening Counter	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure.	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who meet the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator If the patient does not meet the numerator, this case represents a quality failure.	To calculate performance rates: 1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address). 2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical. 3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator	Step 1: Determine the eligible population. Step 1A: Identify all patients 18 years of age or older with a serious mental illness Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year. Step 2: Identify Numerator. Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop. Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening. Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use	Step 1. Identify eligible population at hospital using administrative data. N=total population Step 2. Assess patient chart for indicator status. Pass (A=1) if documentation present of urine drug testing or both urine drug testing and serum alcohol testing. Pass (B=1) if documentation present of serum alcohol testing or both urine drug testing and serum alcohol testing. Step 3. Calculate Patient score= 100*(A+B)/2. Results=0, 50, 100 Step 4. Calculate hospital score=Sum(Patient score)/N

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	to equal zero, Initialize Incomplete Screening Counter to equal zero. Continue processing and proceed to Patient Strengths. 6. Check Patient Strengths a. If Patient Strengths equals No, add one to No Screening Counter. Continue processing and proceed to Psychological Trauma History. b. If Patient Strengths is missing, add one to Missing Counter. Continue processing and proceed to Psychological Trauma History. c. If Patient Strengths equals Yes or X, Continue processing and proceed to check Patient Strengths. 7. Check Patient Strengths a. If Patient Strengths equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Psychological Trauma History. b. If Patient Strengths equals Yes, Continue processing and proceed to Psychological Trauma History. 8. Check Psychological Trauma History a. If Psychological Trauma History equals No, add one to No Screening Counter. Continue processing and proceed to Substance Use. b. If Psychological Trauma History is missing, add one to Missing Counter. Continue processing and proceed to Substance Use. c. If Psychological Trauma History equals Yes or X, Continue processing and proceed to check Psychological Trauma History. 9. Check Psychological Trauma History a. If Psychological Trauma History equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Substance Use. b. If Psychological Trauma History equal Yes, Continue processing and proceed to Substance Use. 10. Check Substance Use			exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.	and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.)	

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	a. If Substance Use equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Others. b. If Substance Use is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Others. c. If Substance Use equals Yes or X, Continue processing and proceed to check Substance Use. 11. Check Substance Use a. If Substance Use equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Others. b. If Substance Use equal Yes, Continue processing and proceed to Violence Risk to Others. 12. Check Violence Risk to Others a. If Violence Risk to Others equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Self. b. If Violence Risk to Others is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Self. c. If Violence Risk to Others equals Yes or X, Continue processing and proceed to check Violence Risk to Others. 13. Check Violence Risk to Others a. If Violence Risk to Others equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Self. b. If Violence Risk to Others equal Yes, Continue processing and proceed to Violence Risk to Self. 14. Check Violence Risk to Self a. If Violence Risk to Self equals No, add one to No Screening Counter. Continue processing and proceed to Incomplete Screening Counter. b. If Violence Risk to Self is missing, add one to Missing Counter. Continue					

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	processing and proceed to Incomplete Screening Counter. c. If Violence Risk to Self equals Yes or X, Continue processing and proceed to check Violence Self. 15. Check Violence Risk to Self a. If Violence Risk to Self equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Incomplete Screening Counter. b. If Violence Risk to Self equal Yes, Continue processing and proceed to Incomplete Screening Counter. 16. Check Incomplete Screening Counter a. If Incomplete Screening Counter equals 5, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Continue processing and proceed to initialize the Measure Category Assignment for each strata measure. b. If Incomplete Screening Counter is less than five, continue processing and proceed to Missing Counter. 17. Check Missing Counter a. If Missing Counter is more than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-1a) and will be rejected. Proceed to step initialize the Measure Category Assignment for each strata measure. b. If Missing Counter equals zero, continue processing and proceed to No Screening Counter. 18. Check No Screening Counter a. If No Screening Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-1a) and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.					

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	b. If No Screening Counter equals zero, the case will proceed to a Measure Category Assignment of E and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure. 19. Initialize the Measure Category Assignment for each strata measure (b-e) equal ´B´. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-1a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-1a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment. 20. Check Overall Rate Category Assignment a. If Overall Rate Category Assignment equals B, retain the Measure Category Assignment for the strata measures (HBIPS-1b through HBIPS-1e) equals B. Stop processing. b. If Overall Rate Category Assignment equals D, E, or X, continue processing and proceed to Patient Age at Discharge. 21. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 1 year and less than 13 years, set the Measure Category Assignment for the measure HBIP-1b equal to Measure Category Assignment for measure HBIP-1a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 13 years, continue processing and proceed to Patient Age at Discharge. 22. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 13 years and less than 18 years, set the Measure Category Assignment for the measure HBIP-1c equal to Measure Category					

	1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	0104eAdult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
	Assignment for measure HBIP-1a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 18 years, continue processing and proceed to Patient Age at Discharge. 23. Check Patient Age at Discharge a. If Patient Age at Discharge is greater than or equal to 18 years and less than 65 years, set the Measure Category Assignment for the measure HBIP-1d equal to Measure Category Assignment for measure HBIP-1a. Stop processing. b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIP-1e equal to Measure Category Assignment for measure HBIP-1a. Stop processing.					
Submission items	5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment 0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use 0111 : Bipolar Disorder: Appraisal for risk of suicide 1365 : Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 2599 : Alcohol Screening and Follow-up for People with Serious Mental Illness 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Five of the six NQF endorsed measures are provider level measures, 2599 is a health plan measure. All pertain to the ambulatory setting for patients. All (except 2152) are specific to the diagnoses of major depression and/or	5.1 Identified measures: 1365 : Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: The guidelines used as evidence in the NQF 1365: Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment explicitly recommend suicide assessment at every visit for MDD whereas the guidelines used for evidence in this measure do not emphasize this level of assessment frequency. 5b.1 If competing, why superior or rationale for additive value: Both of these measures (0104 and 1365) were developed by PCPI and updated and harmonized with each other on an annual basis. They are not competing because they are used in different patient populations and have different frequencies of suicide assessment based on their respective evidence.	5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment 0111 : Bipolar Disorder: Appraisal for risk of suicide 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Our measure addresses a different target population, children and adolescents with MDD, from the related measures that focus on adults with MDD and patients with bipolar disorder. As a result, the recommended frequency of suicide assessment is different in our measure from the other measures. 5b.1 If competing, why superior or rationale for additive value: Because our measure emphasizes a different target population and a different type/frequency of assessment, we feel multiple measures are justified to address suicide risk assessment differently in different high-risk populations.	5.1 Identified measures: 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The related measures listed in 5.1b were developed after our measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible. 5b.1 If competing, why superior or rationale for additive value: No competing NQF-endorsed measure.	5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value:

	1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed	0104eAdult Major Depressive Disorder (MDD): Suicide Risk Assessment	1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2599 Alcohol Screening and Follow-up for People with Serious Mental Illness	2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
	bipolar disorder. The measures only evaluate one aspect of screening: either suicide risk or alcohol or substance use. Measures 0104, 0110, 0111, 2159, and 2599 only evaluate patients age 18 years and older. The SUB-1 measure pertains to all inpatients 18 years and older, with screening limited to substance use. HBIPS-1 addresses inpatient organizational performance for all psychiatric diagnoses and evaluates the care of all patient ages (greater than 1 year). Additionally, HBIPS-1 evaluates several aspects of screening (risk of violence to self or others, substance use, psychological trauma history and patient strengths). 5b.1 If competing, why superior or rationale for additive value: Not Applicable				demonstrated disparities in care - What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda. 5b.1 If competing, why superior or rationale for additive value: Not applicable.	

Comparison of NQF 3488, 0004, 3312, 3453

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services	Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services
Description	The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported: - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). - The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported: • Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.	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.	Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or ordered a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.
Type	Process	Process	Process	Process
Data Source	Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. No data collection instrument provided Attachment 3488_FUA_Value_Sets_Spring_2019.xlsx	Claims NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS). No data collection instrument provided Attachment 0004_IET_Value_Sets.xlsx	Claims Medicaid Analytic eXtract (MAX) 2013 and 2014 eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. The inpatient file only contains inpatient hospital, sterilization, abortion and religious non-medical health care institution claims. No data collection instrument provided Attachment Cont_Care_After_Detox_Value_Sets.xlsx	Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services (OT) file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. No data collection instrument provided Attachment SUD-18_measure_value_sets_FINAL_08.09.18_tested_sets_-_locked.xlsx
Level	Health Plan	Health Plan	Population : Regional and State	Population : Regional and State
Setting	Outpatient Services	Emergency Department and Services, Inpatient/Hospital, Outpatient Services	Inpatient/Hospital, Outpatient Services	Emergency Department and Services, Home Care, Inpatient/Hospital, Outpatient Services
Numerator Statement	The numerator consists of two rates: - 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. - 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. These rates are stratified by age (13–17, 18 and older, total).	Initiation of AOD Treatment: Initiation of treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis. --- Engagement of AOD Treatment:	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.	Discharges in the denominator with an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or filled a prescription for or were administered or ordered a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
		Initiation of AOD treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit.		
Numerator Details	30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit: - IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set). - A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set). - An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set). 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit: - IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set). - A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).	Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence. • For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service. • For an inpatient stay, the IESD is the date of discharge. • For an ED and observation visits that results in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort). • For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort). INITIATION OF AOD TREATMENT Initiation of AOD treatment within 14 days of the IESD. If the Index Episode was an inpatient discharge (or an ED visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant. If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation: • An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions: • Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). • Identify the admission date for the stay. • IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse	Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year. The numerator includes individuals with any of the following within 14 days after discharge from detoxification: -Pharmacotherapy on day of discharge through day 7 or 14. -Outpatient, intensive outpatient, partial hospitalization, or residential treatment procedure with a diagnosis of SUD on the day after discharge through day 7 or 14. -Outpatient, intensive outpatient, partial hospitalization, or residential treatment with standalone SUD procedure on the day after discharge through day 7 or 14. -Inpatient admission with an SUD diagnosis or procedure code on day after discharge through day 7 or 14. -Long-term care institutional claims with an SUD diagnosis on day after discharge through day 7 or 14. Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim. SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes. Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone). A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.	The measure will report two rates, continuity of care within 7 days and within 14 days after discharge. The numerator includes discharges with any of the following after inpatient or residential treatment: • Outpatient visit, intensive outpatient encounter or partial hospitalization with a primary or secondary SUD diagnosis on the day after discharge through day 7 or 14. • Telehealth encounter for SUD on the day after discharge through day 7 or 14 • Pharmacotherapy (filling a prescription or being administered or ordered a medication) on day of discharge through day 7 or 14 • For inpatient discharges only, residential admissions on day 3 through day 7 or day 14 Public comments supported a measure for 7- and 14-day continuity and voiced that beyond that would be too long, risking losing the patient from the treatment system. The Technical Expert Panel unanimously agreed on the appropriateness of 7-day continuity of care. However, three TEP members felt that 14-days continuity of care is too long. Our approach balances clinical best practice thinking that the sooner the patient is connected to treatment the better while also allowing treatment programs more time for placement of patients in continuing treatment. Because it may be difficult at times for treatment programs to place clients in continuing care in a timely fashion after discharge due to limits in systems capacity, it is particularly important to allow more time for continuity of care to occur. Inpatient or residential treatment was considered to be SUD related if it had a primary SUD diagnosis or a procedure indicating SUD. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes. Value sets for the measure are attached in the Excel workbook provided for question S.2b. We include 2016 HEDIS value sets because we used these value sets in measure testing. HEDIS value sets are used because they represent an existing set that states are already familiar with, they are an element of harmonizing with other endorsed measures, and they are updated by the

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
	- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).	and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set). • IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set). • A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An online assessment (Online Assessment Value) set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set). • If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set). For all initiation events except medication treatment (AOD Medication Treatment Value Set; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List), initiation on the same day as the IESD must be with different providers in order to count. • If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The “Total” column is not the sum of the diagnosis columns. • Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year. --- ENGAGEMENT OF AOD TREATMENT 1) Numerator compliant for the Initiation of AOD Treatment numerator and		National Committee on Quality Assurance (NCQA). Also, some states may need to include relevant state-specific codes.

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		2) Members whose initiation of AOD treatment was a medication treatment event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List; AOD Medication Treatment Value Set). These members are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event. 3) Remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2). These members are numerator compliant if they meet either of the following: • At least one engagement medication treatment event. • At least two engagement visits Two engagement visits can be on the same date of service, but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers). Engagement visits: Any of the following meet criteria for an engagement visit: • An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions: – Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). – Identify the admission date for the stay. • IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse		

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		and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. Engagement Medication Treatment Events: Either of the following meets criteria for an engagement medication treatment event: • If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment. • If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment. If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total Column is not the sum of the diagnosis columns.		
Denominator Statement	Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.	Patients age 13 years of age and older as of December 31 of the measurement year who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).	Adult Medicaid beneficiary discharges from detoxification from January 1 to December 15 of the measurement year.	Adult Medicaid beneficiary discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD during from January 1 to December 15 of the measurement year.
Denominator Details	Age: 13 years and older as of the date of the ED visit Benefit: Medical and chemical dependency. Note: Members with detoxification-only chemical dependency benefits do not meet these criteria. Continuous Enrollment: Date of emergency department visit through 30 days after the ED visit Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of	Identify the Index Episode. Identify all members 13 years and older as of December 31 of the measurement year who during the Intake Period had one of the following: • An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria: – IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value	Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year. Target population meets the following conditions: • Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one	Population: Medicaid beneficiaries age 18 through 64 as of January 1 of the measurement year. Benefit: Medical and Behavioral Health Services. Continuous Enrollment: Date of the inpatient or residential SUD treatment discharge through end of the following month. The enrollment requirement is to ensure that beneficiaries are enrolled for sufficient time to allow for the continuity activities, particularly for a discharge that occurs near the end of a month.

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	the measurement year where the member was 13 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below. If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period. Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.	Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). – IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set). • A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An acute or nonacute inpatient discharge with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges: – Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). – Identify the discharge date for the stay. • A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. • An online assessment (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. For members with more than one episode of AOD abuse or dependence, use the first episode. For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD. Select the Index Episode Start Date.	detox discharge during the year January 1-December 15. • Enrolled in Medicaid during the month of detoxification discharge and the following month. The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode. Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.	Diagnosis Criteria: Discharges from inpatient or residential treatment with a primary diagnosis of SUD on any claim during the stay. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 15 of the measurement year. December 15th is selected to allow sufficient time for continuity activities.
Exclusions	Patients in hospice.	Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set)	Not applicable. The measure does not have denominator exclusions.	Exclude from the denominator for both rates:

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
		or an alcohol or opioid dependency treatment medication dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List) during the 60 days (2 months) before the IESD. Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.		• Discharges with hospice services during the measurement year • Both the initial discharge and the admission/direct transfer discharge if the admission/direct transfer discharge occurs after December 15 of the measurement year. Discharges followed by admission or direct transfer to inpatient or SUD residential treatment setting within 7 or 14-day continuity of care period. These discharges are excluded from the measure because transfer, hospitalization or admission to residential treatment within 7 or 14 days may prevent a continuity of care visit from taking place. An exception is admission to residential treatment following discharge from inpatient treatment; we do not exclude these admissions, because continuity into residential treatment after inpatient treatment is considered appropriate treatment.
Exclusion Details	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).	Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set) - For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence. - For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence. - For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence. Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.	Not applicable.	Codes reflecting exclusions are attached in S.2b. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	This measure is stratified by age: - Age 13 to 17 years - Age 18 and older - Total (sum of the age stratifications)	The total population is stratified by age: 13-17 and 18+ years of age. • Report two age stratifications and a total rate. • The total is the sum of the age stratifications. Report the following diagnosis cohorts for each age stratification and the total rate: • Alcohol abuse or dependence. • Opioid abuse or dependence. • Other drug abuse or dependence.	Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox.	Not applicable.

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
		• Total.	The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.	
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug abuse or dependence. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit. Step 2: Identify the numerator. Step 2A: Identify those who had a qualifying follow-up visit within 7 days. Step 2B: Identify those who had a qualifying follow-up visit within 30 days. Step 3: Calculate the rates. Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A). Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A).	Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified denominator criteria (S7-S9). Step 2. Search administrative systems to identify numerator events for all patients in the eligible population (S6). Step 3. Calculate the rate of numerator events in the eligible population. 123834| 140881| 135810| 141015| 110874| 130488	The following step are used to identify the denominator, numerator, and calculation of the measure rate: Step 1: Identify denominator Step 1A: Eligible population: Identify enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year. Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations. Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode. Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction,	In the steps below we reference the Excel workbook we attached for S.2b. The workbook includes: • 2016 HEDIS value sets used in measure testing • 2018 HEDIS value sets used in measure testing for pharmacotherapy and telehealth codes • Value sets developed during the specification and testing of this measure, and the value sets from NQF #3312 Continuity of Care for Medicaid Beneficiaries After Detoxification (Detox) from Alcohol and/or Drugs and NQF #3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD) that were used in the specification of this measure. Note - some states may need to also include relevant state-specific codes. Step 1: Identify denominator Step 1A. Eligible population: : Identify non-dually enrolled Medicaid beneficiaries age 18 through 64 years with any discharges from inpatient or residential treatment with a principal diagnosis of SUD during January 1 - December 15 of the measurement year. Patients must meet enrollment criteria, defined as Medicaid as the first payer and enrolled in the month of discharge and the following month. Age is calculated as of January 1 of the measurement year. Throughout Steps 1 and 2, the principal diagnosis of SUD is identified using a principal diagnosis from the 2016 “HEDIS AOD Dependence” value set (Tab 1 in the attached Excel file) or any procedure code from the 2016 “HEDIS AOD Procedures” value set (Tab 2). Secondary diagnosis of SUD is identified using the same value sets. Step 1B. Flag claims as inpatient or as residential treatment: Among the Medicaid beneficiaries in Step 1A, flag claims as being either in an inpatient or residential setting using all inpatient, outpatient, and ambulatory claims files or tables that contain HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
			other stayover treatment and ambulatory detoxification. Use HCPCs detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox episode being identified via revenue center codes and a more specific category using HCPCs on the SAME claim, the HCPCs location prevails. Step 2: Identify numerator Step 2A: Overall: From the denominator in Step 1B, identify those discharges from detoxification in any setting with a qualifying continuity service within 7 or 14 days after discharge. Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes). The measure includes all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, the specification calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are "First" to occur relative to the detox episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14. Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables. For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted by beneficiary ID and service dates, then multiple pharmacotherapy	service, or UB revenue codes. Residential treatment is identified using the codes in the SUD Residential Treatment value set (Tab 3). If more than one discharge in a year, treat each discharge as a separate episode, e.g., an inpatient hospital discharge in January and a residential treatment discharge in July counts as two episodes. Step 1B.1: Consolidate episodes: Multiple inpatient or residential treatment claims that are up to 2 days apart should be combined into a single episode. To facilitate this consolidation, sort the inpatient, outpatient and ambulatory discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Use all inpatient and residential treatment claims, regardless of diagnosis, to create episodes. Step 1C: Assign treatment location to episodes: Use HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes in the SUD Residential Treatment value set (Tab 3) and the SUD diagnosis value sets as noted in Step 1A to assign each episode as inpatient residential treatment, or a mix of both (also indicating the first setting of each episode and the last setting of each episode). Step 1D: Exclusions: Exclude discharges that meet the exclusion criteria as specified in the "Denominator Exclusion Details" section. • Exclude discharges for patients who receive hospice services during the measurement year. • Exclude discharges after December 15 of the measurement year. • Exclude discharges followed by admission or direct transfer to an inpatient or SUD residential treatment setting within the 7- or 14-day continuity of care period regardless of the principal diagnosis (with exception of admission to residential treatment following discharge from inpatient treatment). • Exclude episodes that do not include at least one claim with primary diagnosis of SUD. The denominator for the 7- and 14-day continuity of care rates will differ because of the different exclusions based on transfer or admission to hospital or residential treatment for 7 versus 14 days. For example, a beneficiary admitted to a residential setting on day 10 after discharge will be excluded from the 7-day rate but not from the 14-day rate. Step 2: Identify numerator

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
			data sources are put together so they will be in chronological order to assign "First" variables. Pharmacotherapy services could be provided on the same day as the discharge from detox through day 7 or 14. Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, it is allowed to remain a continuity service. Step 3: Calculate rate Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B). Step 3B: Calculate the rates separately for each detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C). 120752| 141015	Step 2A: From the denominator, identify discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD with qualifying continuity of care for SUD (principal or secondary diagnosis) within 7 or 14 days of discharge. Step 2A.1: Visits: Identify visits meeting continuity of care criteria using outpatient claims files or tables that contain diagnosis, procedure, or revenue codes, procedure code modifiers, or place of service codes. SUD diagnoses can be in any position – primary or secondary – for continuity services. Visits have to occur the day after discharge through day 7 or 14. We identify visits as: 1. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (Tab 4); or 2. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or 3. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8). The claim must also have procedure code modifier that is missing or a value other than those in the "HEDIS Telehealth Modifier" value set (Tab 9). Step 2.A.2. Telehealth: Identify visits for telehealth meeting continuity of care criteria using outpatient claims files or tables that contain diagnosis, procedure, or revenue codes, procedure code modifiers, or place of service codes. SUD diagnoses can be in any position – primary or secondary – for continuity services. Telehealth has to occur the day after discharge through day 7 or 14. We identify telehealth as: 1. Any procedure code from the "HEDIS Telephone Visit" value set (Tab 12); or 2. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (Tab 4); or 3. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or 4. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8). Claims identified using logic in #2-4 must also have procedure code modifier from the "HEDIS Telehealth Modifier" value set (Tab 9). Step 2A.3: Identify pharmacotherapy events: Indications of pharmacotherapy can occur in outpatient or pharmacy files or tables that contain procedure

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
				codes or NDCs. Pharmacotherapy events could be provided on the same day as the discharge through day 7 or 14. Pharmacotherapy continuity claims are identified as follows: 1. In OT file, a) any procedure code from "HEDIS Medication Assisted Treatment" value set (Tab 10); or b) any HCPCS procedure code from "MAT Additional Codes" value set (Tab 11) (developed as part of testing for NQF 3312); or c) any state-specific procedure code from "MAT Additional Codes" value set (Tab 11) for the two states listed in the value set (these codes were identified through consultation for these states). 2. In RX file, any NDC from "AOD Pharmacotherapy" value set (Tab 13). This value set contains NDCs identified as part of testing for NQF 3312 and 3400. Step 3: Calculate rate Step 3A: Calculate the overall 7- or 14-day continuity of care rate by dividing the number of discharges with evidence of a qualifying continuity of care visit or pharmacotherapy event (Step 2A) by the denominator (after exclusions) (Step 1D). Calculate the rates separately for each continuity of care time period. 120752| 141015| 110874
Submission items	5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not detoxification). Numerator: The measure captures follow-up with a primary alcohol or other drug dependence diagnosis. 5b.1 If competing, why superior or rationale for additive value: Not applicable.	5.1 Identified measures: 5a.1 Are specs completely harmonized? 5a.2 If not completely harmonized, identify difference, rationale, impact: 5b.1 If competing, why superior or rationale for additive value: N/A	5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Follow-up time period: NQF 2605 examines follow-up care 7 days and 30 days after discharge. Our proposed measure (#3312) examines follow-up care 7 days and 14 days after discharge. The 14 day follow-up time period aligns with NQF 0004 and the non-NQF endorsed Continuity of Care After Detoxification measure developed by the Washington Circle, and reflects the input of some public commenters that adults should receive some type of care within two weeks of discharge from detoxification. Diagnoses: NQF 2605 requires a primary diagnosis of alcohol and other drug dependence (AOD) for the follow-up service. Our proposed measure (#3312) requires a primary or secondary diagnosis of AOD. We allow a primary or secondary AOD diagnosis to address potential	5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment 0576 : Follow-Up After Hospitalization for Mental Illness (FUH) 1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) 2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence 3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: Parts of the specifications for the proposed measure harmonize with some measures but not others. Below we describe similarities and differences between the proposed measure and other measures. The differences do not impose additional data collection burden to states, because the data elements are available in administrative data and are consistent with some measures states are already likely collecting. Numerator: Timing of continuity of care. The proposed measure specifies continuity of care within 7- and 14-days of discharge and is harmonized with NQF

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
			inaccuracies in how AOD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an AOD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and AOD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. The differences in follow-up time period, location and diagnoses between NQF 2605 and our proposed measure (3312) do not impact the measure's interpretability in which a higher rate is indicative of better quality. Both measures rely on administrative data. The differences in measure specifications between 2605 and 3312 are minor and expected to have minimal impact on data collection burden. 5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no other NQF-endorsed measures that conceptually address the same measure focus and same target population.	3312, Continuity of care for Medicaid beneficiaries after detoxification (detox) from alcohol and/or drugs, which also focuses on a SUD population. NQF 0576, 1937, and 2605 all specify follow-up within 7 and 30 days. The populations for NQF 0576 and 1937 include patients with mental health related diagnoses rather than focusing on substance use disorders. NQF 2605 has a target mixed population of mental health and SUD patients. In measure testing, stakeholders expressed concern that 30 days is too long for SUD patients to wait for a continuity of care service after discharge from inpatient or residential care. Timelier follow-up with these patients is needed so as not to lose them. NQF 0004 is partially harmonized with the proposed measure in that the initiation visit is specified as within 14 days of the index episode start date (diagnosis). Diagnoses in the continuity of care visit. The proposed measure is harmonized with NQF 3312 and NQF 0004 by allowing SUD to either be the primary or a secondary diagnosis for treatment services that count toward continuity in the numerator. This is to address potential inaccuracies in how SUD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an SUD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and SUD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. NQF 2605 does not allow a secondary SUD diagnosis. NQF 0576, NQF 1937, are not clear on whether only a primary diagnosis is allowed in the numerator. Services to include as continuity of care. The proposed measure includes pharmacotherapy and telehealth as services that count as continuity of care. NQF 2605, 0576, and 1937 do not include these services. Adding an SUD medication or telehealth claim as evidence of continuity of care is consistent with recent changes made to the 2018 HEDIS specification of NQF 0004 (National Committee on Quality Assurance, 2018). Practitioners valid for providing follow-up services. The proposed measure and NQF 2605 allow any practitioner to provide follow-up services, because of the expectation that the follow-up services captured in the measure may be provided by primary care clinicians. NQF 0576 and 1937 only allow non-mental health practitioners in specified settings and with specific diagnosis codes. Denominator: Diagnoses in denominator. The denominators for the proposed measure and all the related measures are harmonized in requiring a primary diagnosis for the condition that is

	3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence	0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs	3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)
				the measure's focus. Age. The proposed measure is intended for an adult Medicaid population. Similar to NQF 3312 and NQF 1937, it includes ages 18-64.The proposed measure excludes adults over 64 years, because complete data on services received by dually-eligible (Medicaid and Medicare) adults are not available in Medicaid data. NQF 2605 includes adults age 18 and older. NQF 0576 includes individuals age 6 and older and NQF 0004 includes age 13 and older. In terms of impact on interpretability, the proposed measure would have lower continuity rates than the measures that have a 30-day follow-up time period and higher continuity rates than the measures that only count non-mental health practitioners in certain settings and with certain diagnosis codes. 5b.1 If competing, why superior or rationale for additive value: Not applicable; there are no competing measures.

Comparison of NQF 3489 and 0576

	3489: Follow-Up After Emergency Department Visit for Mental Illness	0576: Follow-Up After Hospitalization for Mental Illness (FUH)
Steward	National Committee for Quality Assurance	National Committee for Quality Assurance
Description	The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported: - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). - The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported: - The percentage of discharges for which the patient received follow-up within 30 days of discharge - The percentage of discharges for which the patient received follow-up within 7 days of discharge.
Type	Process	Process
Data Source	Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. No data collection instrument provided Attachment 3489_FUM_Value_Sets_Spring_2019.xlsx	Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system. No data collection instrument provided Attachment 0576_FUH_Value_Sets.xlsx
Level	Health Plan	Health Plan, Integrated Delivery System
Setting	Outpatient Services	Inpatient/Hospital, Outpatient Services
Numerator Statement	The numerator consists of two rates: - 30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). - 7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge. 7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.
Numerator Details	30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). Any of the following meet criteria for a follow-up visit: - An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health	For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit: - A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below). - A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set). - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner. - A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set). - Transitional care management services (TCM 7 Day Value Set). The following meets criteria for only the 30-Day Follow-Up indicator: - Transitional care management services (TCM 14 Day Value Set) (See corresponding Excel document for the value sets referenced above) Mental Health Practitioner Definition: A practitioner who provides mental health services and meets any of the following criteria: • An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice. • An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice. • An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice. • A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization

	3489: Follow-Up After Emergency Department Visit for Mental Illness	0576: Follow-Up After Hospitalization for Mental Illness (FUH)
	disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). 7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). Any of the following meet criteria for a follow-up visit: - An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).	in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice. • An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy. • An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

	3489: Follow-Up After Emergency Department Visit for Mental Illness	0576: Follow-Up After Hospitalization for Mental Illness (FUH)
	- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set). - A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set). - An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).	
Denominator Statement	Emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.	Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.
Denominator Details	Age: 6 years and older as of the date of the ED visit Benefit: Medical and mental health. Continuous Enrollment: Date of emergency department visit through 30 days the ED visit Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below. If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1 then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period. Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:	An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the discharge date for the stay. The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year. Acute facility readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge. To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. *Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question S.2b.

	3489: Follow-Up After Emergency Department Visit for Mental Illness	0576: Follow-Up After Hospitalization for Mental Illness (FUH)
	1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Identify the admission date for the stay. These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.	
Exclusions	Patients in hospice.	Exclude from the denominator for both rates, patients who receive hospice services during the measurement year. Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis. Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.
Exclusion Details	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).	Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set). Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year. Exclude discharges followed by readmission or direct transfer to a nonacute care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim. 3. Identify the admission date for the stay. Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting: 1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set). 2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set). 3. Identify the admission date for the stay. These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place. - See corresponding Excel document for the Value Sets referenced above in S.2b.
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification	Not applicable.	N/A
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	Step 1: Determine the eligible population. Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit. Step 2: Identify the numerator. Step 2A: Identify those who had a qualifying follow-up visit within 7 days. Step 2B: Identify those who had a qualifying follow-up visit within 30 days. Step 3: Calculate the rates.	Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7). Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9). Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5). Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2. 123834| 140881

	3489: Follow-Up After Emergency Department Visit for Mental Illness	0576: Follow-Up After Hospitalization for Mental Illness (FUH)
	Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A). Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A). 123834| 140881| 135810| 110874	
Submission items	5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH) 5a.1 Are specs completely harmonized? Yes 5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not inpatient). Numerator: The measure captures follow-up with a primary mental health diagnosis (regardless of the type of provider). 5b.1 If competing, why superior or rationale for additive value: Not applicable.	5.1 Identified measures: 5a.1 Are specs completely harmonized? No 5a.2 If not completely harmonized, identify difference, rationale, impact: N/A 5b.1 If competing, why superior or rationale for additive value: N/A

Appendix E2: Related and Competing Measures (narrative format)

Comparison of NQF 0560, 1879, 2801, 3205

0560 HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification
1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia
2801 Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
3205 Medication Continuation Following Inpatient Psychiatric Discharge

Steward

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

The Joint Commission

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Centers for Medicare and Medicaid Services

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

National Committee for Quality Assurance

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Centers for Medicare & Medicaid Services

Description

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

The proportion of patients, age greater than and equal to 1 year, discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Percentage of individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and had a Proportion of Days Covered (PDC) of at least 0.8 for antipsychotic medications during the measurement period (12 consecutive months).

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Percentage of children and adolescents 1–17 years of age with a new prescription for an antipsychotic, but no indication for antipsychotics, who had documentation of psychosocial care as first-line treatment.

3205: Medication Continuation Following Inpatient Psychiatric Discharge

This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years.

Type

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Process

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Process

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Process

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Process

Data Source

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

No data collection instrument provided Attachment HBIPS_Code_Tables_Med_-636794264289743033.xlsx

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Claims The data source for the measure calculation required the following Medicare files depending on the level of accountability where the measure is being used:

• Denominator tables to determine individual enrollment

• Prescription drug benefit (Part D) coverage tables

• Beneficiary file

• Institutional claims (Part A)

• Non-institutional claims (Part B)—physician carrier/non-DME (durable medical equipment)

• Prescription drug benefit (Part D) claims

• Centers for Medicare and Medicaid Services (CMS) physician and physician specialty tables

• National Plan and Provider Enumeration System (NPPES) database

No data collection instrument provided Attachment NQF_1879_Code_Tables_2018_Final.xlsx

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Claims This measure is part of the Healthcare Effectiveness Data and Information Set (HEDIS). As part of HEDIS, the measure pulls from administrative claims collected in the course of providing care to health plan members. NCQA collects the HEDIS data for this

measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

The measure has also been tested at the state level and could be reported by states if added to a relevant program.

No data collection instrument provided Attachment 2801_APP_Value_Sets.xlsx

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Claims Medicare administrative data from Parts A, B, and D claims.

No data collection instrument provided Attachment Med_Continuation_Data_Dictionary_180816.xlsx

Level

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Facility, Other

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Clinician : Group/Practice, Health Plan, Population : Regional and State

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Health Plan, Integrated Delivery System, Population : Regional and State

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Facility

Setting

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Inpatient/Hospital

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Outpatient Services

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Inpatient/Hospital, Outpatient Services

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Inpatient/Hospital

Numerator Statement

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Psychiatric inpatients discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Children and adolescents from the denominator who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic.

3205: Medication Continuation Following Inpatient Psychiatric Discharge

The numerator for this measure includes:

1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

Numerator Details

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

One data element is used to calculate the numerator:

Appropriate Justification for Multiple Antipsychotic Medications - Documentation in the medical record of appropriate justification for discharging the patient on two or more routine antipsychotic medications. Allowable values: 1. The medical record contains documentation of a history of a minimum of three failed multiple trials of monotherapy. 2. The medical record contains documentation of a recommended plan to taper to monotherapy due to previous use of multiple antipsychotic medications OR documentation of a cross-taper in progress at the time of discharge. 3. The medical record contains documentation of augmentation of Clozapine. 4. The medical record contains documentation of a justification other than those listed in Allowable Values 1-3. 5. The medical record does not contain documentation supporting the reason for being discharged on two or more antipsychotic medications OR unable to determine from medical record documentation.

Patients are eligible for the numerator population when they are discharged on two or more routinely scheduled antipsychotic medications with appropriate justification.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

The numerator is defined as individuals with a PDC of 0.8 or greater.

The PDC is calculated as follows:

PDC NUMERATOR

The PDC numerator is the sum of the days covered by the days' supply of all prescription drug claims for all antipsychotic medications. The period covered by the PDC starts on the day the first prescription is filled (index date) and lasts through the end of the measurement period, or death, whichever comes first. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If there are claims for the same drug (generic name) on the same date of service, keep the claim

with the largest days' supply. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

PDC DENOMINATOR

The PDC denominator is the number of days from the first prescription drug claim date through the end of the measurement period, or death date, whichever comes first.

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

The Psychosocial Care Value Set contains claims codes for behavioral health acute inpatient and outpatient encounters, including psychotherapy for patients, families, and/or groups; psychophysiological therapy; hypnotherapy; activity therapy, such as music, dance, or art; training and educational services related to the care and treatment of mental health issues; community and rehabilitations programs; and crisis interventions. These services align with a recent Institute of Medicine (IOM) report*, which defined psychosocial interventions for mental health and substance use disorders as "interpersonal or informational activities, techniques, or strategies that target biological, behavioral, cognitive, emotional, interpersonal, social, or environmental factors with the aim of reducing symptoms of these disorders and improving functioning or well-being." The IOM notes these interventions include psychotherapies, vocational rehabilitation and peer support services, and that they can utilize different formats, including individual, family, or group therapy.

DEFINITIONS

IPSD: The earliest prescription dispensing date for an antipsychotic medication where the date is in the Intake Period and there is a Negative Medication History.

Negative Medication History: A period of 120 days (4 months) prior to the IPSD when the member had no antipsychotic medications dispensed for either new or refill prescriptions.

*Intitute of Medicine. Committee on Developing Evidence-Based Standards for Psychosocial Interventions for Mental Disorders, Board on Health Sciences Policy. England MJ, Butler AS and Gonazlez ML, eds. Psychosocial Interventions for Mental and Substance Use Disorders: a Framework for Establishing Evidence-Based Standards. 2015. National Academies Press; Washington, DC (Prepublication copy).

3205: Medication Continuation Following Inpatient Psychiatric Discharge

The following are the evidence-based medications by class for the treatment of MDD, schizophrenia, and bipolar disorder. The route of administration includes all oral formulations and the long-acting (depot) injectable of the medications listed in this section, except where noted. Active ingredients for the oral medications listed are limited to oral, buccal, sublingual, and translingual formulations only. Obsolete drug products are excluded from NDCs with an inactive date more than three years prior to the beginning of the measurement period.

MEDICATIONS FOR TREATMENT OF MDD

Monoamine Oxidase Inhibitors

-isocarboxazid

-phenelzine

-selegiline (transdermal patch)

-tranylcypromine

Selective Serotonin Reuptake Inhibitors (SSRI)

-citalopram
-escitalopram
-fluoxetine
-fluvoxamine
-paroxetine
-sertraline
Serotonin Modulators
-nefazodone
-trazodone
-vilazodone
-vortioxetine
Serotonin Norepinephrine Reuptake Inhibitors (SNRI)
-desvenlafaxine
-duloxetine
-levomilnacipran
-venlafaxine
Tricyclic and Tetracyclic Antidepressants
-amitriptyline
-amoxapine
-clomipramine
-desipramine
-doxepin
-imipramine
-maprotiline
-nortriptyline
-protriptyline
-trimipramine
Other Antidepressants
-bupropion
-mirtazapine
Psychotherapeutic Combinations
-amitriptyline-chlordiazepoxide
-amitriptyline-perphenazine
-fluoxetine-olanzapine
MEDICATIONS FOR TREATMENT OF SCHIZOPHRENIA
First-generation Antipsychotics
-chlorpromazine
-fluphenazine
-haloperidol

-haloperidol lactate
-loxapine succinate
-molindone
-perphenazine
-pimozide
-prochlorperazine
-thioridazine
-thiothixene
-trifluoperazine
Second-generation (Atypical) Antipsychotics
-aripiprazole
-asenapine
-brexpiprazole
-cariprazine
-clozapine
-iloperidone
-lurasidone
-olanzapine
-paliperidone
-quetiapine
-risperidone
-ziprasidone
Psychotherapeutic Combinations
-amitriptyline-perphenazine
-fluoxetine-olanzapine
Long-Acting (Depot) Injectable Antipsychotics
-fluphenazine decanoate
-haloperidol decanoate
-aripiprazole
-aripiprazole lauroxil
-olanzapine pamoate
-paliperidone palmitate (1-month extended-release injection)
-paliperidone palmitate (3-month extended-release injection)
-risperidone microspheres
MEDICATIONS FOR TREATMENT OF BIPOLAR DISORDER
Anticonvulsants
-carbamazepine
-divalproex sodium
-lamotrigine

-valproic acid
First-generation Antipsychotics
-chlorpromazine
-fluphenazine
-haloperidol
-haloperidol lactate
-loxapine succinate
-molindone
-perphenazine
-pimozide
-prochlorperazine
-thioridazine
-thiothixene
-trifluoperazine
Second-generation (Atypical) Antipsychotics
-aripiprazole
-asenapine
-brexpiprazole
-cariprazine
-clozapine
-iloperidone
-lurasidone
-olanzapine
-paliperidone
-quetiapine
-risperidone
-ziprasidone
Lithium Salts
-lithium
-lithium carbonate
-lithium citrate
Psychotherapeutic Combinations
-fluoxetine-olanzapine
Long-acting (depot) Injectable Antipsychotics
-fluphenazine decanoate
-haloperidol decanoate
-aripiprazole
-aripiprazole lauroxil
-olanzapine pamoate

-paliperidone palmitate (1-month extended-release injection)

-paliperidone palmitate (3-month extended-release injection)

-risperidone microspheres

Denominator Statement

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Psychiatric inpatient discharges

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Children and adolescents who had a new prescription of an antipsychotic medication for which they do not have a U.S Food and Drug Administration primary indication.

3205: Medication Continuation Following Inpatient Psychiatric Discharge

The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

Denominator Details

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Included populations:

Patients with ICD-10-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 (See S.2b.) discharged on two or more routinely scheduled antipsychotic medications (refer to Appendix C, Table 10.0- Antipsychotic Medications).

Nine data elements are used to calculate the denominator:

1. Admission Date - The month, day and year of admission to acute inpatient care.

2. Birthdate - The month, day and year the patient was born.

3. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.

4. Discharge Disposition- The patient's discharge disposition. Allowable values: 1. Home, 2. Hospice – Home, 3. Hospice – Health Care Facility, 4. Acute Care Facility, 5. Other Health Care Facility, 6. Expired, 7. Left Against Medical Advice/AMA, 8 Not Documented or Unable to Determine (UTD).

5. ICD-10-CM Other Diagnosis Codes- The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization.

6. ICD-10-CM Principal Diagnosis Code- The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

7. Number of Antipsychotic Medications Prescribed at Discharge- The number of routinely scheduled antipsychotic medications prescribed to the patient at discharge as documented in the medical record. Allowable values: 0-99, UTD (Unable to determine)

8. Patient Status at Discharge - Documentation in the medical record of the patient's status at the time the patient left the hospital-based inpatient psychiatric care setting. Allowable values: 1 The medical record contains documentation that the patient was discharged from the inpatient psychiatric care setting under these circumstances:

• Patient is leaving the psychiatric unit within the acute care hospital AND the hospital facility completely.

• Patient is leaving the freestanding inpatient psychiatric facility completely.

2 The medical record contains documentation of one of the following:

• The patient eloped and was discharged

• The patient failed to return from leave and was discharged

• The patient has not yet been discharged from the hospital

• The patient was transferred/discharged from the inpatient psychiatric unit in an acute care setting to another level of care, (i.e. medical unit), and subsequently discharged from that level of care

3 Unable to determine from medical record documentation.

9. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.

Populations: Discharges with Table 10.01 Mental Disorders in the Psychiatric Care Setting who were discharged on two or more routinely scheduled antipsychotic medications on Table 10.0.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Target population meets the following conditions:

1. Continuously enrolled in Medicare Part D with no more than a one-month gap in enrollment during the measurement period;

2. Continuously enrolled in Medicare Part A and Part B with no more than a one-month gap in Part A enrollment and no more than a one-month gap in Part B enrollment during the measurement period; and,

3. No more than one month of HMO (Health Maintenance Organization) enrollment during the measurement period.

IDENTIFICATION OF SCHIZOPHRENIA

Individuals with schizophrenia or schizoaffective disorder are identified by having a diagnosis of schizophrenia within the inpatient or outpatient claims data. Individuals must have:

At least two encounters with a diagnosis of schizophrenia or schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

At least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

CODES USED TO IDENTIFY SCHIZOPHRENIA OR SCHIZOAFFECTIVE DISORDER DIAGNOSIS

Codes used to identify schizophrenia or schizoaffective disorder are included in the attached excel worksheet of codes (NQF_1879_Code Tables_2018_Final.xlsx) under the tab NQF_1879_Schizophrenia.

Table 1: Schizophrenia or Schizoaffective Disorder Diagnosis

ICD-9-CM: 295.xx

ICD-10-CM: F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

CODES USED TO IDENTIFY ENCOUNTER TYPE:

Codes used to identify encounters are under tab NQF_1879_Encounter_types.

Table 2.1: Outpatient Setting

Current Procedural Terminology (CPT): 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99385-99387, 99395-99397, 99401-99404, 99411, 99412, 99429, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, G0463, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485, T1015

UB-92 revenue: 0510, 0511, 0513, 0516-0517, 0519-0523, 0526-0529, 0770, 0771, 0779, 0900-0905, 0907, 0911-0917, 0919, 0982, 0983

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 90880, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

Place of Service (POS): 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 24, 33, 49, 50, 52, 53, 71, 72

Table 2.2: Emergency Department Setting

CPT: 99281-99285

UB-92 revenue: 0450, 0451, 0452, 0456, 0459, 0981

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 23

Table 2.3: Non-Acute Inpatient Setting

CPT: 99304-99310, 99315, 99316, 99318, 99324-99328, 99334-99337

HCPCS: H0017-H0019, T2048

UB-92 revenue: 0118, 0128, 0138, 0148, 0158, 0190-0194, 0199, 0524, 0525, 0550-0552, 0559, 0660-0663, 0669, 1000, 1001, 1003-1005

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99291

WITH

POS: 31, 32, 56

Table 2.4: Acute Inpatient Setting

UB-92 revenue: 0100, 0101, 0110-0114, 0119-0124, 0129-0134, 0139-0144, 0149-0154, 0159, 0160, 0164, 0167, 0169, 0200-0204, 0206-0209, 0210-0214, 0219, 0720-0724, 0729, 0987

OR

CPT: 90791, 90792, 90832-90834, 90836-90840, 90845, 90847, 90849, 90853, 90863, 90867-90870, 90875, 90876, 99221-99223, 99231-99233, 99238, 99239, 99251-99255, 99291

WITH

POS: 21, 51

IDENTIFICATION OF PRESCRIPTION DRUG CLAIMS FOR ANTIPSYCHOTIC MEDICATION:

Individuals with at least two prescription drug claims for any of the following oral antipsychotic medications (Table 3: Oral Antipsychotic Medications) or long-acting injectable antipsychotic medications (see Table 4: Long-acting injectable antipsychotic medications). The National Drug Center (NDC) identifier for medications included in the measure denominator are listed in tab NQF_1879_ Antipsychotics of the attached excel workbook. Obsolete drug products are excluded from National Drug Codes (NDCs) with an inactive date more than six years prior to the beginning of the measurement period or look-back period.

TABLE 3: ORAL ANTIPSYCHOTIC MEDICATIONS

The following are oral formulations only.

Typical Antipsychotic Medications:

chlorpromazine

fluphenazine

haloperidol

loxapine

molindone

perphenazine

prochlorperazine

thioridazine

thiothixene

trifluoperazine

Atypical Antipsychotic Medications:

aripiprazole

asenapine

brexpiprazole

cariprazine

clozapine

iloperidone

lurasidone

olanzapine

paliperidone

quetiapine

quetiapine fumarate (Seroquel)

risperidone

ziprasidone

Antipsychotic Combinations:

perphenazine-amitriptyline

TABLE 4: LONG-ACTING INJECTABLE ANTIPSYCHOTIC MEDICATIONS

The following are the long-acting (depot) injectable antipsychotic medications by class for the denominator. The route of administration includes all injectable and intramuscular formulations of the medications listed below.

Typical Antipsychotic Medications:

fluphenazine decanoate (J2680)

haloperidol decanoate (J1631)

Atypical Antipsychotic Medications:

aripiprazole (J0401)

aripiprazole lauroxil (Aristada)

olanzapine pamoate (J2358)

paliperidone palmitate (J2426)

risperidone microspheres (J2794)

Note: Since the days' supply variable is not reliable for long-acting injections in administrative data, the days' supply is imputed as listed below for the long-acting (depot) injectable antipsychotic medications billed under Medicare Part D and Part B:

fluphenazine decanoate (J2680) – 28 days' supply

haloperidol decanoate (J1631) – 28 days' supply

aripiprazole (J0401) – 28 days' supply

aripiprazole lauroxil (Aristada) - 28 days' supply

olanzapine pamoate (J2358) – 28 days' supply

paliperidone palmitate (J2426) – 28 days' supply

risperidone microspheres (J2794) – 14 days' supply

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Exclude children and adolescents in hospice.

Children and adolescents age 1-17 as of December 31 of the measurement year (January 1 – December 31) who had a new prescription for an antipsychotic medication (antipsychotic Medications List; Antipsychotic Combination Medications List) during the intake period (January 1 through December 1 of the measurement year).

Miscellaneous antipsychotic agents: Aripiprazole; Asenapine; Brexpiprazole; Cariprazine; Clozapine; Haloperidol; Iloperidone; Loxapine; Lurisadone; Molindone; Olanzapine; Paliperidone; Pimozide; Quetiapine; Quetiapine fumarate; Risperidone; Ziprasidone

Phenothiazine antipsychotics: Cholpromazine; Fluphenazine; Perphenazine; Prochloperazine; Thioridazine; Trifluoperazine

Thioxanthenes: Thiothixene

Long-acting injections: Aripiprazole; Fluphenazine decanoate; Haloperidol Decanoate; Olanzapine; Paliperidone palmitate; Risperidone

Antipsychotic Combinations Medications List

Psychotherapeutic combinations: Fluoxetine-olanzapine; Perphenazine-amitriptyline

3205: Medication Continuation Following Inpatient Psychiatric Discharge

The denominator for this measure includes patients discharged from an IPF:

1. With a principal diagnosis of MDD, schizophrenia, or bipolar disorder (ICD codes provided below).

2. 18 years of age or older at admission.

3. Enrolled in Medicare fee-for-service Part A and Part B during the index admission and Parts A, B, and D at least 30-days post-discharge.

4. Alive at discharge and alive during the follow-up period.

5. With a discharge status code indicating that they were discharged to home or home health care.

ICD-10-CM codes to identify MDD, schizophrenia, and bipolar disorder:

MDD

F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.9

Schizophrenia

F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89, F20.9, F25.0, F25.1, F25.8, F25.9

Bipolar disorder

F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4, F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13, F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60, F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72, F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81, F31.89, F31.9, F32.81, F32.89

Exclusions

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

- Patients who expired
- Patients with an unplanned departure resulting in discharge due to elopement
- Patients with an unplanned departure resulting in discharge due to failing to return from leave
- Patients with a length of stay less than or equal to 3 days

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia during the measurement period.

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Patients in hospice.

Exclude children and adolescents with a diagnosis of a condition for which antipsychotic medications have a U.S. Food and Drug Administration indication and are thus clinically appropriate: schizophrenia, bipolar disorder, psychotic disorder, autism, tic disorders.

3205: Medication Continuation Following Inpatient Psychiatric Discharge

The denominator for this measure excludes discharged patients who:

1. Received ECT during the inpatient stay or follow-up period.
2. Received TMS during the inpatient stay or follow-up period.
3. Were pregnant during the inpatient stay.
4. Had a secondary diagnosis of delirium.
5. Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia.

Exclusion Details

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

• Patients who expired are identified by the data element Discharge Disposition.

• Patients with an unplanned departure resulting in discharge due to elopement, failing to return from leave are identified by the data element Patient Status at Discharge.

• Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is equal to or less than 3 days the patient is excluded.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Individuals with any diagnosis of dementia are identified with the diagnosis codes listed below tab NQF_1879_Dementia

Table 5: Codes Used to Identify Dementia

ICD-9-CM: 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 291.2, 292.82, 294.10, 294.11, 294.20, 294.21, 330.1, 331.0, 331.19, 331.82

ICD-10-CM: E75.00, E75.01, E75.02, E75.09, E75.10, E75.11, E75.19, E75.4, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F10.27, F11.122, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, G30.0, G30.1, G30.8, G30.9, G31.09, G31.83

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

Exclude children and adolescents for whom first-line antipsychotic medications may be clinically appropriate. Any of the following during the measurement year (January 1 – December 31) meet criteria:

Children and adolescents who have at least one acute inpatient encounter with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations meet criteria:

-BH Stand Alone Acute Inpatient Value Set with Schizophrenia Value Set.
-BH Stand Alone Acute Inpatient Value Set with Bipolar Disorder Value Set.
-BH Stand Alone Acute Inpatient Value Set with Other Psychotic Disorders Value Set.
-BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Schizophrenia Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
– BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Bipolar Disorder Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
– BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set with Other Psychotic Disorders Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
– BH Acute Inpatient Value Set with Telehealth POS Value Set with Schizophrenia Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
– BH Acute Inpatient Value Set with Telehealth POS Value Set with Bipolar Disorder Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
– BH Acute Inpatient Value Set with Telehealth POS Value Set with Other Psychotic Disorders Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
• At least two
Children and adolescents who have at least two visits in an outpatient, intensive outpatient or partial hospitalization setting, on different dates of service, with a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder during the measurement year. Any of the following code combinations with or without a telehealth modifier (Telehealth Modifier
Value Set), meet criteria:
-
– BH Stand Alone Outpatient/PH/IOP Value Set with Schizophrenia Value Set.
– BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Schizophrenia Value Set.
– BH Stand Alone Outpatient/PH/IOP Value Set with Bipolar Disorder Value Set.
– BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Bipolar Disorder Value Set.
– BH Stand Alone Outpatient/PH/IOP Value Set with Other Psychotic Disorders Value Set.
– BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set with Other Psychotic Disorders Value Set.
- BH Outpatient/PH/IOP Value Set with Telehealth POS Value Set with Schizophrenia Value Set.
- BH Outpatient/PH/IOP Value Set with Telehealth POS Value Set with Bipolar

Disorder Value Set.

-BH Outpatient/PH/IOP Value Set with Telehealth POS Value Set with Other Psychotic Disorders Value Set.

See attachment for all value sets (S.2b).

3205: Medication Continuation Following Inpatient Psychiatric Discharge

1. ECT During Inpatient Stay or Follow-Up Period

Rationale: Some patients who receive ECT during the inpatient stay or follow-up period may have failed pharmacotherapy and would not fill an evidence-based prescription post-discharge.

Source: Identified from Part A and Part B claims data if treatment occurred on a date between the admission date and 30 days post-discharge.

2. TMS During Inpatient Stay or Follow-Up Period

Rationale: Some patients who receive TMS during the inpatient stay or follow-up period may have failed pharmacotherapy and would not fill an evidence-based prescription post-discharge.

Source: Identified from Part A and Part B claims data if treatment occurred on a date between the admission date and 30 days post-discharge.

3. Pregnant During Inpatient Stay

Rationale: Some of the evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder are contraindicated during pregnancy.

Source: Identified from Part A claims data from the index admission.

4. Secondary Diagnosis of Delirium

Rationale: Some of the evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder are contraindicated for patients with delirium.

Source: Identified from Part A claims data from the index admission.

5. Principal Diagnosis of Schizophrenia with Secondary Diagnosis of Dementia

Rationale: APA Practice guidelines suggest caution in the use of antipsychotics in dementia patients so not all dementia patients would fill an evidence-based medication (antipsychotic) following discharge for schizophrenia.

Source: Identified from Part A claims data from the index admission.

Risk Adjustment

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

No risk adjustment or risk stratification

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

No risk adjustment or risk stratification

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

No risk adjustment or risk stratification

3205: Medication Continuation Following Inpatient Psychiatric Discharge

No risk adjustment or risk stratification

Stratification

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

The measure is stratified by the following age groups:

• Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years

• Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years

• Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years

• Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Depending on the operational use of the measure, measure results can be stratified by:

• State

• Physician Group*

• Age – Divided into six categories: 18-24, 25-44, 45-64, 65-74, 75-84, and 85+ years

• Race/Ethnicity

• Dual Eligibility

*See Calculation Algorithm/Measure Logic S.14 below for physician group attribution methodology used for this measure.

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Report three age stratifications and a total rate:

1–5 years.

6–11 years.

12–17 years.

Total (sum of the age stratifications).

3205: Medication Continuation Following Inpatient Psychiatric Discharge

The measure is not stratified.

Type Score

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

Rate/proportion better quality = higher score

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Rate/proportion better quality = higher score

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Rate/proportion better quality = higher score

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Rate/proportion better quality = higher score

Algorithm

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

1. Run cases that are included in the Initial Patient Population for HBIPS-1,5 and pass the edits defined in the Transmission Data Processing Flow: Clinical through this measure.

2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.

3. Check Length of Stay

a. If Length of Stay is less than or equal 3 days, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

b. If Length of Stay is greater than 3 days, continue processing and proceed to Discharge Status.

4. Check Discharge Disposition

a. If Discharge Disposition is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure.

b. If Discharge Disposition equals 6, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

C. Discharge Disposition equals 1, 2, 3, 4, 5, 7, or 8, continue processing and proceed to Psychiatric Care Setting.

5. Check Psychiatric Care Setting

a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Cat Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

b. If Psychiatric Care Setting is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure.

c. If Psychiatric Care Setting equals Yes, the case will proceed to Patient Status at Discharge.

6. Check Patient Status at Discharge

a. If Patient Status at Discharge is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure.

b. If Patient Status at Discharge equals 2, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population.

Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

c. If Patient Status at Discharge equals 1 or 3, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge.

7. Check Number of Antipsychotic Medications Prescribed at Discharge

a. If Number of Antipsychotic Medications Prescribed at Discharge is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure.

b. If Number of Antipsychotic Medications Prescribed at Discharge is less than or equal 1, the case will proceed to a Measure Category Assignment of B for Overall Rate (HBIPS-5a) and will not be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

c. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2 or equal UTD, the case will continue processing and proceed to Number of Antipsychotic Medications Prescribed at Discharge.

8. Check Number of Antipsychotic Medications Prescribed at Discharge

a. If Number of Antipsychotic Medications Prescribed at Discharge equals UTD, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-5a) and will be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

b. If Number of Antipsychotic Medications Prescribed at Discharge is greater than or equal 2, the case will proceed to Appropriate Justification for Multiple Antipsychotic Medications.

9. Check Appropriate Justification for Multiple Antipsychotic Medications

a. If Appropriate Justification for Multiple Antipsychotic Medications is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-5a) and will be rejected. Continue processing and proceed to step 10 and Initialize the Measure Category Assignment for each strata measure.

b. If Appropriate Justification for Multiple Antipsychotic Medications equals 4 or 5, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-5a) and will be in the measure population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

c. If Appropriate Justification for Multiple Antipsychotic Medications equals 1, 2 or 3, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-5a) and will be in the numerator population. Continue processing and proceed to step 10 and initialize the Measure Category Assignment for each strata measure.

10. Initialize the Measure Category Assignment for each strata measure (b-e) = 'B'. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-5a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate's (HBIPS-5a) Measure Category Assignment.

11. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals B, Set the Measure Category Assignment for the strata measures (HBIPS-5b through HBIPS-5e) = 'B'. Stop processing.

b. If Overall Rate Category Assignment equals D or E or X, continue processing and proceed to Patient Age at Discharge.

12. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-5b = Measure Category Assignment for measure HBIPS-5a. Stop processing.

b. If is greater than or equal 13 years, continue processing and proceed to Patient Age at Discharge.

13. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-5c = Measure Category Assignment for measure HBIPS-5a. Stop processing.

b. If Patient Age at Discharge is greater than or equal 18 years, continue processing and proceed to Patient Age at Discharge.

14. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-5d = Measure Category Assignment for measure HBIPS-5a. Stop processing.

b. If Patient Age at Discharge is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-5e = Measure Category Assignment for measure HBIPS-5a. Stop processing.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Target Population: Individuals at least 18 years of age as of the beginning of the measurement period who have met the enrollment criteria for Medicare Parts A, B, and D.

Denominator: Individuals at least 18 years of age as of the beginning of the measurement period with schizophrenia or schizoaffective disorder and at least two prescription drug claims for antipsychotic medications during the measurement period (12 consecutive months).

CREATE DENOMINATOR:

1. Pull individuals who are 18 years of age or older as of the beginning of the measurement period.

2. Include individuals who were continuously enrolled in Medicare Part D coverage during the measurement period, with no more than a one-month gap in enrollment during the measurement period, or up until their death date if they died during the measurement period.

3. Include individuals who had no more than a one-month gap in Medicare Part A enrollment, no more than a one-month gap in Part B enrollment, and no more than one month of HMO (Health Maintenance Organization) enrollment during the current measurement period (fee-for-service [FFS] individuals only).

4. Of those individuals identified in Step 3, keep individuals who had:

At least two encounters with a diagnosis of schizophrenia of schizoaffective disorder with different dates of service in an outpatient setting, emergency department setting, or non-acute inpatient setting during the measurement period;

OR

Individuals who had at least one encounter with a diagnosis of schizophrenia or schizoaffective disorder in an acute inpatient setting during the measurement period.

5. For the individuals identified in Step 4, extract Medicare Part D claims for any antipsychotic medication during the measurement period. Attach the generic name and the drug ID to the dataset.

6. Of the individuals identified in Step 5, exclude those who did not have at least two prescription drug claims for any antipsychotic medication on different dates of service (identified by having at least two Medicare Part D claims with the specific codes) during the measurement period.

7. Exclude those individuals with a diagnosis of dementia during the measurement period.

Numerator: Individuals with schizophrenia or schizoaffective disorder who had at least two prescription drug claims for antipsychotic medications and have a PDC of at least 0.8 for antipsychotic medications.

CREATE NUMERATOR:

For the individuals in the denominator, calculate the PDC for each individual according to the following methods:

1. Determine the individual's medication therapy period, defined as the number of days from the index prescription date through the end of the measurement period, or death, whichever comes first. The index date is the service date (fill date) of the first prescription drug claim for an antipsychotic medication in the measurement period.

2. Within the medication therapy period, count the days the individual was covered by at least one drug in the antipsychotic medication class based on the prescription drug claim service date and days of supply.

a. Sort and de-duplicate Medicare Part D antipsychotic medication claims by beneficiary ID, service date, generic name, and descending days' supply. If prescriptions for the same drug (generic name) are dispensed on the same date of service for an individual, keep the dispensing with the largest days' supply.

b. Calculate the number of days covered by antipsychotic drug therapy per individual.

i. For prescription drug claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

ii. If claims for the same drug (generic name) overlap, then adjust the prescription start date to be the day after the previous fill has ended.

iii. If claims for different drugs (different generic names) overlap, do not adjust the prescription start date.

3. Calculate the PDC for each individual. Divide the number of covered days found in Step 2 by the number of days in the individual's medication therapy period found in Step 1.

An example of SAS code for Steps 1-3 was adapted from Pharmacy Quality Alliance (PQA) and is available at the URL: http://www2.sas.com/proceedings/forum2007/043-2007.pdf.

4. Of the individuals identified in Step 3, count the number of individuals with a calculated PDC of at least 0.8 for the antipsychotic medications. This is the numerator.

PHYSICIAN GROUP ATTRIBUTION:

Physician group attribution was adapted from Generating Medicare Physician Quality Performance Measurement Results (GEM) Project: Physician and Other Provider Grouping and Patient Attribution Methodologies (http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/GEM/downloads/GEMMethodologies.pdf). The following is intended as guidance and reflects only one of many methodologies for assigning individuals to a medical group. Please note that the physician group attribution methodology excludes patients who died, even though the overall measure does not.

I. Identify Physician and Medical Groups

1. Identify all Tax Identification Numbers (TINs)/National Provider Identification (NPIs) combinations from all Medicare Part B claims in the measurement year and the prior year. Keep records with valid NPI. Valid NPIs have 10 numeric characters (no alpha characters).

2. For valid NPIs, pull credentials and specialty code(s) from the CMS provider tables.

3. Create one record per NPI with all credentials and all specialties. A provider may have more than one specialty.

4. Attach TIN to NPI, keeping only those records with credentials indicating a physician (MD or DO), physician assistant (PA), or nurse practitioner (NP).

5. Identify medical group TINs: Medical group TINs are defined as TINs that had physician, physician assistant, or nurse practitioner provider specialty codes on at least 50% of Medicare Part B carrier claim line items billed by the TIN during the measurement year or prior year. (The provider specialty codes are listed after Patient Attribution.)

a. Pull Part B records billed by TINS identified in Step 4 during the measurement year and prior year.

b. Identify claims that had the performing NPI (npi_prfrmg) in the list of eligible physicians/TINs, keeping those that match by TIN, performing NPI, and provider state code.

c. Calculate the percentage of Part B claims that match by TIN, npi_prfrmg, and provider state code for each TIN, keeping those TINs with percentages greater than or equal to 50%.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

6. Identify TINs that are not solo practices.

a. Pull Part B records billed by physicians identified in Step 4 for the measurement year and/or prior year.

b. Count unique NPIs per TIN.

c. Keep only those TINs having two or more providers.

d. Delete invalid TINs. Examples of invalid TINs are defined as having the same value for all nine digits or values of 012345678, 012345678, 123456789, 987654321, or 87654321.

7. Create final group of TINs from Step 5 and Step 6 (TINs that are medical groups and are not solo practices).

8. Create file of TINs and NPIs associated with those TINs. These are now referred to as the medical group TINs.

9. Determine the specialty of the medical group (TIN) to be used in determining the specialty of nurse practitioners and physician assistants. The plurality of physician providers in the medical group determines the specialty of care for nurse practitioners and physician assistants.

a. From the TIN/NPI list created in Step 8, count the NPIs per TIN/specialty.

b. The specialty with the maximum count is assigned to the medical group.

II. Identify Individual Sample and Claims

10. Create individual sample.

a. Pull individuals with 11+ months of Medicare Parts A, B, and D during the measurement year.

b. Verify the individual did not have any months with Medicare as secondary payer. Remove individuals with BENE_PRMRY_PYR_CD not equal to one of the following:

• A = working-age individual/spouse with an employer group health plan (EGHP)

• B = End Stage Renal Disease (ESRD) in the 18-month coordination period with an EGHP

• G = working disabled for any month of the year

c. Verify the individual resides in the U.S., Puerto Rico, Virgin Islands, or Washington D.C.

d. Exclude individuals who enter the Medicare hospice at any point during the measurement year.

e. Exclude individuals who died during the measurement year.

11. For individuals identified in Step 10, pull office visit claims that occurred during the measurement year and in the six months prior to the measurement year.

a. Office visit claims have CPT codes of 99201-99205, 99211-99215, and 99241-99245.

b. Exclude claims with no npi_prfrmg.

12. Attach medical group TIN to claims by NPI.

III. Patient Attribution

13. Pull all Medicare Part B office claims from Step 12 with specialties indicating primary care or psychiatry (see list of provider specialties and specialty codes below). Attribute each individual to at most one medical group TIN for each measure.

a. Evaluate specialty on claim (HSE_B_HCFA_PRVDR_SPCLTY_CD) first. If specialty on claim does not match any of the measure-specific specialties, then check additional specialty fields.

b. If the provider specialty indicates nurse practitioners or physician assistants (code 50 or code 97), then assign the medical group specialty determined in Step 9.

14. For each individual, count claims per medical group TIN. Keep only individuals with two or more E&M claims.

15. Attribute individual to the medical group TIN with the most claims. If a tie occurs between medical group TINs, attribute the TIN with the most recent claim.

16. Attach the medical group TIN to the denominator and numerator files by individual.

Provider Specialties and Specialty Codes

Provider specialties and specialty codes include only physicians, physician assistants, and nurse practitioners for physician grouping, TIN selection, and patient attribution. The provider specialty codes and the associated provider specialty are shown below:

01—General practice*

02—General surgery

03—Allergy/immunology

04—Otolaryngology

05—Anesthesiology
06—Cardiology
07—Dermatology
08—Family practice*
09—Interventional pain management
10—Gastroenterology
11—Internal medicine*
12—Osteopathic manipulative therapy
13—Neurology
14—Neurosurgery
16—Obstetrics/gynecology*
18—Ophthalmology
20—Orthopedic surgery
22—Pathology
24—Plastic and reconstructive surgery
25—Physical medicine and rehabilitation
26—Psychiatry*
28—Colorectal surgery
29—Pulmonary disease
30—Diagnostic radiology
33—Thoracic surgery
34—Urology
37—Nuclear medicine
38—Geriatric medicine*
39—Nephrology
39—Pediatric medicine
40—Hand surgery
44—Infectious disease
46—Endocrinology
50—Nurse practitioner*
66—Rheumatology
70—Multi-specialty clinic or group practice*
72—Pain management
76—Peripheral vascular disease
77—Vascular surgery
78—Cardiac surgery
79—Addiction medicine
81—Critical care (intensivists)
82—Hematology

83—Hematology/oncology

84—Preventive medicine*

85—Maxillofacial surgery

86—Neuropsychiatry*

90—Medical oncology

91—Surgical oncology

92—Radiation oncology

93—Emergency medicine

94—Interventional radiology

97—Physician assistant*

98—Gynecologist/oncologist

99—Unknown physician specialty

Other—NA

*Provider specialty codes specific to this measure 119011| 120823| 140881| 123834| 141592| 141015| 142428

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

Step 1: Determine the eligible population, or the denominator, by identifying the number of children and adolescents in the specified age range who were dispensed an antipsychotic medication (Table APP-A) during the intake period (January 1 – December 1).

Step 2: Exclude those who did not have a negative medication history and who have a diagnosis for which antipsychotic medications are clinically appropriate (see S.10).

Step 3: Determine the numerator by identifying the number of children and adolescents in the eligible population who had documentation of psychosocial care in the 121-day period from 90 days prior through 30 days after the new prescription of an antipsychotic.

Step 4: Divide the numerator by the denominator to calculate the rate.

3205: Medication Continuation Following Inpatient Psychiatric Discharge

Denominator:

1. Pull all IPF discharges from the Part A data.

2. Include IPF discharges for patients who were at least 18 years of age at admission.

3. Identify interim claims having the same beneficiary, provider, admission dates or having an admission date within 1 day of the discharge date of the previous claim and having a discharge status code of “Still patient.” Collapse or combine the interim claims into one hospital stay using the admission date from the earliest claim and the discharge date from the latest claim. The data values from the latest claim are used for the newly combined hospital stay.

4. De-duplicate the IPF inpatient discharges dataset by Patient ID, Sex, Provider ID, Admission Date, and Discharge Date.

5. Remove the IPF inpatient discharges for patients who do not have Part A and Part B coverage at admission, during the entire stay, at discharge, and during the 30 days post-discharge.

6. Remove the IPF inpatient discharges that do not have a principal diagnosis of MDD, bipolar disorder, or schizophrenia using value sets containing ICD-10 codes for each of the disease conditions.

7. Remove the IPF inpatient discharges for patients who expired during the hospital stay or within 30 days of discharge.

8. Remove the IPF inpatient discharges for patients who do not have Part D coverage during the 30 days post-discharge.

9. Remove the IPF inpatient discharges for patients who were not discharged to home or home health.

10. Exclude IPF inpatient discharges with a secondary diagnosis of pregnancy or delirium.

11. Exclude IPF inpatient discharges having schizophrenia as the principal diagnosis with a secondary diagnosis of dementia.

12. Exclude IPF inpatient discharges with ECT or TMS during the hospital stay or within 30 days post-discharge.

Numerator:

1. Pull all Part D claims for the evidence-based medications used for the treatment of MDD, schizophrenia, and bipolar disorder.

2. Pull all Part A and Part B claims for antipsychotic long-acting injectables (LAIs) and add them to the Part D medication claims for schizophrenia and bipolar disorder.

3. Compare the medication claims to the denominator file of eligible IPF inpatient discharges and remove any claims that occur more than 2 days prior to the discharge date.

4. Determine which claims occur within the follow-up period (2 days prior to discharge through 30 days post-discharge) for each of the 3 disease conditions.

5. Total the denominator cases having at least one medication claim corresponding to the disease condition during the follow-up period.

Submission items

0560: HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable

5b.1 If competing, why superior or rationale for additive value: Not applicable

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia

5.1 Identified measures: 0541 : Proportion of Days Covered (PDC): 3 Rates by Therapeutic Category

0542 : Adherence to Chronic Medications

0543 : Adherence to Statin Therapy for Individuals with Cardiovascular Disease

0544 : Use and Adherence to Antipsychotics among members with Schizophrenia

0545 : Adherence to Statins for Individuals with Diabetes Mellitus

0569 : ADHERENCE TO STATINS

1880 : Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure specifications are harmonized with the related measure, Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder (NQF #1880), where possible. The methodology used to calculate adherence in these measures is proportion of days covered (PDC) which is calculated the same in both measures. The methodology used to identify the denominator population is also calculated the same in both measures with the exception of the clinical conditions which is the target of the measure. The medications included in both measures are specific to the clinical condition targeted in the measure.

5b.1 If competing, why superior or rationale for additive value: The Adherence to Antipsychotic Medications for Individuals with Schizophrenia (NCQA) measure is used for HEDIS reporting and is harmonized with the NQF #1879 in condition, target population, methodology, and medications. The HEDIS measure is only used in Medicaid health plans and therefore is restricted to adults age 18-64.

During development the measure developers identified another competing measure which eventually lost NQF endorsement. The section below is from the original submission of the measures for initial endorsement and compares this measure (#1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia) to a previously NQF-endorsed measure (#0544 Use and Adherence to Antipsychotics among Members with Schizophrenia).

Measure 1879 (Adherence to Antipsychotic Medications for Individuals with Schizophrenia) has both the same measure focus and essentially the same target population as Measure 0544 (Use and Adherence to Antipsychotics among Members with Schizophrenia), which is no longer endorsed after the measure's time-limited endorsement (TLE) status expired. Measure 1879 is superior to the existing Measure 0544 because it represents a more valid and efficient approach to measuring medication adherence to antipsychotic medications. In addition, as discussed above in Section 5a.2, Measure 1879 is harmonized with several other adherence measures in the NQF portfolio. Key differences in measure validity and efficiency are addressed in the sections below.

VALIDITY

The Proportion of Days Covered (PDC), which is the method used to calculate adherence in Measure 1879, has several advantages over the Medication Possession Ratio (MPR), which is used in Measure 0544. First, the PDC was found to be more conservative compared to the Medication Possession Ratio (MPR) and was preferred in clinical scenarios in which there is the potential for more than one drug to be used within a drug class concomitantly (e.g., antipsychotics). This clinical situation applies directly to Measure 1879. Martin et al. (2009) demonstrated this in a study published in the Annals of Pharmacotherapy by comparing the methodology for drugs that are commonly switched, where the MPR was 0.690, truncated MPR was 0.624, and PDC was 0.562 and found significant differences between the values for adherence ($p < 0.001$). Martin et al (2009) also compared drugs with therapeutic duplication where the PDC was 0.669, truncated MPR was 0.774, and MPR was 1.238, and again obtained significant differences ($p < 0.001$). These findings were partially replicated by testing results from FMQAI (now HSAG) of Measure 1879 where MPR produced a higher measure rate (as compared to PDC) as shown below.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Method Measure Rate

Comparison of MPR and PDC

Method Measure Rate

MPR 74.4%

PDC 70.0%

Based on initial draft measure specifications and data from a 100% sample of Medicare fee-for-service beneficiaries

with Part D coverage in Florida and Rhode Island, using 2008 Medicare Parts A, B, and D data.

Additional differences between Measure 1879 and TLE 0544 related to validity include the following concerns:

Denominator: The measure denominator requires at least two antipsychotic medication prescriptions; whereas, the NQF TLE measure (NQF# 0544) does not require any antipsychotic medication prescriptions in the measure denominator. In 0544, an MPR of "0" is assigned to those without any antipsychotic medication prescriptions, which may falsely lower measure rates, specifically in scenarios where the prescriber has made the decision not to prescribe antipsychotic medications for an individual diagnosed with schizophrenia.

Exclusion related to a diagnosis of dementia: Measure 1879 excludes individuals with a diagnosis of dementia during the measurement year which is not considered in Measure 0544. Antipsychotic medications are currently labeled with a Food and Drug Administration (FDA) Black Box warning that states, "Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of seventeen placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients." The Technical Expert Panel, which reviewed the measure, recommended excluding these individuals from the measure denominator, since continued adherence to antipsychotic medications in this subpopulation may increase mortality and not represent quality of care. (Please see Section 2b3.2 that provides descriptive results of testing related to exclusions.)

EFFICIENCY

Measure 1879 requires only one year of administrative claims data, rather than two years of data which is required for TLE 0544. The Technical Expert Panel that reviewed Measure 1879 indicated that the burden of requiring two years of administrative claims data would not meaningfully modify measure rates and would potentially result in the unnecessary exclusion of individuals for which adherence should be assessed but for which only 1 year of claims data were available. Additional rationale for this TEP recommendation was related to an increased length of the continuous enrollment criteria to specify the measure use with two years of data. FMQAI's (now HSAG) empirical analysis of a related adherence measure (NQF 0542 – Adherence to Chronic Medications) using 2007 and 2008 Medicare Part D data for beneficiaries in Florida and Rhode Island validated this concern and indicated that approximately 10% of the eligible population would be excluded from the measure if the enrollment criteria required two years of administrative claims data as opposed to one year.

2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

5.1 Identified measures: 2337 : Antipsychotic Use in Children Under 5 Years Old

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: This new measure assesses receipt of psychosocial care among children and adolescents who are prescribed antipsychotics without a primary indication. Both measures address use of antipsychotics. However, 2337 assesses if children under 5 are prescribed an antipsychotic. Our Psychosocial Care measure assesses children of a broader age range (up to age 18) who are currently on antipsychotics but do not have a primary indication. Our measure also addresses a different focus: whether these children received first-line psychosocial care.

5b.1 If competing, why superior or rationale for additive value: N/A

3205: Medication Continuation Following Inpatient Psychiatric Discharge

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Not applicable because there are no related measures.

5b.1 If competing, why superior or rationale for additive value: Not applicable because there are no competing measures.

Comparison of NQF 0640 and 0687

0640 HBIPS-2 Hours of physical restraint use

0687 Percent of Residents Who Were Physically Restrained (Long Stay)

Steward

0640: HBIPS-2 Hours of physical restraint use

The Joint Commission

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Centers for Medicare & Medicaid Services

Description

0640: HBIPS-2 Hours of physical restraint use

The total number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint.

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

The measure reports the percentage of all long-stay residents who were physically restrained daily during the 7 days prior to the target MDS 3.0 assessment (OBRA, PPS or discharge) during their episode of nursing home care ending in the target quarter (3-month period). Long-stay residents are identified as residents who have had at least 101 cumulative days of nursing facility care.

Type

0640: HBIPS-2 Hours of physical restraint use

Process

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Process

Data Source

0640: HBIPS-2 Hours of physical restraint use

Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

No data collection instrument provided Attachment HBIPS_Code_Tables-636794265307530611.xlsx

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Electronic Health Record (Only) Nursing Home Minimum Data Set 3.0

Available in attached appendix at A.1 No data dictionary

Level

0640: HBIPS-2 Hours of physical restraint use

Facility, Other

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Facility

Setting

0640: HBIPS-2 Hours of physical restraint use

Inpatient/Hospital

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Nursing Home / SNF

Numerator Statement

0640: HBIPS-2 Hours of physical restraint use

The total number of hours that all psychiatric inpatients were maintained in physical restraint.

Numerator Basis: The numerator evaluates the number of hours of physical restraint; however, the algorithm calculates the number of minutes to ensure a more accurate calculation of the measure. Convert the minutes to hours when analyzing and reporting this measure.

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

The numerator is the number of long-stay residents with a selected target Minimum Data Set (MDS) assessment (assessments may be OBRA, PPS or discharge) who have experienced daily physical restraint usage during the 7 days prior to the selected assessment, as indicated by MDS 3.0, Section P, Item P0100, subitems B (P0100B – Trunk restraint used in bed), C (P0100C – Limb restraint used in bed), E (P0100E – Trunk restraint used in chair or out of bed), F (P0100F – Limb restraints used in chair or out of bed), or G (P0100G – Chair prevents rising).

Numerator Details

0640: HBIPS-2 Hours of physical restraint use

Three data elements are used to calculate the numerator:

1. Event Date* - The month, day and year of the event.

2. Event Type* - The measure-related event being identified. Allowable values: 1. Physical Restraint 2. Seclusion

3. Minutes of Physical Restraint - The total minutes recorded in the medical record that a patient was maintained in Event Type 1 (physical restraint(s)) for the associated Event Date. Allowable values 1-1440 minutes

*The data elements Event Date and Event Type are used for both HBIPS-2 (Hours of Physical Restraint Use) and HBIPS-3: Hours of Seclusion Use).

Patients are eligible for the numerator population when a physical restraint event occurs.

A physical restraint is any manual method or physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms,

legs, body or head freely when it is used as a restriction to manage a patient's behavior or restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. This definition is noted in the data element Minutes of Physical Restraint included with the submission.

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Residents are counted if they are long-stay residents, defined as residents whose cumulative length of stay is 101 days or more. Residents who return to the nursing home following a hospital discharge may not have their stay count within the episode of care reset to zero. Residents are counted if any of the following items on the target assessment are coded as "2", meaning that the physical restraint was used daily during the 7 days prior to the assessment: P0100B- Trunk restraint used in bed, P0100C-Limb restraint used in bed, P0100E- Trunk restraint used in chair or out of bed, P0100F-Limb restraint used in chair or out of bed, or P0100G-Chair prevents rising. Target assessments may be an OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, or 90-day assessments (A0310B = 01, 02, 03, 04, 05) or discharge assessment with or without return anticipated (A0310F = 10, 11).

Denominator Statement

0640: HBIPS-2 Hours of physical restraint use

Number of psychiatric inpatient days

Denominator basis: per 1,000 hours

To compute this measure rate, a base of 1000 hours has been applied to total patient days in the denominator (i.e., total patient days are divided by 1000). The purpose of this is to create a smaller denominator number, thus providing a more understandable rate. When multiplied by 1000, this rate measures numerator occurrence per total patient days.

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

The denominator is the total number of all long-stay residents in the nursing facility who have a target OBRA, PPS or discharge MDS 3.0 assessment during the selected quarter and who do not meet the exclusion criteria.

Denominator Details

0640: HBIPS-2 Hours of physical restraint use

Seven data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.

2. Birthdate - The month, day and year the patient was born.

3. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.

4. Psychiatric Inpatient Days - Medicare Only* - The sum of the number of days each Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

5. Psychiatric Inpatient Days – Non-Medicare Only* - The sum of the number of days each non-Medicare patient was included in the psychiatric inpatient census during the month (includes clients on leave status).

6. Total Leave Days - Medicare Only* - The aggregate number of leave days for Medicare patients during the month.

7. Total Leave Days – Non-Medicare Only* - The aggregate number of leave days for non-Medicare patients during the month.

* The distinction between Medicare and Non-Medicare was added to account for the adoption of the HBIPS measures by the Centers for Medicare and Medicaid Services (CMS) Inpatient Psychiatric Facilities Quality Reporting Program

Populations: All psychiatric inpatient days.

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Residents are counted if they are long-stay residents defined as residents whose length of stay is 101 days or more. Residents who return to the nursing home following a hospital discharge may not have their day count within the episode of care reset to zero. The population includes all long-stay residents with a target MDS 3.0 , except those with exclusions. . Target assessments may be an OBRA admission, quarterly, annual or significant change/correction assessments (A0310A = 01, 02, 03, 04, 05, 06) or PPS 5-, 14-, 30-, 60-, or 90-day assessments (A0310B = 01, 02, 03, 04, 05) or discharge assessment with or without return anticipated (A0310F = 10, 11).

Exclusions

0640: HBIPS-2 Hours of physical restraint use

Total leave days

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

A resident is excluded from the denominator if there is missing data in any of the responses to the relevant questions in the MDS (P0100B= -, or P0100C= -, or P0100E= -, or P0100F= -, or P0100G= -).

If the facility sample includes fewer than 30 residents, then the facility is excluded from public reporting.

Exclusion Details

0640: HBIPS-2 Hours of physical restraint use

• Patients who are on leave defined as an authorized or unauthorized absence of the patient from a psychiatric care setting, excluding discharges, during which the patient is absent from the psychiatric care setting at the time of the daily census and is not under the direct supervision of psychiatric care setting staff while absent.

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

The assessment is excluded if the resident is not in the numerator and there are missing values for any of the items in the numerator, i.e., P0100B = [-], Trunk restraint used in bed; P0100C = [-], Limb restraint used in bed; P0100E =[-], Trunk restraint used in chair or out of bed; P0100F =[-], Limb restraint used in chair or out of bed; or P0100G =[-], Chair prevents rising.

If the facility sample includes fewer than 30 residents, then the facility is excluded from public reporting.

Risk Adjustment

0640: HBIPS-2 Hours of physical restraint use

No risk adjustment or risk stratification

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

No risk adjustment or risk stratification

Stratification

0640: HBIPS-2 Hours of physical restraint use

The measure is stratified by the following age groups:

• Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years

• Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years

• Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years

• Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

This is not applicable.

Type Score

0640: HBIPS-2 Hours of physical restraint use

Ratio better quality = lower score

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Rate/proportion better quality = lower score

Algorithm

0640: HBIPS-2 Hours of physical restraint use

1. Run all cases that are included in the Initial Patient Population for HBIPS-2 and 3 and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure.

2. Check Event Type

a. If Event Type equals 2, the case will proceed to a Measure Category Assignment of U for Overall Rate (HBIPS-2a) and will not be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure

b. If Event Type equals 1, continue processing and proceed to Minutes of Physical Restraint.

3. Check Minutes of Physical Restraint

a. If Minutes of Physical Restraint is missing, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-2a) and will be rejected. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

b. If Minutes of Physical Restraint equals UTD, the case will proceed to a Measure Category Assignment of Y for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

c. If Minutes of Physical Restraint equals a Not able to Determine Value, the case will proceed to a Measure Category Assignment of E for Overall Rate (HBIPS-2a) and will be in the measure population. Continue processing and proceed to step 4, Initialize the Measure Category Assignment for each strata measure.

4. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals U, Set the Measure Category Assignment for the strata measures (HBIPS-2b through HBIPS-2e) = ´U´. Stop processing.

b. If Overall Rate Category Assignment equals E, X or Y, continue processing and proceed to Patient Age at Time of Event.

5. Initialize the Measure Category Assignment for each strata measure (b-e) = ´B´. Do not change the Measure Category Assignment or Total Overall Restraint Minutes that was already calculated for the overall rate (HBIPS-2a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-2a) Measure Category Assignment.

6. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 1 years and less than 13 years, set the Measure Category Assignment for measure HBIPS-2b = Measure Category Assignment for measure HBIPS-2a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 13 years, continue processing and proceed to Patient Age at Time of Event.

7. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 13 years and less than 18 years, set the Measure Category Assignment for measure HBIPS-2c = Measure b. Category Assignment for measure HBIPS-2a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 18 years, continue processing and proceed to Patient Age at Time of Event.

8. Check Patient Age at Time of Event

a. If Patient Age at Time of Event is greater than or equal 18 years and less than 65 years, set the Measure Category Assignment for measure HBIPS-2d = Measure Category Assignment for measure HBIPS-2a. Stop processing.

b. If Patient Age at Time of Event is greater than or equal 65 years, set the Measure Category Assignment for measure HBIPS-2e = Measure Category Assignment for measure HBIPS-2a. Stop processing

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

Step 1: Identify the total number of long-stay residents who have a target assessment (OBRA, PPS, or discharge) during the quarter and who did not meet the exclusion criteria (i.e., they are not missing data on use of any type of physical restraint).

Step 2: Starting with the set of residents identified in Step 1, determine the number of long-stay residents who have a target MDS assessment (OBRA, PPS, or discharge) reporting daily incidence of physical restraint use during the 7 days prior to the target assessment.

Step 3: Divide the result of Step 2 by the result of Step 1.

Submission items

0640: HBIPS-2 Hours of physical restraint use

5.1 Identified measures: 0687 : Percent of Residents Who Were Physically Restrained (Long Stay)

0203 : Restraint prevalence (vest and limb)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Measure 203 excludes patients under 18 years of age, only evaluates vest or limb restraint use and is based on a survey conducted at selected time intervals. Measure 0687 evaluates the percent of all patients in a long term care setting who had a vest or limb restraint applied during the reporting period. HBIPS-2 evaluates the total time all patients > 1 year of age in a psychiatric care setting were maintained in all forms of physical restraint for the reporting period.

5b.1 If competing, why superior or rationale for additive value: Not Applicable

0687: Percent of Residents Who Were Physically Restrained (Long Stay)

5.1 Identified measures: 0640 : HBIPS-2 Hours of physical restraint use

0203 : Restraint prevalence (vest and limb)

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: NQF # 0203 Physical restraint (vest and limb only). While this measure has a similar focus, it is for use in acute care and uses a different definition of restraints. NQF # 0640 HBIPS-2 Hours of physical restraint use. This measure also has as similar focus but is for use in hospital-based inpatient psychiatric setting and is based on patient days. Detailed data on days of restraint use is not currently available on the MDS. The measure #0687 is specified to capture daily restraint use over the 7 days preceding the resident's assessment.

5b.1 If competing, why superior or rationale for additive value: This is not applicable. There are no competing measures.

Comparison of NQF 1922, 0104e, 1365e, 2152, 2599, 2806

1922 HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed
0104eAdult Major Depressive Disorder (MDD): Suicide Risk Assessment
1365e Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
2599 Alcohol Screening and Follow-up for People with Serious Mental Illness
2806 Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Steward

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

The Joint Commission

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

PCPI

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

PCPI Foundation

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

PCPI Foundation

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

National Committee for Quality Assurance

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Seattle Children's Research Institute

Description

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

The proportion of patients, age greater than and equal to 1 year, admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths.

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

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

Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user

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

The percentage of patients 18 years and older with a serious mental illness, who were screened for unhealthy alcohol use and received brief counseling or other follow-up care if identified as an unhealthy alcohol user.

Note: The proposed health plan measure is adapted from an existing provider-level measure for the general population (NQF #2152: Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling). It was originally endorsed in 2014 and is currently stewarded by the American Medical Association (AMA-PCPI).

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Percentage of children/adolescents age =5 to =19 years-old seen in the emergency department with psychotic symptoms who are screened for alcohol or drugs of abuse

Type

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Process

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Process

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

Process

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Process

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

Process

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Process

Data Source

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Electronic Health Records, Paper Medical Records Each data element in the data dictionary includes suggested data sources. The data are collected using contracted Performance Measurement Systems (vendors) that develop data collection tools based on the measure specifications. The tools are verified and tested by Joint Commission staff to confirm the accuracy and conformance of the data collection tool with the measure specifications. The vendor may not offer the measure set to hospitals until verification has been passed.

No data collection instrument provided Attachment HBIPS_Code_Tables-636794265723952869.xlsx

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Electronic Health Records Not Applicable

No data collection instrument provided Attachment 0104_MDD_SuicideRisk_ValueSets_2017September29.xlsx

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

Electronic Health Records Not Applicable

No data collection instrument provided Attachment 1365_CMS177_Child_Adolescent_MDD_Value_Sets_05042018.xlsx

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Registry Data Not applicable.

No data collection instrument provided No data dictionary

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

Claims, Electronic Health Records, Paper Medical Records The denominator for this measure is based on administrative claims. The numerator for this measure is based on administrative claims and/or medical record documentation collected in the course of providing care to health plan patients.

No data collection instrument provided Attachment 2599_Alcohol_Screening_for_People_With_Mental_Illness_Value_Set-636583545268612951-636769175260262857.xlsx

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Claims, Other, Paper Medical Records The data collection tool is publicly available on the website in S.1. and also attached in the Appendix materials.

Title: “Medical Record Measure Electronic Abstraction and Scoring Tool” under “Mental Health Measures”

Available at measure-specific web page URL identified in S.1 Attachment PSYCHOSIS_ICD9_and_ICD10_Codes_for_Denominator_Identification_SUBMITTED-635803493103736421.xlsx

Level

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Facility, Other

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Clinician : Group/Practice, Clinician : Individual

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

Clinician : Group/Practice, Clinician : Individual

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Clinician : Group/Practice, Clinician : Individual

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

Health Plan

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Facility

Setting

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Inpatient/Hospital

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Emergency Department and Services, Other, Outpatient Services Behavioral Health Day Treatment

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

Outpatient Services

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Home Care, Outpatient Services

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

Outpatient Services

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Emergency Department and Services, Inpatient/Hospital

Numerator Statement

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Psychiatric inpatients with admission screening within the first three days of admission for all of the following: risk of violence to self or others; substance use; psychological trauma history; and patient strengths

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

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

Patient visits with an assessment for suicide risk

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

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

Patients 18 years and older who are screened for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and received two events of counseling if identified as an unhealthy alcohol user.

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Eligible patients with documentation of drug and alcohol screening using urine drug or serum alcohol tests.

Numerator Details

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Five data elements are used to calculate the numerator:

1. Patient Strengths - Documentation in the medical record that an admission screening for a minimum of two patient strengths was performed within the first three days of admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

2. Psychological Trauma History - Documentation in the medical record that an admission screening for a psychological trauma history was performed within the first three days of admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

3. Substance Use - Documentation in the medical record that an admission screening for substance use and alcohol use which occurred over the past twelve (12) months was performed within the first three days of admission. The screening must include: the type, amount, frequency of use and any problems due to past use. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

4. Violence Risk to Others - Documentation in the medical record that an admission screening for violence risk to others over the past six months was performed within the first three days of admission. Violence Risk to Others includes: threats of violence and/or actual commission of violence toward others. Documentation should include violence risk within the 6 months prior to admission AND any lifetime risk of violence to others beyond the 6 months prior to admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

5. Violence Risk to Self - Documentation in the medical record that an admission screening for violence risk to self over the past six months was performed within the first three days of admission. Violence Risk to Self includes: ideation, plans/preparation and/or intent to act if ideation present, past suicidal behavior and risk/protective factors within the 6 months prior to admission. Allowable values: Yes, No/UTD, or X unable to complete admission screening.

Patients are eligible for the numerator population when the allowable value equals “yes” for all five data elements: Patient Strengths, Psychological Trauma History, Substance Use, Violence Risk to Others and Violence Risk to Self as defined above.

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Time Period for Data Collection: At every visit where a new diagnosis or recurrent episode of Major Depressive Disorder is identified [initial evaluation during the episode]

Definition:

Suicide risk assessment - Must include questions about the following:

1) Suicidal ideation

2) Patient's intent of initiating a suicide attempt

AND, if either is present,

3) Patient plans for a suicide attempt

4) Whether the patient has means for completing suicide

GUIDANCE:

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped

to the concept “Intervention, Performed: Suicide Risk Assessment” included in the numerator logic in the attached HQMF in field

S.2a.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

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

Time Period for Data Collection: At each visit for major depressive disorder during the measurement period.

HQMF eCQM developed and is included in this submission.

We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification.

NUMERATOR DEFINITION:

The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. 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.

NUMERATOR GUIDANCE:

A suicide risk assessment should be performed at every visit for major depressive disorder during the measurement period.

Use of a standardized tool or instrument to assess suicide risk will meet numerator performance. Standardized tools can be mapped to the concept "Intervention, Performed: Suicide Risk Assessment" included in the numerator logic in the HQMF eCQM attached in field S.2a.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: At least once during the 24 month period.

Definitions:

Systematic screening method - For purposes of this measure, one of the following systematic methods to assess unhealthy alcohol use must be utilized. Systematic screening methods and thresholds for defining unhealthy alcohol use include:

- AUDIT Screening Instrument (score >= 8)
- AUDIT-C Screening Instrument (score >= 4 for men; score >= 3 for women)

• Single Question Screening - How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day? (response >= 2)

Brief counseling - Brief counseling for unhealthy alcohol use refers to one or more counseling sessions, a minimum of 5-15 minutes, which may include: feedback on alcohol use and harms; identification of high risk situations for drinking and coping strategies; increased motivation and the development of a personal plan to reduce drinking.

NUMERATOR NOTE: In the event that a patient is screened for unhealthy alcohol use and identified as a user but did not receive brief alcohol cessation counseling submit G9624.

For Registry:

Report Quality Data Code:

G9621 - Patient identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method and received brief counseling

OR

G9622 - Patient not identified as an unhealthy alcohol user when screened for unhealthy alcohol use using a systematic screening method

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

Alcohol Use Screening

ADMINISTRATIVE:

Patients who had systematic screening for unhealthy alcohol use (see Alcohol Screening Value Set) as identified by claim/encounter data during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year.

MEDICAL RECORD:

Patients who had systematic screening for unhealthy alcohol use during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year.

Systematic Screening

A systematic screening method is defined as:

Asking the patient about their weekly use (alcoholic drinks per week), or

Asking the patient about their per occasion use (alcoholic drinks per drinking day) or

Using a standardized tool such as the AUDIT, AUDIT-C, or CAGE or

Using another standardized tool

Unhealthy Alcohol Use

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as >7 standard drinks per week or >3 drinks per occasion for women and persons >65 years of age; >14 standard drinks per week or >4 drinks per occasion for men =65 years of age.

Follow-Up

ADMINISTRATIVE:

Patients who received two events of counseling (see Alcohol Screening and Brief Counseling Value Set) as identified by claim/encounter data within three months of screening if identified as unhealthy alcohol users.

MEDICAL RECORD:

Patients who received two events of counseling within three months of screening if identified as unhealthy alcohol users. The two event of counseling could be with the provider who performed screening or another provider including health plan clinical case managers. Participation in peer led support activities (such as Alcoholics Anonymous or Narcotics Anonymous) can count if documented in the health record (referrals alone do not count).

Counseling

Counseling may include at least one of the following:

Feedback on alcohol use and harms

Identification of high risk situations for drinking and coping strategies

Increase the motivation to reduce drinking

Development of a personal plan to reduce drinking

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Patients passing the quality measure are identified during medical record abstraction using the guidelines below. The item numbers match the "Medical Records Abstraction Tool Guidelines" under "Mental Health Measures"provided on the website in S.1. This language is also in the "Medical Records Electronic Abstraction and Scoring Tool" on the website.

11. Urine Drug Screening /Serum Alcohol Screening – [Module: Psychosis, ED care] This item applies to children and adolescents presenting with psychotic symptoms who were admitted to the marker ED. Indicate if the patient had a urine drug screen and/or serum alcohol screen while in the ED. The alcohol test will be a separate test from the drug tests. The drug test must be comprehensive in that it tests for multiple types of illicit drugs. Do NOT give credit for tests that include results of just a single drug. Drug screens commonly include tests for benzodiazepines, barbiturates, methamphetamine, cocaine, methadone, opiates, tetrahydrocannabinol, etc.

Denominator Statement

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Psychiatric inpatient discharges

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

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

All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

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

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

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Patients aged =5 to =19 years-old seen in the emergency department with psychotic symptoms.

Denominator Details

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Included Populations:

• Patients with ICD-10-CM Principal or Other Diagnosis Codes for Mental Disorders as defined in Appendix A, Table 10.01 (See S.2b.)

(See S.2b for attached code table)

Six data elements are used to calculate the denominator:

1. Admission Date – The month, day and year of admission to acute inpatient care.

2. Birthdate - The month, day and year the patient was born.

3. Discharge Date – The month day and year the patient was discharged from acute care, left against medical advice or expired during the stay.

4. ICD-10-CM Other Diagnosis Codes- The other or secondary (ICD-10-CM) codes associated with the diagnosis for this hospitalization.

5. ICD-10-CM Principal Diagnosis Code- The ICD-10-CM diagnosis code that is primarily responsible for the admission of the patient to the hospital for care during this hospitalization.

6. Psychiatric Care Setting - Documentation in the medical record that the patient was receiving care primarily for a psychiatric diagnosis in an inpatient psychiatric setting, i.e., a psychiatric unit of an acute care hospital or a free-standing psychiatric hospital. Allowable values: Yes, No.

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Time Period for Data Collection: 12 consecutive months

Guidance:

This measure is an episode-of-care measure and should be reported for each instance of a new or recurrent episode of major depressive disorder (MDD); every new or recurrent episode will count separately in the Initial Population.

It is expected that a suicide risk assessment will be completed at the visit during which a new diagnosis is made or at the visit during which a recurrent episode is first identified (ie, at the initial evaluation). For the purposes of this measure, an episode of MDD would be considered to be recurrent if a patient has not had an MDD-related encounter in the past 105 days. If there is a gap of 105 or more days between visits for MDD, that would imply a recurrent episode. The 105-day look-back period is an operational provision and not a clinical recommendation, or definition of relapse, remission, or recurrence.

The measure description outlined in the header for this measure states, 'patients aged 18 years and older' while the logic statement states, '>= 17 year(s) at: "Measurement Period"'. The logic statement, as written, captures patients who turn 18 years old during the measurement period so that these patients are included in the measure. To ensure all patients with major depressive disorder (MDD) are assessed for suicide risk, there are two clinical quality measures addressing suicide risk assessment; CMS 177 covers children and adolescents aged 6 through 17, and CMS 161 covers the adult population aged 18 years and older.

HQMF eCQM developed and is attached to this submission in fields S.2a and S.2b.

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

Time Period for Data Collection: 12 consecutive months.

HQMF eCQM developed and is included in this submission.

We have provided the following definitions and/or guidance for convenience; please see HQMF eCQM for complete details related to the specification.

DENOMINATOR DEFINITION:

None

DENOMINATOR GUIDANCE:

This measure is an episode-of-care measure; the level of analysis for this measure is every visit for major depressive disorder during the measurement period. For example, at every visit for MDD, the patient should have a suicide risk assessment.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: 12 consecutive months

For Registry:

Patients aged >= 18 years

AND

At least two patient encounters during the performance period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 2

OR

At Least One Preventive Visit during the performance period (CPT or HCPCS): 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99429, G0438, G0439

WITHOUT

Telehealth Modifier: GQ, GT, 95, POS 02

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

Age: 18 years and older

Benefit: Medical

Continuous Enrollment: No more than one gap in enrollment of up to 45 days during each year of the measurement year and the year prior. To determine continuous enrollment for a Medicaid beneficiary for whom enrollment is verified monthly, the person may not have more than a one month gap in coverage (i.e., a person whose coverage lapses for two months [60 days] is not considered continuously enrolled).

Diagnosis Criteria: Identify patients with a serious mental illness. They must meet at least one of the following criteria during the measurement year or the year prior:

At least one acute inpatient claim/encounter with any diagnosis of schizophrenia, bipolar I disorder, or major depression using any of the following code combinations:

BH Stand Alone Acute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set
- Major Depression Value Set

BH Acute Inpatient Value Set with BH Acute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set
- Major Depression Value Set

At least two visits in an outpatient, intensive outpatient, partial hospitalization, ED or non-acute inpatient setting, on different dates of service, with any diagnosis of schizophrenia or bipolar I disorder. Any two of the following code combinations meet criteria:

BH Stand Alone Outpatient/PH/IOP Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Outpatient/PH/IOP Value Set with BH Outpatient/PH/IOP POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

ED Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH ED Value Set with BH ED POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Stand Alone Nonacute Inpatient Value Set with one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

BH Nonacute Inpatient Value Set with BH Nonacute Inpatient POS Value Set and one of the following diagnoses:

- Schizophrenia Value Set
- Bipolar Disorder Value Set

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Cases are identified from hospital administrative data.

Patients aged =5-=19 years-old

Patients have at least one of the following ICD9 codes for psychosis, as a primary or secondary diagnosis: 291.3, 291.5, 292.11, 292.12, 293.81, 293.82, 295.30, 295.31, 295.32, 295.33, 295.34, 295.40, 295.41, 295.42, 294.43, 295.44, 295.70, 295.71, 295.72, 295.73, 295.74, 295.90, 295.91, 295.92, 295.93, 295.94, 296.24, 296.44, 297.1, 297.2, 297.3, 298.X

These codes were chosen by Members of the COE4CCN Mental Health Working Group (see Ad.1) co-chaired by Psychiatric Health Services Researchers Drs. Michael Murphy and Bonnie Zima.

Exclusions

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

• Patients for whom there is an inability to complete admission screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths within the first three days of admission due to the patient's inability or unwillingness to answer screening questions

• Patients with a Length of Stay = or less than 3 days or = or greater than 365 days

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

None

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

None

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)

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

Active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year (see Alcohol Disorders Value Set).

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

No patients were excluded from the target population.

Exclusion Details

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

• Patients for whom screening cannot be completed due to the patient's inability or unwillingness to answer assessment questions within the first three days of admission OR patients with a previous admission to the psychiatric unit during a single hospitalization.

• Length of stay (LOS) in days is equal to the Discharge Date minus the Admission Date. If the LOS is less than 3 days or greater than 365 days, the patient is excluded.

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Not Applicable

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

N/A

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Time Period for Data Collection: Denominator Exception(s) are determined on the date of the most recent denominator eligible encounter.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, exceptions may include medical reason(s) (eg, limited life expectancy, other medical reasons). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Registry:

Report Quality Data Code:

G9623 - Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy, other medical reasons)

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

Denominator exclusions are found through medical record or claims data (see Alcohol Disorders Value Set).

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

N/A

Risk Adjustment

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

No risk adjustment or risk stratification

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

No risk adjustment or risk stratification

Stratification

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

The measure is stratified by the following age groups:

• Children (1 through 12 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 1 year and less than 13 years

• Adolescent (13 through 17 years) — A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 13 years and less than 18 years

• Adult (18 through 64 years) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 18 years and less than 65 years

• Older Adult (65 years or greater) - A Patient Age at Discharge (Discharge Date minus Birthdate) greater than or = 65 years

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

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

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF, the PCPI encourages the collection of race and ethnicity data as well as the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

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

Not applicable.

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

N/A

Type Score

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

Rate/proportion better quality = higher score

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Ratio better quality = higher score

Algorithm

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

1. Run all cases that are included in the Initial Patient Population for HBIPS Discharge and pass the edits defined in the Transmission Data Processing Flow: Clinical Through this measure

2. Calculate Length of Stay. Length of Stay, in days, is equal to the Discharge Date minus the Admission Date.

3. Check Length of Stay

a. If Length of Stay is less than or equal to 3 days or greater than or equal to 365 days, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Length of Stay is greater than 3 days and less than 365 days, continue processing and proceed to Psychiatric Care Setting.

4. Check Psychiatric Care Setting

a. If Psychiatric Care Setting equals No, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Stop processing.

b. If Psychiatric Care Setting equals Yes, continue processing.

5. Initialize Missing Counter to equal zero. Initialize No Screening Counter to equal zero, Initialize Incomplete Screening Counter to equal zero. Continue processing and proceed to Patient Strengths.

6. Check Patient Strengths

a. If Patient Strengths equals No, add one to No Screening Counter. Continue processing and proceed to Psychological Trauma History.

b. If Patient Strengths is missing, add one to Missing Counter. Continue processing and proceed to Psychological Trauma History.

c. If Patient Strengths equals Yes or X, Continue processing and proceed to check Patient Strengths.

7. Check Patient Strengths

a. If Patient Strengths equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Psychological Trauma History.

b. If Patient Strengths equals Yes, Continue processing and proceed to Psychological Trauma History.

8. Check Psychological Trauma History

a. If Psychological Trauma History equals No, add one to No Screening Counter. Continue processing and proceed to Substance Use.

b. If Psychological Trauma History is missing, add one to Missing Counter. Continue processing and proceed to Substance Use.

c. If Psychological Trauma History equals Yes or X, Continue processing and proceed to check Psychological Trauma History.

9. Check Psychological Trauma History

a. If Psychological Trauma History equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Substance Use.

b. If Psychological Trauma History equal Yes, Continue processing and proceed to Substance Use.

10. Check Substance Use

a. If Substance Use equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Others.

b. If Substance Use is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Others.

c. If Substance Use equals Yes or X, Continue processing and proceed to check Substance Use.

11. Check Substance Use

a. If Substance Use equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Others.

b. If Substance Use equal Yes, Continue processing and proceed to Violence Risk to Others.

12. Check Violence Risk to Others

a. If Violence Risk to Others equals No, add one to No Screening Counter. Continue processing and proceed to Violence Risk to Self.

b. If Violence Risk to Others is missing, add one to Missing Counter. Continue processing and proceed to Violence Risk to Self.

c. If Violence Risk to Others equals Yes or X, Continue processing and proceed to check Violence Risk to Others.

13. Check Violence Risk to Others

a. If Violence Risk to Others equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Violence Risk to Self.

b. If Violence Risk to Others equal Yes, Continue processing and proceed to Violence Risk to Self.

14. Check Violence Risk to Self

a. If Violence Risk to Self equals No, add one to No Screening Counter. Continue processing and proceed to Incomplete Screening Counter.

b. If Violence Risk to Self is missing, add one to Missing Counter. Continue processing and proceed to Incomplete Screening Counter.

c. If Violence Risk to Self equals Yes or X, Continue processing and proceed to check Violence Self.

15. Check Violence Risk to Self

a. If Violence Risk to Self equals X, add one to Incomplete Screening Counter. Continue processing and proceed to Incomplete Screening Counter.

b. If Violence Risk to Self equal Yes, Continue processing and proceed to Incomplete Screening Counter.

16. Check Incomplete Screening Counter

a. If Incomplete Screening Counter equals 5, the case will proceed to a Measure Category Assignment of B and will not be in the measure population. Continue processing and proceed to initialize the Measure Category Assignment for each strata measure.

b. If Incomplete Screening Counter is less than five, continue processing and proceed to Missing Counter.

17. Check Missing Counter

a. If Missing Counter is more than zero, the case will proceed to a Measure Category Assignment of X for Overall Rate (HBIPS-1a) and will be rejected. Proceed to step initialize the Measure Category Assignment for each strata measure.

b. If Missing Counter equals zero, continue processing and proceed to No Screening Counter.

18. Check No Screening Counter

a. If No Screening Counter is greater than zero, the case will proceed to a Measure Category Assignment of D for Overall Rate (HBIPS-1a) and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.

b. If No Screening Counter equals zero, the case will proceed to a Measure Category Assignment of E and will be in the measure population. Continue processing and proceed to step 19 and initialize the Measure Category Assignment for each strata measure.

19. Initialize the Measure Category Assignment for each strata measure (b-e) equal ´B´. Do not change the Measure Category Assignment that was already calculated for the overall rate (HBIPS-1a). The rest of the algorithm will reset the appropriate Measure Category Assignment to be equal to the overall rate´s (HBIPS-1a) Measure Category Assignment. Continue processing and proceed to Overall Rate Category Assignment.

20. Check Overall Rate Category Assignment

a. If Overall Rate Category Assignment equals B, retain the Measure Category Assignment for the strata measures (HBIPS-1b through HBIPS-1e) equals B. Stop processing.

b. If Overall Rate Category Assignment equals D, E, or X, continue processing and proceed to Patient Age at Discharge.

21. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal to 1 year and less than 13 years, set the Measure Category Assignment for the measure HBIP-1b equal to Measure Category Assignment for measure HBIP-1a. Stop processing.

b. If Patient Age at Discharge is greater than or equal to 13 years, continue processing and proceed to Patient Age at Discharge.

22. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal to 13 years and less than 18 years, set the Measure Category Assignment for the measure HBIP-1c equal to Measure Category Assignment for measure HBIP-1a. Stop processing.

b. If Patient Age at Discharge is greater than or equal to 18 years, continue processing and proceed to Patient Age at Discharge.

23. Check Patient Age at Discharge

a. If Patient Age at Discharge is greater than or equal to 18 years and less than 65 years, set the Measure Category Assignment for the measure HBIP-1d equal to Measure Category Assignment for measure HBIP-1a. Stop processing.

b. If Patient Age at Discharge is greater than or equal to 65 years, set the Measure Category Assignment for the measure HBIP-1e equal to Measure Category Assignment for measure HBIP-1a. Stop processing.

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

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

To calculate performance rates:

1) Find the patients who meet the initial patient population (ie, the general group of patients that a set of performance measures is designed to address).

2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.

3) From the patients within the denominator, find the patients who meet the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

If the patient does not meet the numerator, this case represents a quality failure.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, limited life expectancy, other medical reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

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

Step 1: Determine the eligible population.

Step 1A: Identify all patients 18 years of age or older with a serious mental illness

Step 1B: Exclude patients from step 1A who have a diagnosis of unhealthy alcohol use during the first 9 months of the year prior to the measurement year.

Step 2: Identify Numerator.

Step 2A: Identify the date of screening for unhealthy alcohol use during the measurement year or the year prior within the medical chart

Step 2B: Identify the unhealthy alcohol screening result within the medical chart. If negative for unhealthy alcohol use, stop.

Step 2C: If positive for unhealthy alcohol use, identify the date of any follow-up care occurring within three months of screening.

Step 3: Calculate the rate by adding the number of patients with a negative screening for unhealthy alcohol use (from step 2B) plus the number of patients with positive screening for unhealthy alcohol use and those who received follow-up care (from step 2C) and divide this by the number of patients calculated to be in the eligible population (those remaining after Step 1B is complete.)

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

Step 1. Identify eligible population at hospital using administrative data. N=total population

Step 2. Assess patient chart for indicator status. Pass (A=1) if documentation present of urine drug testing or both urine drug testing and serum alcohol testing. Pass (B=1) if documentation present of serum alcohol testing or both urine drug testing and serum alcohol testing.

Step 3. Calculate Patient score= 100*(A+B)/2. Results=0, 50, 100

Step 4. Calculate hospital score=Sum(Patient score)/N

Submission items

1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed

5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

0110 : Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

0111 : Bipolar Disorder: Appraisal for risk of suicide

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

2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

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

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Five of the six NQF endorsed measures are provider level measures, 2599 is a health plan measure. All pertain to the ambulatory setting for patients. All (except 2152) are specific to the diagnoses of major depression and/or bipolar disorder. The measures only evaluate one aspect of screening: either suicide risk or alcohol or substance use. Measures 0104, 0110, 0111, 2159, and 2599 only evaluate patients age 18 years and older. The SUB-1 measure pertains to all inpatients 18 years and older, with screening limited to substance use. HBIPS-1 addresses inpatient organizational performance for all psychiatric diagnoses and evaluates the care of all patient ages (greater than 1 year). Additionally, HBIPS-1 evaluates several aspects of screening (risk of violence to self or others, substance use, psychological trauma history and patient strengths).

5b.1 If competing, why superior or rationale for additive value: Not Applicable

0104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

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

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: The guidelines used as evidence in the NQF 1365: Child and Adolescent Major Depressive Disorder (MDD) Suicide Risk Assessment explicitly recommend suicide assessment at every visit for MDD whereas the guidelines used for evidence in this measure do not emphasize this level of assessment frequency.

5b.1 If competing, why superior or rationale for additive value: Both of these measures (0104 and 1365) were developed by PCPI and updated and harmonized with each other on an annual basis. They are not competing because they are used in different patient populations and have different frequencies of suicide assessment based on their respective evidence.

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

5.1 Identified measures: 0104 : Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

0111 : Bipolar Disorder: Appraisal for risk of suicide

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Our measure addresses a different target population, children and adolescents with MDD, from the related measures that focus on adults with MDD and patients with bipolar disorder. As a result, the recommended frequency of suicide assessment is different in our measure from the other measures.

5b.1 If competing, why superior or rationale for additive value: Because our measure emphasizes a different target population and a different type/frequency of assessment, we feel multiple measures are justified to address suicide risk assessment differently in different high-risk populations.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

5.1 Identified measures:

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The related measures listed in 5.1b were developed after our measure. The NCQA measure focuses on a specific sub-population (people with serious mental illness) and is intended for use at the health plan level. In the TJC measures, screening and intervention are separate measures. Additionally, the TJC measures are intended for use at the hospital level. PCPI was contacted by these measure stewards respectively while the measures were developed, and they are currently harmonized to the extent feasible.

5b.1 If competing, why superior or rationale for additive value: No competing NQF-endorsed measure.

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

5.1 Identified measures: 2152 : Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact: This measure was adapted from the existing provider-level measure (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling) for use at the health plan level for the high risk subpopulation of people with serious mental illness. The measure is harmonized and has been reviewed with the original measure stewards and developers. The differences between the existing measure and the proposed serious mental illness subpopulation measure were developed with expert input and are described here. -The population focus: This measure focuses on people with serious mental illness, who are at a higher risk of unhealthy alcohol use than the general population and have demonstrated

disparities in care -What counts as follow-up and the number of events for follow-up: This measure requires two events of counseling, raising expectations for the intensity of service for the serious mental illness population compared to the original measure for the general population, and is reasonably achievable, particularly in the health plan context. USPSTF recommendation supports multi-contact counseling which seems to have the best evidence of effectiveness. -In addition, the existing measure (NQF #2152) is reported at the provider level and is focused on follow-up conducted at time of screening making a single event sufficient. However, at the health plan level, there is opportunity/responsibility for follow-up care beyond the visit. We believe our measure focused on screening patients with SMI for unhealthy alcohol use and capturing more intensive evidence-based follow-up care for a vulnerable population contributes to the national quality agenda.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

2806: Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value:

Comparison of NQF 3488, 0004, 3312, 3453

3488 Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs
3453 Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Steward

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

National Committee for Quality Assurance

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

National Committee for Quality Assurance

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

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Centers for Medicare & Medicaid Services, Centers for Medicaid & CHIP Services

Description

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

The percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

This measure assesses the degree to which the organization initiates and engages members identified with a need for alcohol and other drug (AOD) abuse and dependence services and the degree to which members initiate and continue treatment once the need has been identified. Two rates are reported:

- Initiation of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth or medication assisted treatment (MAT) within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of adolescent and adult members with a new episode of AOD abuse or dependence who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit.

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

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.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Percentage of discharges from an inpatient or residential treatment for substance use disorder (SUD) for Medicaid beneficiaries, ages 18 to 64, which was followed by a treatment service for SUD. SUD treatment includes having an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth encounter, or filling a prescription or being administered or ordered a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

Type

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Process

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Process

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

Process

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Process

Data Source

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 3488_FUA_Value_Sets_Spring_2019.xlsx

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Claims NCQA collects HEDIS data directly from Health Management Organizations and Preferred Provider Organizations via a data submission portal - the Interactive Data Submission System (IDSS).

No data collection instrument provided Attachment 0004_IET_Value_Sets.xlsx

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

Claims Medicaid Analytic eXtract (MAX) 2013 and 2014 eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided. The inpatient file only contains inpatient hospital, sterilization, abortion and religious non-medical health care institution claims.

No data collection instrument provided Attachment Cont_Care_After_Detox_Value_Sets.xlsx

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Claims Medicaid Alpha-MAX 2014 data: eligible (EL), inpatient (IP), other services (OT), long-term care (LT) and drug (RX) files. The other services (OT) file contains facility and individual provider services data. Most notably, it may contain both residential and other stayover service claims data as claims are assigned to MAX claims file types based upon the category of service provided.

No data collection instrument provided Attachment SUD-18_measure_value_sets_FINAL_08.09.18_tested_sets_-_locked.xlsx

Level

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Health Plan

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Health Plan

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

Population : Regional and State

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Population : Regional and State

Setting

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Outpatient Services

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Emergency Department and Services, Inpatient/Hospital, Outpatient Services

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

Inpatient/Hospital, Outpatient Services

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Emergency Department and Services, Home Care, Inpatient/Hospital, Outpatient Services

Numerator Statement

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

The numerator consists of two rates:

- 30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit.

- 7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit.

These rates are stratified by age (13–17, 18 and older, total).

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Initiation of AOD Treatment:

Initiation of treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication treatment within 14 days of the diagnosis.

Engagement of AOD Treatment:

Initiation of AOD treatment and two or more additional AOD services or medication treatment within 34 days of the initiation visit.

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

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.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Discharges in the denominator with an outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or filled a prescription for or were administered or ordered a medication for SUD. (After an inpatient discharge only, residential treatment also counts as continuity of care.) Two rates are reported, continuity within 7 and 14 days after discharge.

Numerator Details

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

30-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

7-day follow-up: A follow-up visit with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days). Include visits that occur on the date of the ED visit. Any of the following meet criteria for a follow-up visit:

- IET Stand Alone Visits Value Set with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- A telephone visit (Telephone Visits Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

- An online assessment (Online Assessments Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set).

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Index Episode Start Date. The earliest date of service for an eligible encounter during the Intake Period with a diagnosis of AOD abuse or dependence.

- For an outpatient, intensive outpatient, partial hospitalization, observation, telehealth, detoxification or ED visit (not resulting in an inpatient stay), the IESD is the date of service.
- For an inpatient stay, the IESD is the date of discharge.
- For an ED and observation visits that results in an inpatient stay, the IESD is the date of the inpatient discharge (an AOD diagnosis is not required for the inpatient stay; use the diagnosis from the ED or observation visit to determine the diagnosis cohort).
- For direct transfers, the IESD is the discharge date from the last admission (an AOD diagnosis is not required for the transfer; use the diagnosis from the initial admission to determine the diagnosis cohort).

INITIATION OF AOD TREATMENT

Initiation of AOD treatment within 14 days of the IESD.

If the Index Episode was an inpatient discharge (or an ED visit that resulted in an inpatient stay), the inpatient stay is considered initiation of treatment and the member is compliant.

If the Index Episode was not an inpatient discharge, the member must initiate treatment on the IESD or in the 13 days after the IESD (14 total days). Any of the following code combinations meet criteria for initiation:

- An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient admissions:
- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Identify the admission date for the stay.
- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set with or without a telehealth modifier (Telehealth Modifier Value Set).
- A telephone visit (Telephone Visit Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessment Value) set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

• If the Index Episode was for a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).

• If the Index Episode was for a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set) a medication treatment dispensing event (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set).

For all initiation events except medication treatment (AOD Medication Treatment Value Set; Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List), initiation on the same day as the IESD must be with different providers in order to count.

• If a member is compliant for the Initiation numerator for any diagnosis cohort (i.e., alcohol, opioid, other drug) or for multiple cohorts, count the member only once in the Total Initiation numerator. The "Total" column is not the sum of the diagnosis columns.

• Exclude the member from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) if the initiation of treatment event is an inpatient stay with a discharge date after November 27 of the measurement year.

ENGAGEMENT OF AOD TREATMENT

1) Numerator compliant for the Initiation of AOD Treatment numerator and

2) Members whose initiation of AOD treatment was a medication treatment event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List; AOD Medication Treatment Value Set).

These members are numerator compliant if they have two or more engagement events where only one can be an engagement medication treatment event.

3) Remaining members whose initiation of AOD treatment was not a medication treatment event (members not identified in step 2).

These members are numerator compliant if they meet either of the following:

• At least one engagement medication treatment event.

• At least two engagement visits

Two engagement visits can be on the same date of service, but they must be with different providers in order to count as two events. An engagement visit on the same date of service as an engagement medication treatment event meets criteria (there is no requirement that they be with different providers).

Engagement visits:

Any of the following meet criteria for an engagement visit:

• An acute or nonacute inpatient admission with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute or nonacute inpatient admissions:

– Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

– Identify the admission date for the stay.

- IET Stand Alone Visits Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- Observation Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).
- A telephone visit (Telephone Visits Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.
- An online assessment (Online Assessments Value Set) with a diagnosis matching the IESD diagnosis cohort using one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

Engagement Medication Treatment Events:

Either of the following meets criteria for an engagement medication treatment event:

- If the IESD diagnosis was a diagnosis of alcohol abuse or dependence (Alcohol Abuse and Dependence Value Set), one or more medication treatment dispensing events (Medication Treatment for Alcohol Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Alcohol Abuse and Dependence Treatment.
- If the IESD diagnosis was a diagnosis of opioid abuse or dependence (Opioid Abuse and Dependence Value Set), one or more medication dispensing events (Medication Treatment for Opioid Abuse or Dependence Medications List) or medication treatment during a visit (AOD Medication Treatment Value Set), beginning on the day after the initiation encounter through 34 days after the initiation event (total of 34 days), meets criteria for Opioid Abuse and Dependence Treatment.

If the member is compliant for multiple cohorts, only count the member once for the Total Engagement numerator. The Total Column is not the sum of the diagnosis columns.

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

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

The numerator includes individuals with any of the following within 14 days after discharge from detoxification:

-Pharmacotherapy on day of discharge through day 7 or 14.

-Outpatient, intensive outpatient, partial hospitalization, or residential

treatment procedure with a diagnosis of SUD on the day after discharge through day 7 or 14.

-Outpatient, intensive outpatient, partial hospitalization, or residential treatment with standalone SUD procedure on the day after discharge through day 7 or 14.

-Inpatient admission with an SUD diagnosis or procedure code on day after discharge through day 7 or 14.

-Long-term care institutional claims with an SUD diagnosis on day after discharge through day 7 or 14.

Continuity is reset to zero if an overdose diagnosis code appears on the same outpatient or inpatient claim.

SUD diagnoses are used to identify procedures connected to SUD diagnoses. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

Pharmacotherapy includes naltrexone (short or long acting), acamprosate, or disulfiram for alcohol dependence treatment and buprenorphine for opioid dependence treatment, as well HCPCS codes to identify procedures related to injecting drugs (e.g., long-acting injectable naltrexone).

A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. States may need to adapt the list of codes to include state-specific codes.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

The measure will report two rates, continuity of care within 7 days and within 14 days after discharge.

The numerator includes discharges with any of the following after inpatient or residential treatment:

- Outpatient visit, intensive outpatient encounter or partial hospitalization with a primary or secondary SUD diagnosis on the day after discharge through day 7 or 14.
- Telehealth encounter for SUD on the day after discharge through day 7 or 14
- Pharmacotherapy (filling a prescription or being administered or ordered a medication) on day of discharge through day 7 or 14
- For inpatient discharges only, residential admissions on day 3 through day 7 or day 14

Public comments supported a measure for 7- and 14-day continuity and voiced that beyond that would be too long, risking losing the patient from the treatment system. The Technical Expert Panel unanimously agreed on the appropriateness of 7-day continuity of care. However, three TEP members felt that 14-days continuity of care is too long. Our approach balances clinical best practice thinking that the sooner the patient is connected to treatment the better while also allowing treatment programs more time for placement of patients in continuing treatment. Because it may be difficult at times for treatment programs to place clients in continuing care in a timely fashion after discharge due to limits in systems capacity, it is particularly important to allow more time for continuity of care to occur.

Inpatient or residential treatment was considered to be SUD related if it had a primary SUD diagnosis or a procedure indicating SUD. SUD diagnoses are identified through ICD-9 codes. Procedures are defined using a combination of Healthcare Common Procedure Coding System (HCPCS) codes, Uniform Billing (UB) Revenue Codes and ICD-9/ICD-10 procedure codes.

Value sets for the measure are attached in the Excel workbook provided for question S.2b. We include 2016 HEDIS value sets because we used these value sets in measure testing. HEDIS value sets are used because they represent an existing set that states are already familiar with, they are an element of harmonizing with other endorsed measures, and they are updated by the National Committee on Quality Assurance (NCQA). Also, some states may need to include relevant state-specific codes.

Denominator Statement

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Emergency department (ED) visits with a primary diagnosis of alcohol or other drug abuse or dependence on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the date of the visit.

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Patients age 13 years of age and older as of December 31 of the measurement year who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1-November 15).

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

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

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Adult Medicaid beneficiary discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD during from January 1 to December 15 of the measurement year.

Denominator Details

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Age: 13 years and older as of the date of the ED visit

Benefit: Medical and chemical dependency.

Note: Members with detoxification-only chemical dependency benefits do not meet these criteria.

Continuous Enrollment: Date of emergency department visit through 30 days after the ED visit

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set) on or between January 1 and December 1 of the measurement year where the member was 13 years or older on the

date of the visit. The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1, then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit, regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Identify the Index Episode. Identify all members 13 years and older as of December 31 of the measurement year who during the Intake Period had one of the following:

- An outpatient visit, telehealth, intensive outpatient visit or partial hospitalization with a diagnosis of AOD abuse or dependence. Any of the following code combinations meet criteria:

  – IET Stand Alone Visits Value Set with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

  – IET Visits Group 1 Value Set with IET POS Group 1 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

  – IET Visits Group 2 Value Set with IET POS Group 2 Value Set and with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set, with or without a telehealth modifier (Telehealth Modifier Value Set).

- A detoxification visit (Detoxification Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

- An ED visit (ED Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

• An observation visit (Observation Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

• An acute or nonacute inpatient discharge with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set. To identify acute and nonacute inpatient discharges:

– Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

– Identify the discharge date for the stay.

• A telephone visit (Telephone Visits Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

• An online assessment (Online Assessments Value Set) with one of the following: Alcohol Abuse and Dependence Value Set, Opioid Abuse and Dependence Value Set, Other Drug Abuse and Dependence Value Set.

For members with more than one episode of AOD abuse or dependence, use the first episode.

For members whose first episode was an ED or observation visit that resulted in an inpatient stay, use the diagnosis from the ED or observation visit to determine the diagnosis cohort and use the inpatient discharge date as the IESD.

Select the Index Episode Start Date.

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

Measure data will be reported annually (12 months). To account for the 14-day time period after discharge from detoxification, the denominator period will start January 1 and end December 15 of the measurement year.

Target population meets the following conditions:

• Medicaid beneficiaries aged 18 years and older and less than 65 years with at least one detox discharge during the year January 1-December 15.

• Enrolled in Medicaid during the month of detoxification discharge and the following month.

The denominator is based on discharges, not individuals. A beneficiary may have more than one qualifying detox episode.

Detoxification is identified using a combination of HCPCS codes, UB Revenue Codes and ICD-9/ICD-10 procedure codes. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b. As with the numerator specifications, this document lists standardized specification for this measure. States will likely need to modify the specifications to include their state-specific codes.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Population: Medicaid beneficiaries age 18 through 64 as of January 1 of the measurement year.

Benefit: Medical and Behavioral Health Services.

Continuous Enrollment: Date of the inpatient or residential SUD treatment discharge through end of the following month. The enrollment requirement is to ensure that beneficiaries are enrolled for sufficient time to allow for the continuity activities, particularly for a discharge that occurs near the end of a month.

Diagnosis Criteria: Discharges from inpatient or residential treatment with a primary diagnosis of SUD on any claim during the stay. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.

The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 15 of the measurement year. December 15th is selected to allow sufficient time for continuity activities.

Exclusions

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Patients in hospice.

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Exclude members who had a claim/encounter with a diagnosis of AOD abuse or dependence (AOD Abuse and Dependence Value Set), AOD medication treatment (AOD Medication Treatment Value Set) or an alcohol or opioid dependency treatment medication dispensing event (Medication Treatment for Alcohol Abuse or Dependence Medications List; Medication Treatment for Opioid Abuse or Dependence Medications List) during the 60 days (2 months) before the IESD.

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began.

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

Not applicable. The measure does not have denominator exclusions.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Exclude from the denominator for both rates:

- Discharges with hospice services during the measurement year
- Both the initial discharge and the admission/direct transfer discharge if the admission/direct transfer discharge occurs after December 15 of the measurement year.

Discharges followed by admission or direct transfer to inpatient or SUD residential treatment setting within 7 or 14-day continuity of care period. These discharges are excluded from the measure because transfer, hospitalization or admission to residential treatment within 7 or 14 days may prevent a continuity of care visit from taking place. An exception is admission to residential treatment following discharge from inpatient treatment; we do not exclude these admissions, because continuity into residential treatment after inpatient treatment is considered appropriate treatment.

Exclusion Details

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Exclude patients who had a claim/encounter with a diagnosis of AOD during the 60 days (2 months) before the Index Episode Start Date. (See corresponding Excel document for the AOD Dependence Value Set)

- For an inpatient Index Episode Start Date, use the admission date to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

- For an ED visit that results in an inpatient event, use the ED date of service to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

- For direct transfers, use the first admission to determine if the patient had a period of 60 days prior to the Index Episode Start Date with no claims with a diagnosis of AOD dependence.

Exclude from the denominator for both indicators (Initiation of AOD Treatment and Engagement of AOD Treatment) patients whose initiation of treatment event is an inpatient stay with a discharge date after December 1 of the measurement year.

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

Not applicable.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Codes reflecting exclusions are attached in S.2b. Residential treatment is identified using the value sets in Tabs 1-3 of the attached Excel file. SUD diagnoses are identified using the value sets in Tabs 1-2.

Risk Adjustment

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

No risk adjustment or risk stratification

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

No risk adjustment or risk stratification

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

No risk adjustment or risk stratification

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

No risk adjustment or risk stratification

Stratification

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

This measure is stratified by age:

- Age 13 to 17 years

- Age 18 and older

- Total (sum of the age stratifications)

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

The total population is stratified by age: 13-17 and 18+ years of age.

- Report two age stratifications and a total rate.
- The total is the sum of the age stratifications.

Report the following diagnosis cohorts for each age stratification and the total rate:

- Alcohol abuse or dependence.
- Opioid abuse or dependence.
- Other drug abuse or dependence.
- Total.

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

Location of detox is used as a stratification variable in analyses. If an inpatient hospital claim had an ICD-9/ICD-10 detoxification procedure code or a UB revenue code indicating detoxification, hospital inpatient treatment is assigned as the location of detox. In addition, hospital inpatient treatment is also assigned if a non-inpatient claim contains a HCPCS code indicating hospital inpatient detox. The remaining detox location assignments are very straightforward. Whenever possible, use of the HCPCS codes to determine location is most desired as it reflects the more precise detoxification location. The other stayover treatment location is designed to capture detox location from non-inpatient claims that do not contain a HCPCS code. A list of value sets for the measure is attached in the Excel workbook provided for question S.2b.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Not applicable.

Type Score

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Rate/proportion better quality = higher score

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Rate/proportion better quality = higher score

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

Rate/proportion better quality = higher score

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

Rate/proportion better quality = higher score

Algorithm

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug abuse or dependence. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A).

Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A).

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

Step 1. Determine the eligible population. The eligible population is all patients who satisfy all specified denominator criteria (S7-S9).

Step 2. Search administrative systems to identify numerator events for all patients in the eligible population (S6).

Step 3. Calculate the rate of numerator events in the eligible population. 123834| 140881| 135810| 141015| 110874| 130488

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

The following step are used to identify the denominator, numerator, and calculation of the measure rate:

Step 1: Identify denominator

Step 1A: Eligible population: Identify enrolled Medicaid beneficiaries ages 18-64 years who have any detoxification (withdrawal management) in inpatient hospital, residential addiction treatment program, or ambulatory detoxification (withdrawal management) discharge from January 1 to December 15 of the measurement year and are enrolled the month of detoxification and the following month. Age is calculated as of January 1 of the measurement year.

Step 1B: Overall: Among the Medicaid beneficiaries in Step 1A, identify all detoxification discharges using all inpatient, outpatient and ambulatory claims files or tables that contain HCPCS or ICD-9/ICD-10 procedure codes and UB revenue codes. If more than one detoxification in a year, treat each detoxification as a separate observation, e.g., an inpatient hospital detoxification in January and an ambulatory detoxification in July, counts as two observations.

Step 1B.1: Multiple detox claims that are within 1-2 days are combined into a single detox episode. Accordingly, sort the inpatient, outpatient and ambulatory detox discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in chronological order. Then combine close-proximity episodes while retaining all clinical fields from each episode.

Step 1C: Detox location assignment: hospital inpatient, inpatient residential addiction, outpatient residential outpatient addiction, other stayover treatment and ambulatory detoxification. Use HCPCs detox procedure codes to assign detox location whenever possible; revenue center detox will map to the hospital inpatient location when the revenue codes appear on an inpatient claim or table. They will map to other stayover treatment when the revenue codes appear on a non-inpatient claim. If there is more than 1 detox location when episodes are combined, assign the location using the first claim's location. If there is a TIE between a detox episode being identified via revenue center codes and a more specific category using HCPCs on the SAME claim, the HCPCs location prevails.

Step 2: Identify numerator

Step 2A: Overall: From the denominator in Step 1B, identify those discharges from detoxification in any setting with a qualifying continuity service within 7 or 14 days after discharge.

Step 2A.1: Identify SUD continuity services: Continuity services are assigned using clinical claims billing information (e.g., diagnosis, procedure, revenue codes). The measure includes all claims files or data tables that contain clinical fields (e.g., inpatient hospital, outpatient, other ambulatory and long-term care). SUD diagnoses can be in any position – primary or secondary – for continuity services. Since multiple claims files or tables could each contain a continuity claim, the specification calls for creating continuity variables separately within each file type or table, sorting the files or tables by beneficiary ID and service dates, then putting them together in order to assign the set of variables that are “First” to occur relative to the detox episode discharge date. Continuity services have to occur the day after discharge through day 7 or 14.

Step 2A.2: Identify pharmacotherapy which may occur in multiple files or tables. For example, one claims file or data source may contain injectables, another claims file or table data source may contain oral medications. Consequently, pharmacotherapy variables are created separately in each source, the data sources are then sorted by beneficiary ID and service dates, then multiple pharmacotherapy data sources are put together so they will be in chronological order to assign “First” variables. Pharmacotherapy services could be provided on the same day as the discharge from detox through day 7 or 14.

Step 2A.3: Co-occurring events: Continuity service flags and pharmacotherapy flags are reset to zero if an overdose diagnosis code appears on the SAME claim as the continuity service. Further, outpatient continuity is also reset to zero if an emergency department

visit occurs on the same day. If an inpatient continuity claim has an emergency department visit, it is allowed to remain a continuity service.

Step 3: Calculate rate

Step 3A: Calculate the overall 7- or 14-day continuity rates by dividing the number of discharges with a qualifying continuity service (Step 2A) by the denominator (Step 1B).

Step 3B: Calculate the rates separately for each detox location by dividing the respective number of discharges by each location with a qualifying continuity service (Step 2A) by the denominator (Step 1C). 120752| 141015

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

In the steps below we reference the Excel workbook we attached for S.2b. The workbook includes:

- 2016 HEDIS value sets used in measure testing
- 2018 HEDIS value sets used in measure testing for pharmacotherapy and telehealth codes
- Value sets developed during the specification and testing of this measure, and the value sets from NQF #3312 Continuity of Care for Medicaid Beneficiaries After Detoxification (Detox) from Alcohol and/or Drugs and NQF #3400 Use of Pharmacotherapy for Opioid Use Disorder (OUD) that were used in the specification of this measure.

Note - some states may need to also include relevant state-specific codes.

Step 1: Identify denominator

Step 1A. Eligible population: : Identify non-dually enrolled Medicaid beneficiaries age 18 through 64 years with any discharges from inpatient or residential treatment with a principal diagnosis of SUD during January 1 - December 15 of the measurement year. Patients must meet enrollment criteria, defined as Medicaid as the first payer and enrolled in the month of discharge and the following month. Age is calculated as of January 1 of the measurement year.

Throughout Steps 1 and 2, the principal diagnosis of SUD is identified using a principal diagnosis from the 2016 “HEDIS AOD Dependence” value set (Tab 1 in the attached Excel file) or any procedure code from the 2016 “HEDIS AOD Procedures” value set (Tab 2). Secondary diagnosis of SUD is identified using the same value sets.

Step 1B. Flag claims as inpatient or as residential treatment: Among the Medicaid beneficiaries in Step 1A, flag claims as being either in an inpatient or residential setting using all inpatient, outpatient, and ambulatory claims files or tables that contain HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes. Residential treatment is identified using the codes in the SUD Residential Treatment value set (Tab 3). If more than one discharge in a year, treat each discharge as a separate episode, e.g., an inpatient hospital discharge in January and a residential treatment discharge in July counts as two episodes.

Step 1B.1: Consolidate episodes: Multiple inpatient or residential treatment claims that are up to 2 days apart should be combined into a single episode. To facilitate this consolidation, sort the inpatient, outpatient and ambulatory discharges by Beneficiary ID and service dates to ensure the discharges from these multiple data sources are in

chronological order. Use all inpatient and residential treatment claims, regardless of diagnosis, to create episodes.

Step 1C: Assign treatment location to episodes: Use HCPCS, ICD-9/ICD-10 procedure or diagnosis codes, place of service, or UB revenue codes in the SUD Residential Treatment value set (Tab 3) and the SUD diagnosis value sets as noted in Step 1A to assign each episode as inpatient residential treatment, or a mix of both (also indicating the first setting of each episode and the last setting of each episode).

Step 1D: Exclusions: Exclude discharges that meet the exclusion criteria as specified in the "Denominator Exclusion Details" section.

- Exclude discharges for patients who receive hospice services during the measurement year.
- Exclude discharges after December 15 of the measurement year.
- Exclude discharges followed by admission or direct transfer to an inpatient or SUD residential treatment setting within the 7- or 14-day continuity of care period regardless of the principal diagnosis (with exception of admission to residential treatment following discharge from inpatient treatment).
- Exclude episodes that do not include at least one claim with primary diagnosis of SUD.

The denominator for the 7- and 14-day continuity of care rates will differ because of the different exclusions based on transfer or admission to hospital or residential treatment for 7 versus 14 days. For example, a beneficiary admitted to a residential setting on day 10 after discharge will be excluded from the 7-day rate but not from the 14-day rate.

Step 2: Identify numerator

Step 2A: From the denominator, identify discharges from inpatient or residential treatment for SUD with a principal diagnosis of SUD with qualifying continuity of care for SUD (principal or secondary diagnosis) within 7 or 14 days of discharge.

Step 2A.1: Visits: Identify visits meeting continuity of care criteria using outpatient claims files or tables that contain diagnosis, procedure, or revenue codes, procedure code modifiers, or place of service codes. SUD diagnoses can be in any position – primary or secondary – for continuity services. Visits have to occur the day after discharge through day 7 or 14. We identify visits as:

1. Any procedure code or UB revenue code from "HEDIS IET Stand Alone Visits" value set (Tab 4); or

2. Any procedure code from "HEDIS IET Visits Group 1" value set (Tab 5) along with place of service from "HEDIS IET POS Group 1" value set (Tab 6); or

3. Any procedure code from "HEDIS IET Visits Group 2" value set (Tab 7) along with place of service from "HEDIS IET POS Group 2" value set (Tab 8).

The claim must also have procedure code modifier that is missing or a value other than those in the "HEDIS Telehealth Modifier" value set (Tab 9).

Step 2.A.2. Telehealth: Identify visits for telehealth meeting continuity of care criteria using outpatient claims files or tables that contain diagnosis, procedure, or revenue codes, procedure code modifiers, or place of service codes. SUD diagnoses can be in any position – primary or secondary – for continuity services. Telehealth has to occur the day after discharge through day 7 or 14. We identify telehealth as:

1. Any procedure code from the "HEDIS Telephone Visit" value set (Tab 12); or

2. Any procedure code or UB revenue code from “HEDIS IET Stand Alone Visits” value set (Tab 4); or

3. Any procedure code from “HEDIS IET Visits Group 1” value set (Tab 5) along with place of service from “HEDIS IET POS Group 1” value set (Tab 6); or

4. Any procedure code from “HEDIS IET Visits Group 2” value set (Tab 7) along with place of service from “HEDIS IET POS Group 2” value set (Tab 8).

Claims identified using logic in #2-4 must also have procedure code modifier from the “HEDIS Telehealth Modifier” value set (Tab 9).

Step 2A.3: Identify pharmacotherapy events: Indications of pharmacotherapy can occur in outpatient or pharmacy files or tables that contain procedure codes or NDCs. Pharmacotherapy events could be provided on the same day as the discharge through day 7 or 14. Pharmacotherapy continuity claims are identified as follows:

1. In OT file, a) any procedure code from “HEDIS Medication Assisted Treatment” value set (Tab 10); or b) any HCPCS procedure code from “MAT Additional Codes” value set (Tab 11) (developed as part of testing for NQF 3312); or c) any state-specific procedure code from “MAT Additional Codes” value set (Tab 11) for the two states listed in the value set (these codes were identified through consultation for these states).

2. In RX file, any NDC from “AOD Pharmacotherapy” value set (Tab 13). This value set contains NDCs identified as part of testing for NQF 3312 and 3400.

Step 3: Calculate rate

Step 3A: Calculate the overall 7- or 14-day continuity of care rate by dividing the number of discharges with evidence of a qualifying continuity of care visit or pharmacotherapy event (Step 2A) by the denominator (after exclusions) (Step 1D). Calculate the rates separately for each continuity of care time period. 120752| 141015| 110874

Submission items

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

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

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not detoxification). Numerator: The measure captures follow-up with a primary alcohol or other drug dependence diagnosis.

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0004: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

5.1 Identified measures:

5a.1 Are specs completely harmonized?

5a.2 If not completely harmonized, identify difference, rationale, impact:

5b.1 If competing, why superior or rationale for additive value: N/A

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

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Follow-up time period: NQF 2605 examines follow-up care 7 days and 30 days after discharge. Our proposed measure (#3312) examines follow-up care 7 days and 14 days after discharge. The 14 day follow-up time period aligns with NQF 0004 and the non-NQF endorsed Continuity of Care After Detoxification measure developed by the Washington Circle, and reflects the input of some public commenters that adults should receive some type of care within two weeks of discharge from detoxification. Diagnoses: NQF 2605 requires a primary diagnosis of alcohol and other drug dependence (AOD) for the follow-up service. Our proposed measure (#3312) requires a primary or secondary diagnosis of AOD. We allow a primary or secondary AOD diagnosis to address potential inaccuracies in how AOD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an AOD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and AOD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. The differences in follow-up time period, location and diagnoses between NQF 2605 and our proposed measure (3312) do not impact the measure's interpretability in which a higher rate is indicative of better quality. Both measures rely on administrative data. The differences in measure specifications between 2605 and 3312 are minor and expected to have minimal impact on data collection burden.

5b.1 If competing, why superior or rationale for additive value: Not applicable. There are no other NQF-endorsed measures that conceptually address the same measure focus and same target population.

3453: Continuity of care after inpatient or residential treatment for substance use disorder (SUD)

5.1 Identified measures: 0004 : Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

2605 : Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

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

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: Parts of the specifications for the proposed measure harmonize with some measures but not others. Below we describe similarities and differences between the proposed measure and other

measures. The differences do not impose additional data collection burden to states, because the data elements are available in administrative data and are consistent with some measures states are already likely collecting. Numerator: Timing of continuity of care. The proposed measure specifies continuity of care within 7- and 14-days of discharge and is harmonized with NQF 3312, Continuity of care for Medicaid beneficiaries after detoxification (detox) from alcohol and/or drugs, which also focuses on a SUD population. NQF 0576, 1937, and 2605 all specify follow-up within 7 and 30 days. The populations for NQF 0576 and 1937 include patients with mental health related diagnoses rather than focusing on substance use disorders. NQF 2605 has a target mixed population of mental health and SUD patients. In measure testing, stakeholders expressed concern that 30 days is too long for SUD patients to wait for a continuity of care service after discharge from inpatient or residential care. Timelier follow-up with these patients is needed so as not to lose them. NQF 0004 is partially harmonized with the proposed measure in that the initiation visit is specified as within 14 days of the index episode start date (diagnosis). Diagnoses in the continuity of care visit. The proposed measure is harmonized with NQF 3312 and NQF 0004 by allowing SUD to either be the primary or a secondary diagnosis for treatment services that count toward continuity in the numerator. This is to address potential inaccuracies in how SUD diagnoses are coded. For example, some providers may be concerned about the stigma associated with an SUD diagnosis and therefore code it as a secondary diagnosis. Also, for adults with co-occurring mental health and SUD disorders, the assignment of primary and secondary diagnoses can be challenging and sometimes arbitrary. NQF 2605 does not allow a secondary SUD diagnosis. NQF 0576, NQF 1937, are not clear on whether only a primary diagnosis is allowed in the numerator. Services to include as continuity of care. The proposed measure includes pharmacotherapy and telehealth as services that count as continuity of care. NQF 2605, 0576, and 1937 do not include these services. Adding an SUD medication or telehealth claim as evidence of continuity of care is consistent with recent changes made to the 2018 HEDIS specification of NQF 0004 (National Committee on Quality Assurance, 2018). Practitioners valid for providing follow-up services. The proposed measure and NQF 2605 allow any practitioner to provide follow-up services, because of the expectation that the follow-up services captured in the measure may be provided by primary care clinicians. NQF 0576 and 1937 only allow non-mental health practitioners in specified settings and with specific diagnosis codes. Denominator: Diagnoses in denominator. The denominators for the proposed measure and all the related measures are harmonized in requiring a primary diagnosis for the condition that is the measure's focus. Age. The proposed measure is intended for an adult Medicaid population. Similar to NQF 3312 and NQF 1937, it includes ages 18-64.The proposed measure excludes adults over 64 years, because complete data on services received by dually-eligible (Medicaid and Medicare) adults are not available in Medicaid data. NQF 2605 includes adults age 18 and older. NQF 0576 includes individuals age 6 and older and NQF 0004 includes age 13 and older. In terms of impact on interpretability, the proposed measure would have lower continuity rates than the measures that have a 30-day follow-up time period and higher continuity rates than the measures that only count non-mental health practitioners in certain settings and with certain diagnosis codes.

5b.1 If competing, why superior or rationale for additive value: Not applicable; there are no competing measures.

Comparison of NQF 3489 and 0576

3489: Follow-Up After Emergency Department Visit for Mental Illness

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Steward

3489: Follow-Up After Emergency Department Visit for Mental Illness

National Committee for Quality Assurance

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

National Committee for Quality Assurance

Description

3489: Follow-Up After Emergency Department Visit for Mental Illness

The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. Two rates are reported:

- The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

Type

3489: Follow-Up After Emergency Department Visit for Mental Illness

Process

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Process

Data Source

3489: Follow-Up After Emergency Department Visit for Mental Illness

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 3489_FUM_Value_Sets_Spring_2019.xlsx

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Claims This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0576_FUH_Value_Sets.xlsx

Level

3489: Follow-Up After Emergency Department Visit for Mental Illness

Health Plan

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Health Plan, Integrated Delivery System

Setting

3489: Follow-Up After Emergency Department Visit for Mental Illness

Outpatient Services

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Inpatient/Hospital, Outpatient Services

Numerator Statement

3489: Follow-Up After Emergency Department Visit for Mental Illness

The numerator consists of two rates:

- 30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

- 7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

30-Day Follow-Up: A follow-up visit with a mental health practitioner within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health practitioner within 7 days after discharge.

Numerator Details

3489: Follow-Up After Emergency Department Visit for Mental Illness

30-day follow-up: The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

7-day follow-up: The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days). Any of the following meet criteria for a follow-up visit:

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- An outpatient visit (Visit Setting Unspecified Value Set with Outpatient POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An outpatient visit (BH Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set with Partial Hospitalization POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization/Intensive Outpatient Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set with Community Mental Health Center POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

- A telehealth visit (Visit Setting Unspecified Value Set with Telehealth POS Value Set), with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set), with or without a telehealth modifier (Telehealth Modifier Value Set).

- An observation visit (Observation Value Set) with a principal diagnosis of intentional self-harm (Intentional Self-Harm Value Set), with any diagnosis of a mental health disorder (Mental Health Diagnosis Value Set).

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below).

- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner.

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).

- Transitional care management services (TCM 7 Day Value Set).

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set)

(See corresponding Excel document for the value sets referenced above)

Mental Health Practitioner Definition:

A practitioner who provides mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

Denominator Statement

3489: Follow-Up After Emergency Department Visit for Mental Illness

Emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm on or between January 1 and December 1 of the measurement year.

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

Denominator Details

3489: Follow-Up After Emergency Department Visit for Mental Illness

Age: 6 years and older as of the date of the ED visit

Benefit: Medical and mental health.

Continuous Enrollment: Date of emergency department visit through 30 days the ED visit

Event/diagnosis criteria: An ED visit (ED Value Set) with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on or between January 1 and December 1 of the measurement year where the member was 6 years or older on the date of the visit.

The denominator for this measure is based on ED visits, not on members. If a member has more than one ED visit, identify all eligible ED visits between January 1 and December 1 of the measurement year and do not include more than one visit per 31-day period as described below.

If a member has more than one ED visit in a 31-day period, include only the first eligible ED visit. For example, if a member has an ED visit on January 1 then include the January 1 visit and do not include ED visits that occur on or between January 2 and January 31; then, if applicable, include the next ED visit that occurs on or after February 1. Identify visits chronologically including only one per 31-day period. Note: Removal of multiple visits in a 31-day period is based on eligible visits. Assess each ED visit for exclusions before removing multiple visits in a 31-day period.

Exclude ED visits that result in an inpatient stay and ED visits followed by admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit (31 total days), regardless of principal diagnosis for the admission. To identify admissions to an acute or nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Identify the admission date for the stay.

These events are excluded from the measure because admission to an acute or nonacute inpatient setting may prevent an outpatient follow-up visit from taking place.

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year.

To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute facility readmission or direct transfer:

If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge.

To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

*Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question S.2b.

Exclusions

3489: Follow-Up After Emergency Department Visit for Mental Illness

Patients in hospice.

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Exclusion Details

3489: Follow-Up After Emergency Department Visit for Mental Illness

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data (Hospice Value Set).

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data

(Hospice Value Set).

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

- See corresponding Excel document for the Value Sets referenced above in S.2b.

Risk Adjustment

3489: Follow-Up After Emergency Department Visit for Mental Illness

No risk adjustment or risk stratification

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

No risk adjustment or risk stratification

Stratification

3489: Follow-Up After Emergency Department Visit for Mental Illness

Not applicable.

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

N/A

Type Score

3489: Follow-Up After Emergency Department Visit for Mental Illness

Rate/proportion better quality = higher score

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Rate/proportion better quality = higher score

Algorithm

3489: Follow-Up After Emergency Department Visit for Mental Illness

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health. Do not include ED visits that result in an inpatient stay, or are followed by an admission to an acute or nonacute inpatient care setting on the date of the ED visit or within the 30 days after the ED visit.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of ED visits with qualifying follow-up visit within 7 days (Step 2A) by the denominator (Step 1A).

Step 3B: Calculate the 30-day rate by dividing the number of ED visits with qualifying follow-up visit within 30 days (Step 2B) by the denominator (Step 1A). 123834| 140881| 135810| 110874

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7).

Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9).

Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5).

Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2. 123834| 140881

Submission items

3489: Follow-Up After Emergency Department Visit for Mental Illness

5.1 Identified measures: 0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

5a.1 Are specs completely harmonized? Yes

5a.2 If not completely harmonized, identify difference, rationale, impact: The measure is harmonized with the existing NQF-endorsed measure. The following highlights the differences between the measures: Population focus (denominator): The measure targets patients discharged from the emergency department (not inpatient). Numerator: The measure captures follow-up with a primary mental health diagnosis (regardless of the type of provider).

5b.1 If competing, why superior or rationale for additive value: Not applicable.

0576: Follow-Up After Hospitalization for Mental Illness (FUH)

5.1 Identified measures:

5a.1 Are specs completely harmonized? No

5a.2 If not completely harmonized, identify difference, rationale, impact: N/A

5b.1 If competing, why superior or rationale for additive value: N/A

Appendix F: Pre-Evaluation Comments

No comments were received as of June 5, 2019.

National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org

ISBN