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Behavioral Health and Substance Use Spring 2022 Cycle: Public and Member Comments

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Post-Evaluation Measure-Specific Comments on Behavioral Health and Substance Use Spring 2022 Submissions

NQF #1884 Depression Response at Six Months- Progress Towards Remission (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8120 (Submitted: 07/21/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, Based on the committee discussion that occurred during the measure review meeting, there are three areas that we wanted to follow up on to ensure that the committee has clarity on the measures as they consider issues related to validity. Data Element Validity: Data element validity demonstrates that there is agreement with an authoritative source of the same information. The data elements for these measures are contained in structured fields extracted directly from the EHR, not abstracted, and agreement with the source (medical record) is high. However, because extraction is occurring, MNCM performs patient level data element audits against the source medical record to demonstrate that extraction programs are working correctly. Critical data element audit against the medical record demonstrated 100% agreement with diagnosis of depression or dysthymia, 100% agreement with exclusions, 95% agreement with assessment date of PHQ-9, and 94% agreement with the PHQ-9 score. Risk Adjustment: MNCM provided additional information to the committee about the fit of the risk adjustment model, in response to concerns raised by NQF staff. Missing Data: This criteria ensures that missing data does not bias the data results. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Several committee members suggested that patients who are not assessed with a follow-up PHQ-9/PHQ-9M should be removed from the denominator, however this would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up. Thank you for your consideration!

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8182 (Submitted: 09/07/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Greetings, MN Community Measurement (MNCM) would like to clarify an issue that was raised in the Overarching Themes in the draft Behavioral and Substance Use Spring 2022 Cycle report. It was noted in the report that the committee had concerns about the lack of telehealth services included in the specifications of several measures. Telehealth services are included in the use and specification of the measures we steward (NQF #0710e, NQF #0711, NQF #1884, NQF #1885, and NQF #0712) and have been included as part of the denominator definition for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement period. *For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. We look forward to addressing any additional questions or concerns the committee may have during the post-comment webinar. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer MN Community Measurement

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Koryn Y. Rubin, MHA, American Medical Association
Comment ID#: 8217 (Submitted: 09/08/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) continues to have concerns with the insufficient evidence demonstrating that depression scores can be successfully reduced by at least 50% across the defined patient population within a six-month timeframe nor was any evidence provided supporting this requirement of 50%. We also do not see any discussion of our request for clarification on whether this measure has met all of the requirements for electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve

Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing for National Quality Forum (NQF) #710e would also apply to this measure. In addition, we agree with the Standing Committee's concerns over the omission of telehealth services and inclusion of patients lost to follow-up in this measure as there is significant potential for the quality of care to be misrepresented. The AMA continues to question whether this measure meets the NQF measure evaluation criteria and as a result, believes that these concerns must be addressed before endorsement is continued.

Developer Response

Thank you for your comments and interest in measures that strive to improve health outcomes for patients with major depression or dysthymia. The response measures are considered as an interim outcome, or progress towards the ultimate outcome of the remission of symptoms. It is not an unreasonable expectation to have symptoms reduced at six months which has a +60-day window extending the assessment timeframe out to eight months. The acute treatment phase of depression is 6 to 12 weeks, so an assessment of symptoms during the measure's timeframe is well into the continuation phase of treatment. It is not unreasonable to have an interim goal that is reduced by 50% or greater during this timeframe. Soares et al in their 2014 study of the duration of current episode and treatment with desvenlafaxine or placebo used as one of their study outcomes defined a response of greater than or equal to 50% decrease in SDS and HDRS-17 total score. Howland et al in the evaluation of the effectiveness of duloxetine also used a measure of greater than or equal to 50% decrease in the HDRS-17 total score. [Functional Recovery in Major Depressive Disorder: Focus on Early Optimized Treatment PSYCHIATRIST.COM Sept 2016] In terms of e-CQM development, we agree. This measure has the same denominator of patients, using the same tool to measure outcomes. MNCM had early discussions with CMS about including the response measures as well, but at that time the Measure Authoring Tool could not handle the mathematical equation to calculate the measure, so the response measures were not included in the e-CQM program. This measure is not an e-CQM, but it is a digital quality measure. All components are captured from discrete data elements in the electronic record and MNCM has been capturing this information in a digital format via EHR extraction for 10+ years. Regarding telehealth services, they are included in the measure and have been for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. Lastly, in terms of missing data, all patients who are eligible for the measure (have the diagnosis of major depression or dysthymia and an elevated PHQ-9 score) remain in the denominator of the measure. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Removing patients who are not assessed with a follow-up PHQ-9/PHQ-9M from the denominator would introduce bias into the

measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

Response pending Standing Committee discussion.

Ms. Stacy Miller, Mental Health Outcomes

Comment ID#: 8248 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Depression and the PHQ-9 is a strong combination for PRO due to the proportion of impacted patients and the PHQ-9's brief nature, ability to detect depression improvement across care settings, and presence in the public domain. Though these strengths remain, the BH quality measure landscape has changed since this set was first endorsed in 2011. Many payers and The Joint Commission now require PRO measurement and CMS is investigating PRO adoption for IPFQR. We believe re-endorsement of the set must include consideration of its place in the modern landscape. Alignment of PRO tools across organizations is more beneficial for providers, facilities, and patients alike. When different organizations endorse tools that result in disrupted continuity across and within care settings, facilities and providers have higher burden, providers must become intimately familiar with multiple tools and results, and patients and providers lose continuity of measurement. Therefore, re-endorsement of the set is also endorsement of the PHQ-9 as the NQF's tool of choice in measuring outcomes for depressed patients. This may be appropriate, however it may also be that TJC's approach of allowing facilities to choose a tool meeting specified criteria is a path toward PRO that allows facilities and providers to align tools across organizations.

Developer Response

N/A

NQF Response

NQF thanks you for your comment. We appreciate your concern that NQF endorsement of a measure may appear to endorse a certain tool due to its use in recommended measures but want to assure you that NQF does not endorse measurement tools. Any measure developer may submit quality measures for the Standing Committee to review against the measure evaluation criteria and no preference is given to measures using specific tools.

NQF Committee Response

N/A

Dr. Tim Hernandez

Comment ID#: 8257 (Submitted: 06/07/2022)

Council / Public: Public

Level of Support: N/A

Comment

My organization, Entira Family Clinics, has been using the suite of depression measures for over 15 years. We strongly feel that our success in developing our entire care coordination system is in large part attributed to the infrastructure that we needed to build to be successful with this measure. The measure pushes us to have a robust registry tool to successfully follow these patients. In addition, we must do outreach in a population that eschews follow up. Complete remission can be a challenge. Having a measure that tracks progress towards the overall goal of complete remission is an excellent incentive to clinicians who deal with difficult to manage populations. My hope is that NQF continues to support the good work that this measure has allowed us to do.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

Andrew Lyzenga, American Psychiatric Association; Submitted by Andrew Lyzenga

Comment ID#: 8253 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: Member Does NOT Support

Comment

The American Psychiatric Association appreciates the opportunity to provide feedback on these measures being considered by the Behavioral Health and Substance Use Standing Committee. Gathering information through clinician or patient-completed screening and assessment tools is a critical part of quality care for patients with behavioral health conditions, as is measurement and tracking of outcomes over time. These activities are a core aspect of measurement-based care (MBC), which has been shown to be effective in improving outcomes and patient and provider satisfaction in both primary and specialty care. We would urge the developers to ensure that telehealth visits are included in these measures; we are encouraged that comments submitted by MN Community Measurement after the Standing Committee's initial evaluation suggest that telehealth services are indeed included in the measure specifications. Given mental health workforce shortages and maldistribution of providers, psychiatric consultations through telehealth have become an integral part of clinical practice, especially for communities that lack local

expertise. We have some concern that there remains a lack of widespread and standardized infrastructure for collecting and reporting data on measures, and that there may be associated challenges with implementing these measures at a national level. However, we are hopeful that continued emphasis on measurement and data collection will spur allocation of additional resources and development of improved infrastructure in this area.

Developer Response

Thank you for your comments and support for the depression measures. Thank you also for reviewing the response comment regarding telehealth services, which are included in the denominators for the depression measures. We agree that the provision of telehealth services is important to the overall ability to deliver mental health services. It appears that there is one positive related to the covid-19 pandemic: the rapid expansion of telehealth. We have received feedback from our behavioral health providers in MN that telehealth has allowed them to provide more services and expand their reach in the rural settings where distance may have prohibited the delivery of services. We share your concern (and hope!) about a lack of widespread and standardized infrastructure for collecting and reporting data on measures on a national level. We have witnessed a widespread adoption of the PHQ-9/ PHQ-9M as a tool for assessing and monitoring depression symptoms, not only in Minnesota, but nationally as well, although perhaps more in the primary care space nationally than specialty care. In the 10+ years that MN has been reporting this measure, we have seen a significant uptake in use of the tool by behavioral specialists and many view the common tool as a great communication mechanism between primary and specialty care. We also understand your concern surrounding infrastructure as well but believe that there is hope on the horizon. Many EHR vendors have incorporated the PHQ-9 into their system, we are most experienced with Epic, but several other vendors list having the PHQ-9 screening tool available within their system- GE Centricity, Kareo, athenaOne, TherapyNotes, RXNT, NextGen and TheraNest to name a few. We are hopeful that continued emphasis on measurement and data collection for patients with depression will focus attention and resources in this area and lead to improved health outcomes.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Proposed Committee Response

N/A

NQF #1885 Depression Response at Twelve Months- Progress Towards Remission (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8184 (Submitted: 09/07/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Greetings, MN Community Measurement (MNCM) would like to clarify an issue that was raised in the Overarching Themes in the draft Behavioral and Substance Use Spring 2022 Cycle report. It was noted in the report that the committee had concerns about the lack of telehealth services included in the specifications of several measures. Telehealth services are included in the use and specification of the measures we steward (NQF #0710e, NQF #0711, NQF #1884, NQF #1885, and NQF #0712) and have been included as part of the denominator definition for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement period. *For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. We look forward to addressing any additional questions or concerns the committee may have during the post-comment webinar. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer MN Community Measurement

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8121 (Submitted: 07/21/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, Based on the committee discussion that occurred during the measure review meeting, there are three areas that we wanted to follow up on to ensure that the committee has clarity on the measures as they consider issues related to validity. Data Element Validity: Data element validity demonstrates that there is agreement with an authoritative source of the same information. The data elements for these measures are contained in structured fields extracted directly from the EHR, not abstracted, and agreement with the source (medical record) is high. However, because extraction is occurring, MNCM performs patient level data element audits against the source medical record to demonstrate that extraction programs are working correctly. Critical data element audit against the medical record demonstrated 100% agreement with diagnosis of depression or dysthymia, 100% agreement with exclusions, 95% agreement with assessment date of PHQ-9, and 94% agreement with the PHQ-9 score. Risk Adjustment: MNCM provided additional information to the committee about the fit of the risk adjustment model, in response to concerns

raised by NQF staff. Missing Data: This criteria ensures that missing data does not bias the data results. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Several committee members suggested that patients who are not assessed with a follow-up PHQ-9/PHQ-9M should be removed from the denominator, however this would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up. Thank you for your consideration!

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Koryn Y. Rubin, MHA, American Medical Association

Comment ID#: 8218 (Submitted: 09/08/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) continues to have concerns with the insufficient evidence demonstrating that depression scores can be successfully reduced by at least 50% across the defined patient population within a twelve-month timeframe nor was any evidence provided supporting this requirement of 50%. We also do not see any discussion of our request for clarification on whether this measure has met all of the requirements for electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing for National Quality Forum (NQF) #710e would also apply to this measure. In addition, we agree with the Standing Committee's concerns over the omission of telehealth services and inclusion of patients lost to follow-up in this measure as there is significant potential for the quality of care to be misrepresented. The AMA continues to question whether this measure meets the NQF measure evaluation criteria and as a result, believes that these concerns must be addressed before endorsement is continued.

Developer Response

Thank you for your comments and interest in measures that strive to improve health outcomes for patients with major depression or dysthymia. The response measures are considered as an interim outcome, or progress towards the ultimate outcome of the remission of symptoms. It is a

reasonable expectation to have symptoms reduced at 12 months with the +60-day window extending the assessment timeframe out to fourteen months. The development workgroup members supported a stepwise approach to depression treatment in that patients not responding successfully to treatment need a re-evaluation and a change to their plan of care. This was grounded in the STAR*D study Sequenced Treatment Alternatives to Relieve Depression which noted that "measurement-based care—that is, using brief, easy-to-administer instruments to monitor depression severity and side effects, following an evidence-based treatment algorithm, making decisions at key time points, and having remission as a goal of treatment—is a feasible strategy that can be adapted in real-world practice settings—both psychiatric and primary care settings." [Gaynes, B.N et al What did STAR*D Teach Us? Results From a Large-Scale, Practical, Clinical Trial for Patients with Depression https://doi.org/10.1176/ps.2009.60.11.1439] The acute treatment phase of depression is 6 to 12 weeks, so an assessment of symptoms during the measure's timeframe is well into the continuation phase of treatment. It is not unreasonable to have an interim goal that is reduced by 50% or greater during this timeframe. Soares et al in their 2014 study of the duration of current episode and treatment with desvenlafaxine or placebo used as one of their study outcomes defined a response of greater than or equal to 50% decrease in SDS and HDRS-17 total score. Howland et al in the evaluation of the effectiveness of duloxetine also used a measure of greater than or equal to 50% decrease in the HDRS-17 total score. [Functional Recovery in Major Depressive Disorder: Focus on Early Optimized Treatment PSYCHIATRIST.COM Sept 2016] In terms of e-CQM development, we agree. This measure has the same denominator of patients, using the same tool to measure outcomes. MNCM had early discussions with CMS about including the response measures as well, but at that time the Measure Authoring Tool could not handle the mathematical equation to calculate the measure, so the response measures were not included in the e-CQM program. This measure is not an e-CQM, but it is a digital quality measure. All components are captured from discrete data elements in the electronic record and MNCM has been capturing this information in a digital format via EHR extraction for 10+ years. Regarding telehealth services, they are included in the measure and have been for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. Lastly, in terms of missing data, all patients who are eligible for the measure (have the diagnosis of major depression or dysthymia and an elevated PHQ-9 score) remain in the denominator of the measure. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Removing patients who are not assessed with a follow-up PHQ-9/PHQ-9M from the denominator would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up.

NQF Response

N/A

Proposed NQF Committee Response

Response pending Standing Committee discussion.

Ms. Stacy Miller, Mental Health Outcomes

Comment ID#: 8249 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Depression and the PHQ-9 is a strong combination for PRO due to the proportion of impacted patients and the PHQ-9's brief nature, ability to detect depression improvement across care settings, and presence in the public domain. Though these strengths remain, the BH quality measure landscape has changed since this set was first endorsed in 2011. Many payers and The Joint Commission now require PRO measurement and CMS is investigating PRO adoption for IPFQR. We believe re-endorsement of the set must include consideration of its place in the modern landscape. Alignment of PRO tools across organizations is more beneficial for providers, facilities, and patients alike. When different organizations endorse tools that result in disrupted continuity across and within care settings, facilities and providers have higher burden, providers must become intimately familiar with multiple tools and results, and patients and providers lose continuity of measurement. Therefore, re-endorsement of the set is also endorsement of the PHQ-9 as the NQF's tool of choice in measuring outcomes for depressed patients. This may be appropriate, however it may also be that TJC's approach of allowing facilities to choose a tool meeting specified criteria is a path toward PRO that allows facilities and providers to align tools across organizations.

Developer Response

N/A

NQF Response

NQF thanks you for your comment. We appreciate your concern that NQF endorsement of a measure may appear to endorse a certain tool due to its use in recommended measures but want to assure you that NQF does not endorse measurement tools. Any measure developer may submit quality measures for the Standing Committee to review against the measure evaluation criteria and no preference is given to measures using specific tools.

NQF Committee Response

N/A

Dr. Tim Hernandez

Comment ID#: 8256 (Submitted: 06/07/2022)

Council / Public: Public

Level of Support: N/A

Comment

My organization, Entira Family Clinics, has been using the suite of depression measures for over 15 years. We strongly feel that our success in developing our entire care coordination system is in large part attributed to the infrastructure that we needed to build to be successful with this measure. The measure pushes us to have a robust registry tool to successfully follow these patients. In addition, we must do outreach in a population that eschews follow up. Complete remission can be a challenge. Having a measure that tracks progress towards the overall goal of complete remission is an incentive to clinicians who deal with difficult to manage populations. My hope is that NQF continues to support the good work that this measure has allowed. We need measures, as well as the support of payers to help us manage these measures, to push the excellent work that we have done in the state of Minnesota.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

Andrew Lyzenga, American Psychiatric Association; Submitted by Andrew Lyzenga

Comment ID#: 8253 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: Member Does NOT Support

Comment

The American Psychiatric Association appreciates the opportunity to provide feedback on these measures being considered by the Behavioral Health and Substance Use Standing Committee. Gathering information through clinician or patient-completed screening and assessment tools is a critical part of quality care for patients with behavioral health conditions, as is measurement and tracking of outcomes over time. These activities are a core aspect of measurement-based care (MBC), which has been shown to be effective in improving outcomes and patient and provider satisfaction in both primary and specialty care. We would urge the developers to ensure that telehealth visits are included in these measures; we are encouraged that comments submitted by MN Community Measurement after the Standing Committee's initial evaluation suggest that telehealth services are indeed included in the measure specifications. Given mental health workforce shortages and maldistribution of providers, psychiatric consultations through telehealth have become an integral part of clinical practice, especially for communities that lack local expertise. We have some concern that there remains a lack of widespread and standardized infrastructure for collecting and reporting data on measures, and that there may be associated challenges with implementing these measures at a national level. However, we are hopeful that

continued emphasis on measurement and data collection will spur allocation of additional resources and development of improved infrastructure in this area.

Developer Response

Thank you for your comments and support for the depression measures. Thank you also for reviewing the response comment regarding telehealth services, which are included in the denominators for the depression measures. We agree that the provision of telehealth services is important to the overall ability to deliver mental health services. It appears that there is one positive related to the covid-19 pandemic: the rapid expansion of telehealth. We have received feedback from our behavioral health providers in MN that telehealth has allowed them to provide more services and expand their reach in the rural settings where distance may have prohibited the delivery of services. We share your concern (and hope!) about a lack of widespread and standardized infrastructure for collecting and reporting data on measures on a national level. We have witnessed a widespread adoption of the PHQ-9/ PHQ-9M as a tool for assessing and monitoring depression symptoms, not only in Minnesota, but nationally as well, although perhaps more in the primary care space nationally than specialty care. In the 10+ years that MN has been reporting this measure, we have seen a significant uptake in use of the tool by behavioral specialists and many view the common tool as a great communication mechanism between primary and specialty care. We also understand your concern surrounding infrastructure as well but believe that there is hope on the horizon. Many EHR vendors have incorporated the PHQ-9 into their system, we are most experienced with Epic, but several other vendors list having the PHQ-9 screening tool available within their system- GE Centricity, Kareo, athenaOne, TherapyNotes, RXNT, NextGen and TheraNest to name a few. We are hopeful that continued emphasis on measurement and data collection for patients with depression will focus attention and resources in this area and lead to improved health outcomes.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

NQF #0711 Depression Remission at Six Months (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8118 (Submitted: 07/21/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, Based on the committee discussion that occurred during the measure review meeting, there are three areas that we wanted to follow up on to ensure that the committee has clarity on the measures as they consider issues related to validity. Data Element Validity: Data element validity demonstrates that there is agreement with an authoritative source of the same information. The

data elements for these measures are contained in structured fields extracted directly from the EHR, not abstracted, and agreement with the source (medical record) is high. However, because extraction is occurring, MNCM performs patient level data element audits against the source medical record to demonstrate that extraction programs are working correctly. Critical data element audit against the medical record demonstrated 100% agreement with diagnosis of depression or dysthymia, 100% agreement with exclusions, 95% agreement with assessment date of PHQ-9, and 94% agreement with the PHQ-9 score. Risk Adjustment: MNCM provided additional information to the committee about the fit of the risk adjustment model, in response to concerns raised by NQF staff. Missing Data: This criteria ensures that missing data does not bias the data results. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Several committee members suggested that patients who are not assessed with a follow-up PHQ-9/PHQ-9M should be removed from the denominator, however this would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up. Thank you for your consideration!

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8180 (Submitted: 09/07/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Greetings, MN Community Measurement (MNCM) would like to clarify an issue that was raised in the Overarching Themes in the draft Behavioral and Substance Use Spring 2022 Cycle report. It was noted in the report that the committee had concerns about the lack of telehealth services included in the specifications of several measures. Telehealth services are included in the use and specification of the measures we steward (NQF #0710e, NQF #0711, NQF #1884, NQF #1885, and NQF #0712) and have been included as part of the denominator definition for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement period. *For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression

"face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. We look forward to addressing any additional questions or concerns the committee may have during the post-comment webinar. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer MN Community Measurement

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Koryn Y. Rubin, MHA, American Medical Association

Comment ID#: 8216 (Submitted: 09/08/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) continues to have concerns with the insufficient evidence demonstrating that remission can be successfully achieved across the defined patient population within a six-month timeframe. We also do not see any discussion of our request for clarification on whether this measure has met all of the requirements for electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing for National Quality Forum (NQF) #710e also apply to this measure. In addition, we agree with the Standing Committee's concerns over the omission of telehealth services and inclusion of patients lost to follow-up in this measure as there is significant potential for the quality of care to be misrepresented. The AMA continues to question whether this measure meets the NQF measure evaluation criteria and as a result, believes that these concerns must be addressed before endorsement is continued.

Developer Response

Thank you for your comments and interest in measures that strive to improve health outcomes for patients with major depression or dysthymia. This patient-centric outcome measure is seeking to improve symptoms of depression significantly; remission defined as a PHQ-9 or PHQ-9M score of less than 5 which is defined by the tool's cut points as mild or no symptoms. The Depression Remission at Six Months measure seeks an assessment of outcomes at six months +60 days which has a window extending the assessment timeframe out to eight months. The acute treatment phase of depression is 6 to 12 weeks, so an assessment of symptoms during the measure's timeframe is well into the continuation phase of treatment. It is not unreasonable to strive for this patient centric outcome of remission of symptoms during this timeframe. In terms of e-CQM

development, we agree. This measure, Depression Remission at Six Months was simultaneously developed as an e-CQM along with the companion measure (#0710-e Depression Remission at 12 months). This six-month measure not adopted into the e-CQM program, however it is a digital quality measure. All components are captured from discrete data elements in the electronic record and MNCM has been capturing this information in a digital format via EHR extraction for 10+ years. Regarding telehealth services, they are included in the measure and have been for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. Lastly, in terms of missing data, all patients who are eligible for the measure (have the diagnosis of major depression or dysthymia and an elevated PHQ-9 score) remain in the denominator of the measure. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Removing patients who are not assessed with a follow-up PHQ-9/PHQ-9M from the denominator would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up.

NQF Response

N/A

Proposed NQF Committee Response

The NQF Behavioral Health Standing Committee thanks you for your comment. The Standing Committee agreed that there are advantages to examining remission at six months and had no concerns with the evidence supporting this measure. Additionally, this measure is not being reviewed as an eCQM and therefore is not required to meet eCQM standards, so the Standing Committee has no concerns related to the measure meeting these requirements.

Ms. Stacy Miller, Mental Health Outcomes

Comment ID#: 8246 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Depression and the PHQ-9 is a strong combination for PRO due to the proportion of impacted patients and the PHQ-9's brief nature, ability to detect depression improvement across care settings, and presence in the public domain. Though these strengths remain, the BH quality measure landscape has changed since this set was first endorsed in 2011. Many payers and The Joint Commission now require PRO measurement and CMS is investigating PRO adoption for IPFQR. We believe re-endorsement of the set must include consideration of its place in the modern

landscape. Alignment of PRO tools across organizations is more beneficial for providers, facilities, and patients alike. When different organizations endorse tools that result in disrupted continuity across and within care settings, facilities and providers have higher burden, providers must become intimately familiar with multiple tools and results, and patients and providers lose continuity of measurement. Therefore, re-endorsement of the set is also endorsement of the PHQ-9 as the NQF's tool of choice in measuring outcomes for depressed patients. This may be appropriate, however it may also be that TJC's approach of allowing facilities to choose a tool meeting specified criteria is a path toward PRO that allows facilities and providers to align tools across organizations.

Developer Response

N/A

NQF Response

NQF thanks you for your comment. We appreciate your concern that NQF endorsement of a measure may appear to endorse a certain tool due to its use in recommended measures but want to assure you that NQF does not endorse measurement tools. Any measure developer may submit quality measures for the Standing Committee to review against the measure evaluation criteria and no preference is given to measures using specific tools.

NQF Committee Response

N/A

Dr. Tim Hernandez

Comment ID#: 8260 (Submitted: 06/07/2022)

Council / Public: Public

Level of Support: N/A

Comment

My organization, Entira Family Clinics, has been using the suite of depression measures for over 15 years. We strongly feel that our success in developing our entire care coordination system is in large part attributed to the infrastructure that we needed to build to be successful with this measure. The measure pushes us to have a robust registry tool to successfully follow these patients. In addition, we must do outreach in a population that eschews follow up. Our clinicians are challenged by the timing of the measure to "treat to target" in order to get this population at their stated goal, as measured by a PROM. My organization has been amongst the top performing primary clinics in achieving high rates of depression remission in large part due to the laser focus that this measure dictates. My hope is that NQF will continue to endorse this measure as well as other measures in the depression remission/response suite.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

Andrew Lyzenga, American Psychiatric Association; Submitted by Andrew Lyzenga
Comment ID#: 8253 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: Member Does NOT Support

Comment

The American Psychiatric Association appreciates the opportunity to provide feedback on these measures being considered by the Behavioral Health and Substance Use Standing Committee. Gathering information through clinician or patient-completed screening and assessment tools is a critical part of quality care for patients with behavioral health conditions, as is measurement and tracking of outcomes over time. These activities are a core aspect of measurement-based care (MBC), which has been shown to be effective in improving outcomes and patient and provider satisfaction in both primary and specialty care. We would urge the developers to ensure that telehealth visits are included in these measures; we are encouraged that comments submitted by MN Community Measurement after the Standing Committee's initial evaluation suggest that telehealth services are indeed included in the measure specifications. Given mental health workforce shortages and maldistribution of providers, psychiatric consultations through telehealth have become an integral part of clinical practice, especially for communities that lack local expertise. We have some concern that there remains a lack of widespread and standardized infrastructure for collecting and reporting data on measures, and that there may be associated challenges with implementing these measures at a national level. However, we are hopeful that continued emphasis on measurement and data collection will spur allocation of additional resources and development of improved infrastructure in this area.

Developer Response

Thank you for your comments and support for the depression measures. Thank you also for reviewing the response comment regarding telehealth services, which are included in the denominators for the depression measures. We agree that the provision of telehealth services is important to the overall ability to deliver mental health services. It appears that there is one positive related to the covid-19 pandemic: the rapid expansion of telehealth. We have received feedback from our behavioral health providers in MN that telehealth has allowed them to provide more services and expand their reach in the rural settings where distance may have prohibited the delivery of services. We share your concern (and hope!) about a lack of widespread and standardized infrastructure for collecting and reporting data on measures on a national level. We have witnessed a widespread adoption of the PHQ-9/ PHQ-9M as a tool for assessing and monitoring depression symptoms, not only in Minnesota, but nationally as well, although perhaps more in the primary care space nationally than specialty care. In the 10+ years that MN has been reporting this measure, we have seen a significant uptake in use of the tool by behavioral specialists and many view the common tool as a great communication mechanism between primary and specialty care. We also understand your concern surrounding infrastructure as well but believe that there is hope on the horizon. Many EHR vendors have incorporated the PHQ-9 into their system, we are most experienced with Epic, but several other vendors list having the PHQ-9 screening tool available within their system- GE Centricity, Kareo, athenaOne, TherapyNotes, RXNT, NextGen and TheraNest to name a few. We are hopeful that continued emphasis on measurement

and data collection for patients with depression will focus attention and resources in this area and lead to improved health outcomes.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

NQF #3312 Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs (Recommended)

Dr. Uddin and Aaron Mchone, UnityPoint Health ; Submitted by Stephanie Collingwood

Comment ID#: 8147 (Submitted: 09/01/2022)

Council / Public: Public

Level of Support: N/A

Comment

UnityPoint Health supports NQF measures 3312 and 3313. In general, UnityPoint Health feels <7 and <14 day follow ups after discharges from a medically managed withdrawal episode as well as <28 day follow ups after new antipsychotic prescriptions is a best practice that we support. However, we do have concerns around the age range and payor population proposed within the measures. We would fully support future broadening of these measures to a larger patient population(age group) and payor mix. As currently proposed, these measures are limited to Medicaid patients only and within certain age ranges. For example, it's clinically appropriate for a 65-year-old discharging from medical managed withdrawal and a 17-year-old on a new antipsychotic to also meet these measurement requirements. Additionally, we find a significant number of patients who qualify for these metrics are dual eligible (Medicaid and Medicare). In our experience, CMS and Medicaid MCOs have historically been unable to share claims data effectively. As such we are concerned that data for this metric would be inaccurate as different claims would go to different health plans. This is particularly true for patients discharging from a medically managed withdrawal facility which tend to be primarily reimbursed by Medicaid with the follow up being reimbursed through Medicare Part B. Overall, we are concern that claims-based data may not be as accurate for these measures due to a relatively high volume of dual eligibility patients and thus the outcomes of these measures may not reveal a complete view of the patients who receive, or should receive, this best practice, standard of care.

Developer Response

In response to your concerns about the age range of the measures in question: • For NQF 3312, the upper limit of 64 years was chosen after careful consideration of evidence from the literature, input from experts, feasibility of data collection, and findings from measure testing. CMS will continue to review the relevant research and reconsider the age range should new evidence emerge. • For NQF 3313, the current specifications currently do not set an upper limit for the age of individuals eligible for inclusion in the measure; only pediatric cases (i.e., those under age 18) are excluded from

assessment. Like NQF 3312, CMS will reassess the age of those included in the measure's population, should new relevant research emerge. To your feedback about the accuracy of claims-based data for individuals eligible for both Medicare and Medicaid (i.e., dually enrolled participants): • CMS and its measurement development contractor completed comprehensive reevaluation of the NQF 3312 and NQF 3313 technical specifications in advance of NQF endorsement review. As part of this effort, CMS reviewed data sources to ensure the most accurate and complete data were used for measure calculation and testing. The primary data used for testing in the NQF 3312 and NQF 3313 submissions were Transformed Medicaid Statistical Information System (T-MSIS) Analytical Files (TAF); for participants dually enrolled in both Medicare and Medicaid, Medicare Parts A, B, C, and D claims data were also used. Using your example, an individual who had been discharged from a facility for medically managed withdrawal whose care was reimbursed using both Medicare and Medicaid would be captured in the NQF 3312 denominator population

NQF Response

N/A

NQF Committee Response

Response pending Standing Committee discussion.

Ms. Stacy Miller, Mental Health Outcomes

Comment ID#: 8236 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Mental Health Outcomes recognizes the importance of continuity of care for patients discharging from a medically managed withdrawal episode. With behavioral health challenges impacting greater numbers following the COVID-19 pandemic, it is important to consider the applications of measures that focus on the quality of inpatient psychiatric services. However, we are concerned with the exclusion of telemedicine codes in the current specifications for NQF#3312. According to the Morbidity and Mortality Weekly Report from CDC, telemedicine services have nearly doubled since the start of the pandemic. As smartphone ownership continues to increase among low-income populations, telehealth further increases patient access to care services. We are concerned that the measure in its current state is not consistent with the World Health Organization's recommendations to apply approaches that build supportive services for the future.

Developer Response

Thank you for your comment about Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs (NQF 3312). Testing of the technical specifications for NQF 3312 endorsement maintenance used Medicaid claims data from January 1, 2018, through December 15, 2018 (allowing for 7- and 14-day follow-up after the discharge); thus, the measure was assessed,

quantitatively, using data for services provided prior to the COVID-19 public health emergency. In the future, when more recent Medicaid administrative claims data are available, CMS will consider retesting and updating of the technical specifications to capture follow up for those seeking medically managed care using a telemedicine CPT code(s).

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

NQF #3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (Not Recommended)

Dr. Uddin and Aaron Mchone, UnityPoint Health; Submitted by Stephanie Collingwood

Comment ID#: 8148 (Submitted: 09/01/2022)

Council / Public: Public

Level of Support: N/A

Comment

UnityPoint Health supports NQF measures 3312 and 3313. In general, UnityPoint Health feels <7 and <14 day follow ups after discharges from a medically managed withdrawal episode as well as <28 day follow ups after new antipsychotic prescriptions is a best practice that we support. However, we do have concerns around the age range and payor population proposed within the measures. We would fully support future broadening of these measures to a larger patient population(age group) and payor mix. As currently proposed, these measures are limited to Medicaid patients only and within certain age ranges. For example, it's clinically appropriate for a 65-year-old discharging from medical managed withdrawal and a 17-year-old on a new antipsychotic to also meet these measurement requirements. Additionally, we find a significant number of patients who qualify for these metrics are dual eligible (Medicaid and Medicare). In our experience, CMS and Medicaid MCOs have historically been unable to share claims data effectively. As such we are concerned that data for this metric would be inaccurate as different claims would go to different health plans. This is particularly true for patients discharging from a medically managed withdrawal facility which tend to be primarily reimbursed by Medicaid with the follow up being reimbursed through Medicare Part B. Overall, we are concern that claims-based data may not be as accurate for these measures due to a relatively high volume of dual eligibility patients and thus the outcomes of these measures may not reveal a complete view of the patients who receive, or should receive, this best practice, standard of care.

Developer Response

Thank you for your support of continued endorsement for NQF 3312 and 3313. In response to your concerns about the age range of the measures in question: • For NQF 3312, the upper limit of 64 years was chosen after careful consideration of evidence from the literature, input from experts, feasibility of data collection, and findings from measure testing. CMS will continue to review the relevant research and reconsider the age range should new evidence emerge. • For NQF 3313, the

current specifications currently do not set an upper limit for the age of individuals eligible for inclusion in the measure; only pediatric cases (i.e., those under age 18) are excluded from assessment. Like NQF 3312, CMS will reassess the age of those included in the measure's population, should new relevant research emerge. To your feedback about the accuracy of claims-based data for individuals eligible for both Medicare and Medicaid (i.e., dually enrolled participants): • CMS and its measurement development contractor completed comprehensive reevaluation of the NQF 3312 and NQF 3313 technical specifications in advance of NQF endorsement review. As part of this effort, CMS reviewed data sources to ensure the most accurate and complete data were used for measure calculation and testing. The primary data used for testing in the NQF 3312 and NQF 3313 submissions were Transformed Medicaid Statistical Information System (T-MSIS) Analytical Files (TAF); for participants dually enrolled in both Medicare and Medicaid, Medicare Parts A, B, C, and D claims data were also used. Using your example, an individual who had been discharged from a facility for medically managed withdrawal whose care was reimbursed using both Medicare and Medicaid would be captured in the NQF 3312 denominator population.

NQF Response

N/A

NQF Committee Response

Response pending Standing Committee discussion.

NQF #0710e Depression Remission at Twelve Months (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8181 (Submitted: 09/07/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Greetings, MN Community Measurement (MNCM) would like to clarify an issue that was raised in the Overarching Themes in the draft Behavioral and Substance Use Spring 2022 Cycle report. It was noted in the report that the committee had concerns about the lack of telehealth services included in the specifications of several measures. Telehealth services are included in the use and specification of the measures we steward (NQF #0710e, NQF #0711, NQF #1884, NQF #1885, and NQF #0712) and have been included as part of the denominator definition for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement period. *For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in

which a diagnosis was made. We look forward to addressing any additional questions or concerns the committee may have during the post-comment webinar. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer MN Community Measurement

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8119 (Submitted: 07/21/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, Based on the committee discussion that occurred during the measure review meeting, there are three areas that we wanted to follow up on to ensure that the committee has clarity on the measures as they consider issues related to validity. Data Element Validity: Data element validity demonstrates that there is agreement with an authoritative source of the same information. The data elements for these measures are contained in structured fields extracted directly from the EHR, not abstracted, and agreement with the source (medical record) is high. However, because extraction is occurring, MNCM performs patient level data element audits against the source medical record to demonstrate that extraction programs are working correctly. Critical data element audit against the medical record demonstrated 100% agreement with diagnosis of depression or dysthymia, 100% agreement with exclusions, 95% agreement with assessment date of PHQ-9, and 94% agreement with the PHQ-9 score. Risk Adjustment: MNCM provided additional information to the committee about the fit of the risk adjustment model, in response to concerns raised by NQF staff. Missing Data: This criteria ensures that missing data does not bias the data results. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Several committee members suggested that patients who are not assessed with a follow-up PHQ-9/PHQ-9M should be removed from the denominator, however this would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up. Thank you for your consideration!

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Koryn Y. Rubin, MHA, American Medical Association

Comment ID#: 8215 (Submitted: 09/08/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) continues to have concerns with the insufficient evidence demonstrating that remission can be successfully achieved across the defined patient population within a twelve-month timeframe. We also do not see any discussion of our request for clarification on whether this measure has met all of the requirements for electronic clinical quality measures (eCQMs) since the National Quality Forum (NQF) measure evaluation criteria require patient-encounter-level validity testing. In addition, we agree with the Standing Committee's concerns over the omission of telehealth services and inclusion of patients lost to follow-up in this measure as there is significant potential for the quality of care to be misrepresented. The AMA continues to question whether this measure meets the NQF measure evaluation criteria and as a result, believes that these concerns must be addressed before endorsement is continued.

Developer Response

Thank you for your comments and interest in measures that strive to improve health outcomes for patients with major depression or dysthymia. This patient-centric outcome measure is seeking to improve symptoms of depression significantly; remission defined as a PHQ-9 or PHQ-9M score of less than 5 which is defined by the tool's cut points as mild or no symptoms. The Depression Remission at Twelve Months measure seeks an assessment of outcomes at twelve months +60 days which has a window extending the assessment timeframe out to fourteen months. The acute treatment phase of depression is 6 to 12 weeks, so an assessment of symptoms (outcome) during the measure's timeframe is well beyond the continuation phase of treatment. It is not unreasonable to strive for this patient centric outcome of remission of symptoms during this timeframe. Patient level, and in fact contact level (each PHQ-9/PHQ-9M) validation did occur. In addition to the NQF feasibility scorecard, the HQMF specifications (Measure Authoring Tool) and BONNIE testing results, individual data element (patient, encounter and contact level) validity results were submitted in question 2b.02 and 2b.03 of the application. In response to questions from the committee, additional statistics about the data element validation were provided: Data element validity demonstrates that there is agreement with an authoritative source of the same information. The data elements for these measures are contained in structured fields extracted directly from the EHR, not abstracted, and agreement with the source (medical record) is high. However, because extraction is occurring, MNCM performs patient level data element audits against the source medical record to demonstrate that extraction programs are working correctly. Critical data element audit against the medical record demonstrated 100% agreement with diagnosis of depression or dysthymia, 100% agreement with exclusions, 95% agreement with assessment date of PHQ-9, and 94% agreement with the PHQ-9 score. Regarding telehealth services, they are included in the measure and have been for several years. Currently, the

denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. Lastly, in terms of missing data, all patients who are eligible for the measure (have the diagnosis of major depression or dysthymia and an elevated PHQ-9 score) remain in the denominator of the measure. The measure construct purposely includes patients without a follow up in denominator in order to avoid bias in the measure. (e.g., selective tool administration to only patients who are doing well). It is important to note that lack of a follow-up assessment is not missing data, rather represents a gap in care. Removing patients who are not assessed with a follow-up PHQ-9/PHQ-9M from the denominator would introduce bias into the measure that currently does not exist. The current construct of keeping eligible patients in the denominator promotes inclusiveness and accountability for follow-up.

NQF Response

N/A

Proposed NQF Committee Response

The NQF Behavioral Health Standing Committee thanks you for your comment. The Standing Committee agreed that there are advantages to examining remission at twelve months and had no concerns with the evidence supporting this measure. Additionally, this measure is not an eCQM and therefore is not required to meet eCQM standards, so the Standing Committee has no concerns about eCQM status..

Ms. Stacy Miller, Mental Health Outcomes

Comment ID#: 8247 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Depression and the PHQ-9 is a strong combination for PRO due to the proportion of impacted patients and the PHQ-9's brief nature, ability to detect depression improvement across care settings, and presence in the public domain. Though these strengths remain, the BH quality measure landscape has changed since this set was first endorsed in 2011. Many payers and The Joint Commission now require PRO measurement and CMS is investigating PRO adoption for IPFQR. We believe re-endorsement of the set must include consideration of its place in the modern landscape. Alignment of PRO tools across organizations is more beneficial for providers, facilities, and patients alike. When different organizations endorse tools that result in disrupted continuity across and within care settings, facilities and providers have higher burden, providers must become intimately familiar with multiple tools and results, and patients and providers lose continuity of measurement. Therefore, re-endorsement of the set is also endorsement of the PHQ-9 as the

NQF's tool of choice in measuring outcomes for depressed patients. This may be appropriate, however it may also be that TJC's approach of allowing facilities to choose a tool meeting specified criteria is a path toward PRO that allows facilities and providers to align tools across organizations.

Developer Response

N/A

NQF Response

NQF thanks you for your comment. We appreciate your concern that NQF endorsement of a measure may appear to endorse a certain tool due to its use in recommended measures but want to assure you that NQF does not endorse measurement tools. Any measure developer may submit quality measures for the Standing Committee to review against the measure evaluation criteria and no preference is given to measures using specific tools.

NQF Committee Response

Dr. Tim Hernandez

Comment ID#: 8259 (Submitted: 06/07/2022)

Council / Public: Public

Level of Support: N/A

Comment

My organization, Entira Family Clinics, has been using the suite of depression measures for over 15 years. We strongly feel that our success in developing our entire care coordination system is in large part attributed to the infrastructure that we needed to build to be successful with this measure. The measure pushes us to have a robust registry tool to successfully follow these patients. In addition, we must do outreach in a population that eschews follow up. The 12 month time period keeps us focused on what is clearly a chronic disease. Our clinicians are challenged by the timing of the measure to "treat to target" in order to get this population at their stated goal, as measured by a PROM. My organization has been amongst the top performing primary clinics in achieving high rates of depression remission in large part due to the laser focus that this measure dictates. My hope is that NQF will continue to endorse this measure as well as other measures in the depression remission/response suite.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

Andrew Lyzenga, American Psychiatric Association; Submitted by Andrew Lyzenga
Comment ID#: 8253 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: Member Does NOT Support

Comment

The American Psychiatric Association appreciates the opportunity to provide feedback on these measures being considered by the Behavioral Health and Substance Use Standing Committee. Gathering information through clinician or patient-completed screening and assessment tools is a critical part of quality care for patients with behavioral health conditions, as is measurement and tracking of outcomes over time. These activities are a core aspect of measurement-based care (MBC), which has been shown to be effective in improving outcomes and patient and provider satisfaction in both primary and specialty care. We would urge the developers to ensure that telehealth visits are included in these measures; we are encouraged that comments submitted by MN Community Measurement after the Standing Committee's initial evaluation suggest that telehealth services are indeed included in the measure specifications. Given mental health workforce shortages and maldistribution of providers, psychiatric consultations through telehealth have become an integral part of clinical practice, especially for communities that lack local expertise. We have some concern that there remains a lack of widespread and standardized infrastructure for collecting and reporting data on measures, and that there may be associated challenges with implementing these measures at a national level. However, we are hopeful that continued emphasis on measurement and data collection will spur allocation of additional resources and development of improved infrastructure in this area.

Developer Response

Thank you for your comments and support for the depression measures. Thank you also for reviewing the response comment regarding telehealth services, which are included in the denominators for the depression measures. We agree that the provision of telehealth services is important to the overall ability to deliver mental health services. It appears that there is one positive related to the covid-19 pandemic: the rapid expansion of telehealth. We have received feedback from our behavioral health providers in MN that telehealth has allowed them to provide more services and expand their reach in the rural settings where distance may have prohibited the delivery of services. We share your concern (and hope!) about a lack of widespread and standardized infrastructure for collecting and reporting data on measures on a national level. We have witnessed a widespread adoption of the PHQ-9/ PHQ-9M as a tool for assessing and monitoring depression symptoms, not only in Minnesota, but nationally as well, although perhaps more in the primary care space nationally than specialty care. In the 10+ years that MN has been reporting this measure, we have seen a significant uptake in use of the tool by behavioral specialists and many view the common tool as a great communication mechanism between primary and specialty care. We also understand your concern surrounding infrastructure as well but believe that there is hope on the horizon. Many EHR vendors have incorporated the PHQ-9 into their system, we are most experienced with Epic, but several other vendors list having the PHQ-9 screening tool available within their system- GE Centricity, Kareo, athenaOne, TherapyNotes, RXNT,

NextGen and TheraNest to name a few. We are hopeful that continued emphasis on measurement and data collection for patients with depression will focus attention and resources in this area and lead to improved health outcomes.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Proposed Committee Response

N/A

NQF #0712 Depression Assessment with PHQ-9/ PHQ-9M (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement

Comment ID#: 8117 (Submitted: 07/21/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, Based on the preliminary worksheet feedback and committee discussion during the measure review meeting, we would like to provide the information that was shared verbally during the measure introduction to address concerns related to evidence that administering a PHQ-9/PHQ-9M assessment tool is unrelated to the outcomes of the improvement in depression symptoms. Simply administering a PHQ-9 tool itself in isolation will not improve outcomes. Administering the PHQ-9 is like taking a blood pressure; you need to do something with the information to affect the outcome of hypertension. Depression is now being considered the sixth vital sign by many and assessing patients is critical to identifying depression and improving outcomes. We examined a set of over 26,000 patients to determine if the actual frequency of assessments was related to the outcomes of response and remission. Patients who are assessed more frequently, for example those with four to twelve PHQ-9's during the assessment period were three times more likely to achieve remission or response outcomes at twelve months as compared to patients who were assessed only one to three times. Odds ratio 2.79 for remission and 3.36 for response. In other words, patients with 3 or less assessments had a 6.3% rate of remission compared to 15.8% for those assessed more frequently. Patients with 3 or less assessments had a 10.5% rate of response compared to 28.3% for those assessed more frequently. Thank you for you consideration!

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8179 (Submitted: 09/07/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Greetings, MN Community Measurement (MNCM) would like to clarify an issue that was raised in the Overarching Themes in the draft Behavioral and Substance Use Spring 2022 Cycle report. It was noted in the report that the committee had concerns about the lack of telehealth services included in the specifications of several measures. Telehealth services are included in the use and specification of the measures we steward (NQF #0710e, NQF #0711, NQF #1884, NQF #1885, and NQF #0712) and have been included as part of the denominator definition for several years. Currently, the denominator encounter event is defined as "Patients with an encounter* coded with Major Depression or Dysthymia (Major Depression or Dysthymia Value Set) during the specific measurement period. *For this measure, an encounter includes but is not limited to any of the following: office visit, psychiatry, or psychotherapy visit, telephone, or online encounter." https://helpdesk.mncm.org/helpdesk/KB/View/24186732-data-collection-technical-guide--depression-care. Specifications were updated in this manner to clarify the previous expression "face to face visit or contact" in which the intent of contact was any contact with the patient in which a diagnosis was made. We look forward to addressing any additional questions or concerns the committee may have during the post-comment webinar. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer MN Community Measurement

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee.

NQF Committee Response

N/A

Ms. Stacy Miller, Mental Health Outcomes
Comment ID#: 8245 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: N/A

Comment

Depression and the PHQ-9 is a strong combination for PRO due to the proportion of impacted patients and the PHQ-9's brief nature, ability to detect depression improvement across care settings, and presence in the public domain. Though these strengths remain, the BH quality

measure landscape has changed since this set was first endorsed in 2011. Many payers and The Joint Commission now require PRO measurement and CMS is investigating PRO adoption for IPFQR. We believe re-endorsement of the set must include consideration of its place in the modern landscape. Alignment of PRO tools across organizations is more beneficial for providers, facilities, and patients alike. When different organizations endorse tools that result in disrupted continuity across and within care settings, facilities and providers have higher burden, providers must become intimately familiar with multiple tools and results, and patients and providers lose continuity of measurement. Therefore, re-endorsement of the set is also endorsement of the PHQ-9 as the NQF's tool of choice in measuring outcomes for depressed patients. This may be appropriate, however it may also be that TJC's approach of allowing facilities to choose a tool meeting specified criteria is a path toward PRO that allows facilities and providers to align tools across organizations.

Developer Response

N/A

NQF Response

NQF thanks you for your comment. We appreciate your concern that NQF endorsement of a measure may appear to endorse a certain tool due to its use in recommended measures but want to assure you that NQF does not endorse measurement tools. Any measure developer may submit quality measures for the Standing Committee to review against the measure evaluation criteria and no preference is given to measures using specific tools.

NQF Committee Response

Dr. Tim Hernandez

Comment ID#: 8258 (Submitted: 06/07/2022)

Council / Public: Public

Level of Support: N/A

Comment

My organization, Entira Family Clinics, has been using the suite of depression measures for over 15 years. We were able to give feedback to Minnesota Community Measurement when they began introducing the PHQ 9 as a diagnostic tool and we have used it since the inception. It is simple and reproducible. As a PROM it is clearly patient centered. We have built it into our systems, i.e. EHR, to hardware the use of the tool. It does not take patients long to fill out and lends itself to a variety of implementation styles. We strongly endorse the continued use of this tool with the hope that NQF supports it.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

N/A

Andrew Lyzenga, American Psychiatric Association; Submitted by Andrew Lyzenga

Comment ID#: 8253 (Submitted: 09/13/2022)

Council / Public: Public

Level of Support: Member Does NOT Support

Comment

The American Psychiatric Association appreciates the opportunity to provide feedback on these measures being considered by the Behavioral Health and Substance Use Standing Committee. Gathering information through clinician or patient-completed screening and assessment tools is a critical part of quality care for patients with behavioral health conditions, as is measurement and tracking of outcomes over time. These activities are a core aspect of measurement-based care (MBC), which has been shown to be effective in improving outcomes and patient and provider satisfaction in both primary and specialty care. We would urge the developers to ensure that telehealth visits are included in these measures; we are encouraged that comments submitted by MN Community Measurement after the Standing Committee's initial evaluation suggest that telehealth services are indeed included in the measure specifications. Given mental health workforce shortages and maldistribution of providers, psychiatric consultations through telehealth have become an integral part of clinical practice, especially for communities that lack local expertise. We have some concern that there remains a lack of widespread and standardized infrastructure for collecting and reporting data on measures, and that there may be associated challenges with implementing these measures at a national level. However, we are hopeful that continued emphasis on measurement and data collection will spur allocation of additional resources and development of improved infrastructure in this area.

Developer Response

Thank you for your comments and support for the depression measures. Thank you also for reviewing the response comment regarding telehealth services, which are included in the denominators for the depression measures. We agree that the provision of telehealth services is important to the overall ability to deliver mental health services. It appears that there is one positive related to the covid-19 pandemic: the rapid expansion of telehealth. We have received feedback from our behavioral health providers in MN that telehealth has allowed them to provide more services and expand their reach in the rural settings where distance may have prohibited the delivery of services. We share your concern (and hope!) about a lack of widespread and standardized infrastructure for collecting and reporting data on measures on a national level. We have witnessed a widespread adoption of the PHQ-9/ PHQ-9M as a tool for assessing and monitoring depression symptoms, not only in Minnesota, but nationally as well, although perhaps more in the primary care space nationally than specialty care. In the 10+ years that MN has been reporting this measure, we have seen a significant uptake in use of the tool by behavioral

specialists and many view the common tool as a great communication mechanism between primary and specialty care. We also understand your concern surrounding infrastructure as well but believe that there is hope on the horizon. Many EHR vendors have incorporated the PHQ-9 into their system, we are most experienced with Epic, but several other vendors list having the PHQ-9 screening tool available within their system- GE Centricity, Kareo, athenaOne, TherapyNotes, RXNT, NextGen and TheraNest to name a few. We are hopeful that continued emphasis on measurement and data collection for patients with depression will focus attention and resources in this area and lead to improved health outcomes.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and developer.

NQF Committee Response

Pre-Evaluation Measure-Specific Comments on Behavioral Health and Substance Use Spring 2022 Submissions

NQF #1884 Depression Response at Six Months- Progress Towards Remission (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8081 (Submitted: 05/23/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, During the process of submitting our scientific testing for this measure NQF# 1884 Depression Response at Six Months, we inadvertently did not include the c-statistic for this measure. This statistic was calculated during the logistic regression procedure but the clinical staff completing the application did not recognize the c-statistic in part due to the large number of pairs and the spacing of the table. The calculated concordance (c-statistic) for this measure was 0.578 (adults) and 0.552 (adolescents) which meet the criteria for a well calibrated model. Association of Predicted Probabilities and Observed Responses Adults Percent Concordant 57.8Somers' D 0.156 Percent Discordant 42.2Gamma 0.156 Percent Tied 0.0Tau-a 0.049 Pairs 2261788815c 0.578 Association of Predicted Probabilities and Observed Responses Adolescents Percent Concordant 55.2Somers' D 0.104 Percent Discordant 44.8Gamma 0.104 Percent Tied 0.0Tau-a 0.027 Pairs 17784665c 0.552 Please consider this additional information in the standing committee's assessment of the risk adjustment model. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer, MN Community Measurement

Ms. Koryn Y. Rubin, MHA, American Medical Association
Comment ID#: 8105 (Submitted: 06/14/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) appreciates the opportunity to comment on this measure. We are writing to express our concerns on the evidence and testing provided in support of this measure. While the AMA agrees that it is useful to understand the rate of response for individuals diagnosed with depression, we do not believe that the developer provided sufficient evidence demonstrating that depression scores can be successfully reduced by at least 50% across the defined patient population within a six-month timeframe nor was any evidence provided supporting this requirement of 50%. For example, would the measure better capture clinical care and patient outcomes if it measured a minimal clinically significant difference in the depression score. It is important that the data demonstrate that practices can implement structures or processes that lead to improved outcomes and the measure results in rates that truly reflect the quality of care delivered by a practice rather than differences in patient mix or other factors outside of the practice's control. We also seek clarification on whether this measure is intended to be captured as an electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing and missing feasibility scorecard for NQF #710e would also apply to this measure. The AMA requests that the gaps in evidence and clarification on whether the measure is intended to be an eCQM be addressed prior to continued endorsement of this measure. We appreciate the Committee's consideration of our comments.

NQF #1885 Depression Response at Twelve Months- Progress Towards Remission (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8082 (Submitted: 05/23/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, During the process of submitting our scientific testing for this measure NQF# 1885 Depression Response at Twelve Months, we inadvertently did not include the c-statistic for this measure. This statistic was calculated during the logistic regression procedure but the clinical staff

completing the application did not recognize the c-statistic in part due to the large number of pairs and the spacing of the table. The calculated concordance (c-statistic) for this measure was 0.587 (adults) and 0.556 (adolescents) which meet the criteria for a well calibrated model. Association of Predicted Probabilities and Observed Responses Adults Percent Concordant 58.7Somers' D 0.173 Percent Discordant 41.3Gamma 0.173 Percent Tied 0.0Tau-a 0.049 Pairs 2042832300c 0.587 Association of Predicted Probabilities and Observed Responses Adolescents Percent Concordant 55.6Somers' D 0.113 Percent Discordant 44.4Gamma 0.113 Percent Tied 0.0Tau-a 0.028 Pairs 16879016c 0.556 Please consider this additional information in the standing committee's assessment of the risk adjustment model. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer, MN Community Measurement

Ms. Koryn Y. Rubin, MHA, American Medical Association
Comment ID#: 8106 (Submitted: 06/14/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) appreciates the opportunity to comment on this measure. We are writing to express our concerns on the evidence and testing provided in support of this measure. While the AMA agrees that it is useful to understand the rate of response for individuals diagnosed with depression, we do not believe that the developer provided sufficient evidence demonstrating that depression scores can be successfully reduced by at least 50% across the defined patient population within a twelve-month timeframe nor was any evidence provided supporting this requirement of 50%. For example, would the measure better capture clinical care and patient outcomes if it measured a minimal clinically significant difference in the depression score. It is important that the data demonstrate that practices can implement structures or processes that lead to improved outcomes and the measure results in rates that truly reflect the quality of care delivered by a practice rather than differences in patient mix or other factors outside of the practice's control. We also seek clarification on whether this measure is intended to be captured as an electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing and missing feasibility scorecard for NQF #710e would also apply to this measure. The AMA requests that the gaps in evidence and clarification on whether the measure is intended to be an eCQM be addressed prior to continued endorsement of this measure. We appreciate the Committee's consideration of our comments.

NQF #0711 Depression Remission at Six Months (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8079 (Submitted: 05/23/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, During the process of submitting our scientific testing for this measure NQF# 0711 Depression Remission at Six Months, we inadvertently did not include the c-statistic for this measure. This statistic was calculated during the logistic regression procedure but the clinical staff completing the application did not recognize the c-statistic in part due to the large number of pairs and the spacing of the table. The calculated concordance (c-statistic) for this measure was 0.608 (adults) and 0.595 (adolescents) which meet the criteria for a well calibrated model. Association of Predicted Probabilities and Observed Responses Adults Percent Concordant 60.8Somers' D 0.217 Percent Discordant 39.2Gamma 0.217 Percent Tied 0.0Tau-a 0.043 Pairs 1449575559c 0.608 Association of Predicted Probabilities and Observed Responses Adolescents Percent Concordant 59.5Somers' D 0.190 Percent Discordant 40.5Gamma 0.190 Percent Tied 0.0Tau-a 0.028 Pairs 10006425c 0.595 Please consider this additional information in the standing committee's assessment of the risk adjustment model. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer, MN Community Measurement

Ms. Koryn Y. Rubin, MHA, American Medical Association
Comment ID#: 8103 (Submitted: 06/14/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) appreciates the opportunity to comment on this measure. We are writing to express our concerns and request clarification on one item with this measure. While the AMA agrees that it is useful to understand the rate of remissions for individuals diagnosed with depression, we do not believe that the developer provided sufficient evidence demonstrating that remission can be successfully achieved across the defined patient population within a six-month timeframe. It is important that the data demonstrate that practices can implement structures or processes that lead to improved outcomes and the measure results in rates that truly reflect the quality of care delivered by a practice rather than differences in patient mix or other factors outside of the practice's control. We also seek clarification on whether this measure is intended to be captured as an electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data

sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing and missing feasibility scorecard for NQF #710e would also apply to this measure. The AMA requests that the gaps in evidence and clarification on whether the measure is intended to be an eCQM be addressed prior to continued endorsement of this measure. We appreciate the Committee's consideration of our comments.

NQF #0710e Depression Remission at Twelve Months (Not Recommended)

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8080 (Submitted: 05/23/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, During the process of submitting our scientific testing for this measure NQF# 0710e Depression Remission at Twelve Months, we inadvertently did not include the c-statistic for this measure. This statistic was calculated during the logistic regression procedure but the clinical staff completing the application did not recognize the c-statistic in part due to the large number of pairs and the spacing of the table. The calculated concordance (c-statistic) for this measure was 0.616 (adults) and 0.592 (adolescents) which meet the criteria for a well calibrated model. Association of Predicted Probabilities and Observed Responses Adults Percent Concordant 61.6Somers' D 0.233 Percent Discordant 38.4Gamma 0.233 Percent Tied 0.0Tau-a 0.042 Pairs 1319452743c 0.616 Association of Predicted Probabilities and Observed Responses Adolescents Percent Concordant 59.1Somers' D 0.183 Percent Discordant 40.8Gamma 0.183 Percent Tied 0.0Tau-a 0.026 Pairs 9810185c 0.592 Please consider this additional information in the standing committee's assessment of the risk adjustment model. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer, MN Community Measurement

Ms. Koryn Y. Rubin, MHA, American Medical Association
Comment ID#: 8102 (Submitted: 06/14/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) appreciates the opportunity to comment on this measure. We are writing to express our concerns on the evidence and testing provided in support of this measure. While the AMA agrees that it is useful to understand the rate of remissions for individuals diagnosed with depression, we do not believe that the developer provided sufficient

evidence demonstrating that remission can be successfully achieved across the defined patient population within a twelve-month timeframe. It is important that the data demonstrate that practices can implement structures or processes that lead to improved outcomes and the measure results in rates that truly reflect the quality of care delivered by a practice rather than differences in patient mix or other factors outside of the practice's control. We also seek clarification on whether this measure has met all of the requirements for electronic clinical quality measures (eCQMs) since the National Quality Forum measure evaluation criteria require patient-encounter-level validity testing. We did not see any information that would satisfy this requirement. We also were unable to find the feasibility scorecard results and therefore were unable to fully evaluate this criterion. The AMA requests that these gaps in evidence and testing be addressed prior to continued endorsement of this measure. We appreciate the Committee's consideration of our comments.

NQF #0712 Depression Assessment with PHQ-9/ PHQ-9M (Not Recommended)

Dr. Steven Inman
Comment ID#: 8084 (Submitted: 05/28/2022)

Council / Public: Public

Level of Support: N/A

Comment

Dear NQF: I represent Children's Health Network, the Network affiliated with Children's Hospitals and Clinics of Minnesota, and I support the re-endorsement of the suite of depression measures currently under review by the Behavioral Health Standing Committee. We have been using these measures for many years at our organization to understand and support positive care and outcomes for patients with depression. Additionally we have pay-for-performance contracts with insurance payers and recognition programs that utilize the rates for these measures. Using the PHQ-9 helps clinics in screening, diagnosing and ongoing monitoring of symptoms of depression. Our organization has increased focus on depression care and value these measures that support our focus. The outcome measures, work together in measuring outcomes at multiple points in time using the same information to measure remission or progress towards remission. The use of this measures on a statewide basis in Minnesota helps to focus attention on these outcomes for an important health problem that impacts many people. I support the continued endorsement of all five measures (NQF#s 0710e, 0711, 0712, 1884 and 1885). Respectfully; Steven Inman, MD Pediatrician Medical Director - Children's Health Network of Minnesota

Ms. Collette M. Cole, BSN, RN, CPHQ, Minnesota Community Measurement
Comment ID#: 8083 (Submitted: 05/25/2022)

Council / Public: PCH

Level of Support: N/A

Comment

Hello, MN Community Measurement is submitting this comment in response to NQF staff feedback about insufficient evidence for this measure #0712 Depression Assessment with the PHQ-9/PHQ9-M. It was noted that there was no empirical evidence to demonstrate that performing the PHQ-9 in and of itself in isolation is associated with any improvement in outcomes. In terms of measurement and assessing outcomes, frequent and ongoing assessment with the PHQ-9/PHQ-9M is key to understanding the patient's progress towards the reduction of depression symptoms. Administering the PHQ-9 is like taking a blood pressure- you need to do something with the information to affect the outcome of hypertension. Depression is now being considered the sixth vital sign by many and assessing patients is critical to identifying depression and improving outcomes. [Trivedi, M., Jha, M. et al VitalSign6: a Primary Care First (PCP-First) Model for Universal Screening and Measurement-Based Care for Depression. Pharmaceuticals 2019, 12, 71; doi:10.3390/ph12020071] Supportive evidence was provided in the context of the Institute for Clinical Systems Improvement Depression Care guidelines for 1) Comprehensive Treatment Plan with Shared Decision Making- Collaborative Care Model and 2) Establish Follow-up Plan. In addition, PubMed lists 14,699 studies associated with the use of the PHQ-9 for measuring or monitoring depression including a 2021 meta-analysis that supports the use of this tool to determine outcomes [Negeri, Z.F., Levis, B., Sun, Y. et al Accuracy of the Patient Health Questionnaire-9 for screening to detect major depression: updated systemic review and individual participant data meta-analysis BMJ 2021 Oct 5;375:n2183. Doi:10.1136/bmj.n.2183]. This measure is an important companion to outcome measures of response and remission, serving two purposes: the first is to understand how well a practice does at assessing their patients who have a diagnosis of depression, and the second is to guard against gaming of the outcome measures through selective administration of the PHQ-9. Sincerely, Collette Cole, RN BSN CPHQ Clinical Measure Developer, MN Community Measurement

Ms. Koryn Y. Rubin, MHA, American Medical Association

Comment ID#: 8104 (Submitted: 06/14/2022)

Council / Public: HPR

Level of Support: Member Does NOT Support

Comment

The American Medical Association (AMA) appreciates the opportunity to comment on this measure. We are writing to request clarification on one item with this measure. We seek clarification on whether this measure is intended to be captured as an electronic clinical quality measures (eCQMs) since the complimentary measure (710e Depression Remission at Twelve Months), which is an eCQM, uses the same data and is specified similarly. It would seem counterintuitive to have related measures endorsed that leverage what appear to be the same data, yet are endorsed with different data sources and specifications. If it is intended to be an eCQM, our concerns on the inadequate testing and missing feasibility scorecard for NQF #710e

would also apply to this measure. The AMA requests clarification on whether the measure is intended to be an eCQM be addressed prior to continued endorsement of this measure. We appreciate the Committee's consideration of our comments.