NATIONAL QUALITY FORUM

Memo

April 18, 2018

To: Behavioral Health and Substance Use Standing Committee

From: NQF staff

Re: Post-comment web meeting to discuss public comments received and NQF member expression of support

Purpose of the Call

The Behavioral Health and Substance Use Standing Committee will meet via web meeting on April 25, 2018 from 12:00pm – 2:00pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period;
- Provide input on proposed responses to the post-evaluation comments;
- Review and discuss NQF members' expression of support of the measures under consideration; and
- Determine whether reconsideration of any measures or other actions are warranted.

Standing Committee Actions

1. Review this briefing memo and draft report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see comment table).
3. Provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: 1-877-829-9898
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?251871
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?251871

Background

The Behavioral Health and Substance Use project aims to endorse measures of accountability for improving the delivery of behavioral health and substance use services and achieving better health outcomes for the U.S. population. NQF's Behavioral Health and Substance Use portfolio includes 50 measures that address tobacco, alcohol, and substance use; depression; medication use; care coordination; and physical health. The most recent review of measures for this project examines measures of continuity of care, follow-up care, antipsychotic use, medication reconciliation, and psychosocial screening in children. The 25-member Behavioral Health Standing Committee evaluated five newly submitted measures against NQF's standard evaluation criteria. Four measures were recommended for endorsement, and one was not recommended for endorsement. The measures recommended for endorsement are:

- 3312 Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) from Alcohol and/or Drugs (CMS)
- 3313 Follow-Up Care for Adult Medicaid Beneficiaries Who are Newly Prescribed an Antipsychotic Medication (CMS)
- 3317 Medication Reconciliation on Admission (CMS)
- 3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) (Massachusetts General Hospital)

The measure not recommended for endorsement is:

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

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through its Quality Positioning System (QPS). Second, NQF solicits member and public comments during a 16-week comment period via an online tool on the project webpage.

Pre-evaluation Comments

NQF solicits comments prior to the evaluation of measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from November 28, 2017 to January 10, 2018 for the measures under review. One comment was received and was sent to the Committee prior to the measure evaluation meetings.

Post-evaluation Comments

The draft report was posted on the project webpage for public and NQF member comment on March 1, 2018 for 30 calendar days. During this commenting period, NQF received 23 comments from six member organizations representing NQF's Health Plan, Health Professional, Public/Community Health Agency, QMRI, and Supplier/Industry Councils, as follows:

Member Council	# of Member Organizations Who Commented
Consumer	0
Health Plan	2
Health Professional	1
Provider Organization	1
Public/Community Health Agency	0
Purchaser	0
Quality Measurement, Research, and Improvement	1
Supplier/Industry	1

All comments (both pre- and post-evaluation) are included in the comment table (excel spreadsheet) posted to the Committee SharePoint site. The comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses (including measure steward/developer responses) for the Committee's consideration. Please review this table in advance of the meeting and consider the individual comments received and the proposed responses to each.

Comments and their Deposition

Themed Comments

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

1. Data Collection Challenges
2. NQF Measure Evaluation Criteria
3. Measure Specific Comments

Theme 1 – Data Collection Challenges

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

Measure Steward/Developer Response:

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

Measure Steward/Developer Response:

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

Proposed Committee Response:

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

Theme 2 – NQF Measure Evaluation Criteria

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

Proposed Committee Response:

Thank you for your comment. You are correct that if the developer provides inter-rater reliability testing results and data element validity testing results for the measure, the Committee needs to vote on both reliability and validity. The committee did vote on both reliability and validity for this measure. However, in the draft report released for public comment, NQF staff incorrectly reported voting results for validity only.

Action Item:

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

Measure-Specific Comments

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

Five comments were received on this measure during the post-evaluation commenting period. One commenter encouraged the developer to incorporate telehealth into the next iteration of the measure. Another commenter suggested that modifications be made to the measure to ensure alignment, harmonization, and consistent terminology among similar measures. For example, use the term “medically supervised withdrawal” rather than “detox,” use the DSM-5 terminology “alcohol use disorder” rather than “alcohol dependence,” and include methadone and naltrexone in pharmacotherapy for opioid use disorder. Finally, one commenter noted concern regarding the performance measurement of emergency physicians, who are completely dependent on community resources, whether it be office-based providers or opioid treatment programs, and that it can sometimes be challenging to connect patients to such services, as they do not always exist.

Measure Steward/Developer Response:

We agree that telehealth can increase access to treatment. We will take this suggestion into consideration during the next annual update opportunity.

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

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

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

Proposed Committee Response:

Thank you for your comments.

Action Item:

Based on comments received and the information provided by the developer, would the Committee like to reconsider this measure?

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

Six comments were received on this measure during the post-evaluation commenting period. One commenter encouraged the developer to incorporate telehealth into the next iteration of the measure. Another commenter had concerns with the availability of prescribers and the variation between states and encouraged the developer to specify whether there should be risk-adjustment based upon provider density data or an exclusion related to the lack of provider availability. Finally, one commenter suggested expanding the measurement period to 30 days or 35 days (from 28) to account for use of long-acting injectable antipsychotics. There were further concerns that limiting the follow-up period may cause errors in the measurement and may have unintended consequences.

Measure Steward/Developer Response:

The measure specifications currently include two codes for “phone visits.” These codes are in the value set that accompanied the NQF materials we submitted for endorsement. At the next annual update opportunity, we will reevaluate the list of telehealth codes and consider incorporating additional telehealth codes in the measure’s specifications.

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

We agree it is important to identify a follow-up time period that accurately measures performance and minimizes unintended consequences. This follow-up period aligns with recommendations from clinical guidelines, which range from 2 to 4 weeks following the

initial prescription. The focus of this follow-up is to monitor side effects and assess the medication's effectiveness. Our clinical advisory workgroup panel recommended a four week follow-up time period.

Proposed Committee Response:

Thank you for your comments.

Action Item:

Based on comments received and the information provided by the developer, would the Committee like to reconsider this measure?

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

Three comments were received on this measure during the post-evaluation commenting period and all agreed with the Committee's decision not to recommend this measure for endorsement. One commenter also suggested that patients with schizoaffective disorder and patients with documented psychotic symptoms (e.g., delusions and hallucinations) also be excluded from the denominator.

Measure Steward/Developer Response:

Thank you for the feedback. We look forward to exploring potential exclusions, including patients with psychotic symptoms or schizoaffective disorder, during further measure development and testing.

Proposed Committee Response:

Thank you for your comments.

Action Item:

None

3317 Medication Reconciliation on Admission

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

Measure Steward/Developer Response:

Thank you for your comments. The Medication Reconciliation on Admission measure does not attempt to assess the accuracy of the medication information collected. The intent of this measure is to set a minimum standard by assessing whether an attempt has been made to collect Prior to Admission (PTA) medications so that these can be reconciled in a timely manner and in a dedicated location in the medical record. While the measure requires a minimum of one external source of PTA medication information,

such as an electronic prescribing network, providers are encouraged to consult as many sources as needed to compile the most accurate list of PTA medications.

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

Proposed Committee Response:

Thank you for your comments.

Action Item:

Based on comments received and the information provided by the developer, would the Committee like to reconsider this measure?

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

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

Measure Steward/Developer Response:

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

endorsements for follow up assessments (as is now done with the PHQ-9) or second stage screens.

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

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

Proposed Committee Response:

Thank you for your comments.

Action Items:

Based on new information in the comments received and the information provided by the developer, has the Committee's view of CPT 96110 in the numerator changed?

NQF Member Expression of Support

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

Appendix A: NQF Member Expression of Support Results

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

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

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	1	0	1
Health Professional	1	0	1
Provider Organization	1	0	1
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	0	0
Supplier/Industry	0	0	0
All Councils	**3**	**0**	**3**

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

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	1	0	1
Provider Organization	1	0	1
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	0	0
Supplier/Industry	0	0	0
All Councils	**2**	**0**	**2**

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

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	0	1	1
Provider Organization	0	1	1
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	0	0
Supplier/Industry	0	0	0
All Councils	**0**	**2**	**2**

3317: Medication Reconciliation on Admission (CMS)

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	1	0	1
Provider Organization	1	0	1
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	0	0
Supplier/Industry	0	0	0
All Councils	**2**	**0**	**2**

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

Member Council	Support	Do Not Support	Total
Consumer	0	0	0
Health Plan	0	0	0
Health Professional	0	0	0
Provider Organization	0	0	0
Public/Community Health Agency	0	0	0
Purchaser	0	0	0
QMRI	0	0	0
Supplier/Industry	0	0	0
All Councils	**0**	**0**	**0**