NATIONAL QUALITY FORUM
Driving measurable health improvements together

Memo

June 19, 2020

To: Behavioral Health and Substance Use Standing Committee

From: NQF staff

Re: Post-Comment Call to Discuss Public and Member Comments

COVID-19 Updates

Considering the recent COVID-19 global pandemic, many organizations needed to focus their attention on the public health crisis. In order to provide greater flexibility for stakeholders and continue the important work in quality measurement, the National Quality Forum (NQF) extended commenting periods and adjusted measure endorsement timelines for the Fall 2019 cycle.

Commenting periods for all measures evaluated in the Fall 2019 cycle were extended from 30 days to 60 days. Based on the comments received during this 60-day extended commenting period, measures entered one of two tracks:

Track 1: Measures Continuing in Fall 2019 Cycle
Measures that did not receive public comments or only received comments in support of the Standing Committees' recommendations will be reviewed by the CSAC on July 28 – 29.

- **Exceptions**
  Exceptions were granted to measures if non-supportive comments received during the extended post-comment period were similar to those received during the pre-evaluation meeting period and have already been adjudicated by the respective Standing Committees during the measure evaluation Fall 2019 meetings.

Track 2: Measures Deferred to Spring 2020 Cycle
Fall 2019 measures requiring further action or discussion from a Standing Committee were deferred to the Spring 2020 cycle. This includes measures where consensus was not reached or those that require a response to public comments received. Measures undergoing maintenance review will retain endorsement during that time. Track 2 measures will be reviewed during the CSAC's meeting in November.

During the Behavioral Health and Substance Use post-comment web meeting on June 19, 2020, the Standing Committee will be reviewing Fall 2019 measures assigned to Track 2. A complete list of Track 1 measures can be found in Appendix B.

Purpose of the Call

The BHSU Standing Committee will meet via web meeting on June 19, 2020 from 11:00 am to 1:00 pm 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.
- Determine whether reconsideration of any measures or other courses of action is 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 and additional documents included with the call materials).
3. Be prepared to 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 #: 800-768-2983 (Access Code: 3772061*)*
Web link: https://core.callinfo.com/callme/?ap=8007682983&ac=3772061&role=p&mode=ad

Background

Behavioral health comprises both mental health and substance use disorders (SUDs) and represents a key construct of healthcare across the globe, unified by brain-based etiology and behavioral symptomology. A comprehensive annual report of behavioral health prevalence data is found in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH). Results from the 2018 NSDUH indicated that, in the U.S., 19.3 million persons aged 18 or older suffered from an apparent SUD (not including tobacco dependence), and 47.6 million persons aged 18 or older suffered from a mental illness. There were 9.2 million persons aged 18 or older who suffered from both SUD and a mental illness. These numbers jointly suggest that substantive behavioral health disease was evident in at least 57.7 million adult Americans in 2018, or roughly 23 percent of the adult population. This rate is consistent with other epidemiologic studies that have previously revealed the prevalence of behavioral health conditions in the U.S.

This project sought to identify and endorse performance measures for accountability and quality improvement that address conditions, treatments, interventions, or procedures relating to behavioral health and substance use.

On January 29 and 31, 2020, NQF convened a multistakeholder Standing Committee composed of 24 individuals to evaluate seven measures undergoing maintenance review.

The Committee recommended five measures for continued endorsement:

- 2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics
- 2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
- 3175: Continuity of Pharmacotherapy for Opioid Use Disorder
- 3539:Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting
- 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (AMO)

The Committee recommended did not reach consensus on one measure:

- 3538: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care

One measure has since been withdrawn:

- 3492: Acute Care Use Due to Opioid Overdose

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 the 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 the measures via an online tool on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from November 26, 2019 to January 21, 2020 for the measures under review. Two comments were received prior to the measure evaluation meeting.

Post-evaluation Comments

The Draft Report went out for Public and Member comment March 16 – May 14. During this commenting period, NQF received six comments from three member organizations:

Consumers – 1

Providers – 3

Public & Community Health – 1

Although all comments are subject to discussion, the intent is not to discuss each individual comment on the June 19 post-comment call. Instead, we will spend the majority of the time considering the two themes discussed below, and the set of comments as a whole. Please note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion. Additionally, please note measure developers were asked to respond where appropriate.

We have included all comments that we received in the excel spreadsheet posted to the Committee SharePoint site. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and the developer or NQF response, where appropriate. Please review this table in advance of the call and consider the individual comments received and the proposed responses to each.

The Standing Committee's recommendations will be reviewed by the Consensus Standards Approval Committee (CSAC) on November 17-18, 2020. The CSAC will determine whether or not to uphold the Standing Committee's recommendation for each measure submitted for endorsement consideration. All committee members are encouraged to attend the CSAC meeting to listen to the discussion.

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

We've also included the comments we received in Appendix A.

Please note measure stewards/developers were asked to respond where appropriate.

Comments and Their Disposition

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

1. ED Use Related to Integration of Behavioral and Physical Health
2. Exclusions for Antipsychotic Use in Older Patients with Dementia

Theme 1 – ED Use Related to Integration of Behavioral and Physical Health

While commenters supported integrated care for patients with behavioral health conditions, commenters expressed concern related to clear links of integrated care in reducing ED utilization and evidence that directly links ED usage and integrated care.

Developer Response:

Developer has reponded to individual comments specific to this issue.

Proposed Committee Response:

Committee will discuss this issue prior to revoting on the evidence criterion.

Theme 2 – Exclusions for Antipsychotic Use in Older Patients with Dementia

Commenters suggested some instances when antipsychotics may be appropriate in the population but were not exclusions within the measure.

Developer Response:

Response #1:

Thank you for your comment. We acknowledge that providers may prescribe AP's for reasons not included in the denominator exclusions, however, the measure excludes psychiatric conditions that align with uses currently approved by the FDA and guidance from the American Geriatrics Association. In addition, the measure excludes patients with antipsychotics present on admission, which may include patients prescribed AP's for delusional parasitosis.

In the case of patients with delirium, there is concern that hospitalized patients experiencing delirium and behavioral and psychological symptoms of dementia are often treated with antipsychotics despite clinical guidelines to the contrary. Our analysis found that among hospitalized patients age 65 and older with delirium, 48 percent of patients without threat of harm received an antipsychotic. If the patient poses a threat of harm to self or others, and this behavior is documented, the patient would be excluded from the measure's numerator. Note, we also learned from our expert work group and test sites that EHRs do not always require providers to document an indication or rationale for use when entering medication orders.

Response #2

Thank you for your comment. The measure, as specified, is consistent with the American Geriatric Society (AGS) Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. With moderate evidence, the Beers Criteria strongly recommends against the use of first and second generation (conventional and atypical) antipsychotics in older adults (65 and older) due to the increased risk of cerebrovascular accident (stroke) and greater rate of cognitive decline and mortality in persons with dementia. (AGS 2019). Further, empirical testing demonstrated only a slight reduction in the performance rate when excluding

encounters in which patients had a diagnosis of treatment-resistant depression (20.1 percent vs. 21.4 percent when not excluded). In reviewing the results of empirical testing, the measure's Expert Work Group (EWG) suggested that the majority of patients receiving antipsychotics for treatment-resistant depression would have these medications initiated in the outpatient setting. These patients would thus be excluded from the measure because they had an antipsychotic present on admission.

With regard to severe aggression and agitation, hospitalized patients threatening harm to themselves or others are excluded from the measure's numerator. In the case of patients receiving antipsychotics for the management of severe aggression and agitation, if these behaviors are documented in the patient's medical record, the encounter would be excluded from the measure's numerator. Thus, the numerator exclusion addresses concern that hospitals may have about receiving lower scores for the management of agitation and aggression among hospitalized patients with delirium or dementia posing a threat to self or others.

Proposed Committee Response:

Committee will discuss this issue.

Measure Specific Comments

3538: All-Cause Emergency Department Utilization Rate for Medicaid Beneficiaries Who May Benefit from Integrated Physical and Behavioral Health Care

1. Commenter expressed that it is extremely important to support and incentivize integrated care and that they support the development of measures in this area. They suggest that it would be helpful to be able to see rates across the different groups included in the denominator to facilitate targeted interventions and quality improvement efforts.

   Measure Steward/Developer Response:

   "Thank you for the comment. CMS will provide an update on differences in emegency department utilization for sub-populations within the measure's denominator as part of endorsement maintenance."

   Action Item:
   Consider this comment in light of a needed discussion and revote for the evidence criterion and a final endorsement recommendation vote.

2. Commenter expressed understanding that it may be difficult to tie reduced ED use by this population directly to their receipt of integrated care. It seems that addressing both co-morbidities would naturally lead to less need to visit hospital EDs as it is often untreated BH conditions that cause additional avoidable medical expense. That said, for the present, commenter agrees with the NQF report that quality measure 3538 should not currently be endorsed as a BH quality measure.

   Commenter strongly supports primary care transformation in payment and services delivery now underway, such as advanced PCMHs, PCMH Level 3 w/ BH Distinction, and provider-led

ACOs. There will never truly be BH integration into medical settings unless clinicians are paid according to a value-based payment system. Integrated med/psych care, in medical settings under the existing FFS payment system, is not financially sustainable. Commenter's top priority is therefore maintenance and acceleration of value-based care reforms, and steadily transitioning a majority of U.S. medical practices to providing and being paid for medical and BH value-based care in a unified medical setting.

Increasingly, healthcare systems are looking to primary care to play a key integrator role as part of delivery and payment reforms. The integration of BH services into primary care is one such key reform. Others include: integrated medical and BH care coordination services; multi-disciplinary care teams; redesigned clinic workflows; advanced patient engagement; referral to social services, inter alia. All practitioners of these advanced services should be paid from an integrated medical and BH funding pool.

Thus, a key concern is that a vastly underfunded, under-resourced, overburdened and overwhelmed part of the healthcare system - primary care - is being asked to do more and more at a time when they face tremendous operational, administrative, and financial pressures. While commenter supports a greater role for primary care, it must be matched by funding that supports and incentivizes primary care to take on these additional tasks. Pilots and trials now demonstrate the improved health and cost savings that integrated services bring in the primary care setting.

The subject of primary care's role in reducing hospital use is complex and more research is needed. Research does show continuity of care by a PCP improves patients health status over time.

Research shows that untreated and/or poorly treated BH conditions do contribute to increased hospital use. For a start, much needs to be done to improve coordination, communications and information exchange between hospitalists and PC clinicians during and after patient hospital visits.

Another means to reduce the use of EDs among the SMI is the appropriate use of long-acting injectables (LAI) antipsychotics and clozapine. There is data showing the superiority of LAIs and clozapine in reducing relapse, rehospitalizations, arrests/jail, and mortality.

Measure Steward/Developer Response:

"Thank you for the comment. Our logic model for this measure identifies consistent and appropriate ambulatory care for physical health, behavioral health, substance use, and severe mental illness as the first step to reducing overuse in the emergency department. By building a relationship with a clinician in the ambulatory space, individuals may have access to early identification of needs that require initiation of or referral to treatment. As a results, we may anticipate a concomitant decrease in utilization of emergency services and, consequently, an improvement in quality of life."

REFERENCES:

Oregon Health Authority. "Oregon Health System Transformation: CCO Metrics 2017 Final Report." June 2018. Available at: https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-CCO-Metrics-Report.pdf. Accessed March 28, 2019.

Washington State Health Care Authority. "Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation." Olympia, WA: Washington State

Health Care Authority, Office of the Chief Medical Officer, March 2014. Available at: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCAReport_3ESHB2127_EmergencyDeptUtilization_ae99b680-c5be-4788-a9a3-91537bdc555d.pdf. Accessed December 26, 2017.

Action Item:
Please note that the commenter incorrectly states that the NQF report suggests that 3538 should not currently be endorsed. The NQF report does not expressly state that 3538 should not be endorsed. Consider this comment in light of a needed discussion and revote for the evidence criterion and a final endorsement recommendation vote.

3. Commenter echoes the remarks of previous commenter: "As a patient advocacy organization working to advance BHI in primary care, NHMH – No Health without Mental Health - understands it may be difficult to tie reduced ED use by this population directly to their receipt of integrated care. It seems that addressing both co-morbidities would naturally lead to less need to visit hospital EDs as it is often untreated BH conditions that cause additional avoidable medical expense. That said, for the present commenter agrees with the NQF report that quality measure 3538 should not currently be endorsed as a BH quality measure."

   Commenter further supports the NHMH submitted observation: "The subject of primary care's role in reducing hospital use is complex and more research is needed. Research does show continuity of care by a primary care provider improves patients health status over time."

   Measure Steward/Developer Response:

   "Thank you for the comment. Our logic model for this measure identifies consistent and appropriate ambulatory care for physical health, behavioral health, substance use, and severe mental illness as the first step to reducing overuse in the emergency department. By building a relationship with a clinician in the ambulatory space, individuals may have access to early identification of needs that require initiation of or referral to treatment. As a results, we may anticipate a concomitant decrease in utilization of emergency services and, consequently, an improvement in quality of life."

   REFERENCES:

Oregon Health Authority. "Oregon Health System Transformation: CCO Metrics 2017 Final Report." June 2018. Available at: https://www.oregon.gov/oha/HPA/ANALYTICS-MTX/Documents/2017-CCO-Metrics-Report.pdf. Accessed March 28, 2019.

Washington State Health Care Authority. "Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation." Olympia, WA: Washington State Health Care Authority, Office of the Chief Medical Officer, March 2014. Available at: https://app.leg.wa.gov/ReportsToTheLegislature/Home/GetPDF?fileName=HCAReport_3ESHB2127_EmergencyDeptUtilization_ae99b680-c5be-4788-a9a3-91537bdc555d.pdf. Accessed December 26, 2017.

Action Item:
Please note that the commenter incorrectly states that the NQF report suggests that 3538 should not currently be endorsed. The NQF report does not expressly state that 3538 should not be endorsed. The Committee did not achieve consensus on the evidence criterion. Consider this comment in light of a needed discussion and revote for the evidence criterion and a final endorsement recommendation vote.

3539: Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

1. Commenter expressed concern that prescribing antipsychotics in older adults alone would be a legitmiate quality measure. Commenter suggests that even with the listed exclusions, there are a number of reasons to prescibes these medicaitons, even in the elderly, with an understanding of the implicit risks. Commenter adds that there are conditions -- such as delusional parasitosis - that are not accounted for, where their use is very much indicated. There are also times when they have to be used for treating delirium, as there are no safe alternatives and not treating patients presents a greater risk. A more useful indicator might be the use of neuroleptics in the elderly without a documented rationale.

   Measure Steward/Developer Response:

   "Thank you for your comment. We acknowledge that providers may prescribe AP's for reasons not included in the denominator exclusions, however, the measure excludes psychiatric conditions that align with uses currently approved by the FDA and guidance from the American Geriatrics Association. In addition, the measure excludes patients with antipsychotics present on admission, which may include patients prescribed AP's for delusional parasitosis.

   In the case of patients with delirium, there is concern that hospitalized patients experiencing delirium and behavioral and psychological symptoms of dementia are often treated with antipsychotics despite clinical guidelines to the contrary. Our analysis found that among hospitalized patients age 65 and older with delirium, 48 percent of patients without threat of harm received an antipsychotic. If the patient poses a threat of harm to self or others, and this behavior is documented, the patient would be excluded from the measure's numerator. Note, we also learned from our expert work group and test sites that EHRs do not always require providers to document an indication or rationale for use when entering medication orders."

   Action Item:
   Consider the need to revisit a discussion of the measure (especially exclusion criteria or overall validity) in light of the comment and developer response.

2. Commenter does not support this measure on the use of antipsychotics in the elderly in hospitals. Two important problems with the measure are that (1) the exclusions do not include certain accepted uses of atypical antipsychotics (e.g., major depression with psychotic features) and (2) it would promote the use of less effective and equally (or more) problematic drugs to treat severe aggression and agitation among delusional/hallucinating patients with delirium or dementia.

   Measure Steward/Developer Response:

   "Thank you for your comment. The measure, as specified, is consistent with the American Geriatric Society (AGS) Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. With moderate evidence, the Beers Criteria strongly recommends against the use of first and second generation (conventional and atypical) antipsychotics in older adults (65 and older) due to the increased risk of cerebrovascular accident (stroke) and greater rate of cognitive decline and mortality in persons with dementia. (AGS 2019). Further, empirical testing demonstrated only a slight reduction in the performance rate when excluding encounters in which patients had a diagnosis of treatment-resistant depression (20.1 percent vs. 21.4 percent when not excluded). In reviewing the results of empirical testing, the measure's Expert Work Group (EWG) suggested that the majority of patients receiving

antipsychotics for treatment-resistant depression would have these medications initiated in the outpatient setting. These patients would thus be excluded from the measure because they had an antipsychotic present on admission.

With regard to severe aggression and agitation, hospitalized patients threatening harm to themselves or others are excluded from the measure's numerator. In the case of patients receiving antipsychotics for the management of severe aggression and agitation, if these behaviors are documented in the patient's medical record, the encounter would be excluded from the measure's numerator. Thus, the numerator exclusion addresses concern that hospitals may have about receiving lower scores for the management of agitation and aggression among hospitalized patients with delirium or dementia posing a threat to self or others."

Action Item:
Consider the need to revisit a discussion of the measure (especially exclusion criteria or overall validity) in light of the comment and developer response.

3175: Continuity of Pharmacotherapy for Opioid Use Disorder

1. Commenter believes this is an extremely important issue. There are good treatments for OUD when patients are on them, but the ability to keep patients in treatment is poor, and this is a key opportunity for improvement in care. However, commenter does not yet have significant evidence supporting interventions to ensure patients are receiving continuous treatment and would like to express some concern about providers' ability to have an impact on this measure.

Measure Steward/Developer Response:

Action Item:
Committee to discuss any known evidence supporting interventions to ensure patients are receiving continuous treatment as well as providers' ability to have an impact on this measure. Committee to discuss if this comment warrants reconsideration of the measure.

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. One NQF members expressed 'Do Not Support' for measure 3539e.

Appendix A:

One NQF member expressed 'do not support' for one recommended measure. Results for this measure are provided below. No other comments received member votes.

3539:Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

Member Council	Support	Do Not Support	Total
Armstrong Institute for Patient Safety and Quality at Johns Hopkins University	0	1	1

Appendix B: Fall 2019 Track 1 Measures

The following measures did not receive public comments or only received comments in support of the Standing Committees' recommendations and will be reviewed by the CSAC on July 28 – 29:

- 2800: Metabolic Monitoring for Children and Adolescents on Antipsychotics (National Committee for Quality Assurance)
- 2801: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (National Committee for Quality Assurance)
- 3541: Annual Monitoring for Persons on Long-Term Opioid Therapy (Pharmacy Quality Alliance)