NATIONAL QUALITY FORUM

Meeting Summary

Behavioral Health and Substance Use Standing Committee Measure Evaluation Web Meetings

The National Quality Forum (NQF) convened the Behavioral Health and Substance Use Standing Committee for two, two-hour web meetings on January 30 and 31, 2019 to evaluate four measures.

Welcome, Introductions, and Review of Meeting Objectives

NQF staff welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. Committee members each introduced themselves and disclosed any conflicts of interest.

Overview of Measure Evaluation Process

Shaconna Gorham, NQF Senior Project Manager, provided an overview of NQF's process for measure discussion and voting and measure evaluation criteria.

Measure Evaluation

During the meetings, the Behavioral Health and Substance Use Standing Committee evaluated four measures for endorsement consideration. A summary of the Committee deliberations will be compiled and provided in the draft technical report. NQF will post the draft technical report on March 11, 2019 for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

Measure Evaluation Criteria Rating Key: H – High; M – Medium; L – Low; I – Insufficient

3451 Non-Acute Mental Health Services Utilization for Dual Eligible Beneficiaries (Centers for Medicare & Medicaid Services)

Measure Steward/Developer Representatives at the Meeting

- John Schurrer
- Mary Barton

Standing Committee Votes

- Evidence: M-7; L-8; I-4

Standing Committee Recommendation for Endorsement: Yes-X; No-X

The Standing Committee did not vote on the recommendation for endorsement because the measure did not pass the Importance criterion—a must-pass criterion.

Since this measure did not reach 60 percent in the medium or higher range, it was not eligible for additional consideration. The Committee did take some time to provide the developer feedback and encourage revising and resubmitting for the next cycle. The key concern that the Committee expressed about this measure's evidentiary presentation is that the specifications of the measures were very broad and did not insure that it identified appropriate (type or duration of)

treatment-diagnoses pairings. The developers concurred with that assessment noting that the intent of this measure presently is to measure access only without prejudice to the appropriateness or continuity of the care provided. Still, concerns about the sensitivity and specificity of the numerator and denominator were expressed, and about the measure's connection to quality improvement.

2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling (PCPI Foundation)

Measure Steward/Developer Representatives at the Meeting

- Kerri Fei
- Beth Bostrom
- Greg Foakes
- Elvia Chavarria
- Nadene Chambers
- Jamie Lehner
- Samantha Tierney

Standing Committee Votes

- Evidence: Previous Evidence Evaluation Accepted
- Performance Gap: H-9; M-9; L-0; I-0
- Reliability: H-3; M-12; L-3; I-0
- Validity: H-3; M-11; L-3; I-0
- Feasibility: H-3; M-12; L-1; I-0
- Use: Pass-15; No Pass-2
- Usability: H-3; M-15; L-1; I-0

Standing Committee Recommendation for Endorsement: Yes-16; No-2

The Standing Committee recommended the measure for continued endorsement. The Standing Committee agreed that the evidence base for the measure has not changed since the previous review and that the developers demonstrated an empirical gap in care. Therefore, they agreed to accept the previous evidence vote. The developer provided updated score-level reliability and validity testing.

Generally, the Committee found this measure to be quite suitable for continued endorsement, though discussion revealed some concern about the absence of telehealth codes and other "hidden" brief intervention encounters not captured in the data because they may be delivered by physician extenders or co-located colleagues who are not otherwise recording their screening or brief screening activity in the medical record.

The developer clarified that primary care physicians could receive credit for achieving the measure because its presence was based only on the entry of a procedure code, not the specialty training or specific ethos of the care provider.

The Committee affirmed the developers' suggestion that the measure has been successfully implemented in PQRS and now in MIPS, and that the measure's benefits greatly outweigh potential harms.

3453 Continuity of Care After Inpatient or Residential Treatment for Substance Use Disorder (SUD) (Centers for Medicare & Medicaid Services)

Measure Steward/Developer Representatives at the Meeting

- Melissa Azur
- Deborah Garnick
- Cindy Thomas

Standing Committee Votes

- Evidence: M-16; L-2; I-0
- Performance Gap: H-10; M-7; L-0; I-0
- Reliability: H-3; M-14; L-0; I-0
- Validity: H-5; M-11; L-1; I-0
- Feasibility: H-10; M-8; L-0; I-0
- Use: Pass-18; No Pass-0
- Usability: H-6; M-12; L-0; I-0

Standing Committee Recommendation for Endorsement: Yes-18; No-0

The Standing Committee recommended the measure for NQF endorsement. The Standing Committee agreed that the evidence supported the general assertion that patients who have better continuity of care have reduced substance use, readmissions, criminal justice involvement, unemployment, and mortality. The developer clarified that the measure includes only hospitalizations or residential treatment with a primary SUD diagnosis (nicotine addiction is not included) and that continuity of care services can be delivered in the primary care setting. The developer confirmed the absence of Alcoholics Anonymous-level services in the numerator, but argued that past research suggest such level of care should not supplant that captured by their measure.

The Standing Committee agreed that based on Medicaid data analysis there is a performance gap with rate variability, especially evident based on insurance type. The developer could not fully explain the finding that some rural achievement rates were higher than urban rates. Future study of these rural/urban differences were thus indicated.

The Standing Committee agreed that the score-level reliability testing suggests that the measure can distinguish between high- and low-performing states. The Standing Committee discussed that services provided the same day as discharge are not credited in the numerator, except for prescription fills. This was a small sensitivity concern, but one that may well be eclipsed by the need for other contacts in the 1-14 day window. The Committee inquired about the developers' decision to exclude inpatient relapses from the denominator. In response to that concern, the developer said that these exclusions were found to have negligible impact on the rates achieved. The validity discussion touched upon recent scientific studies supporting the correlation of this measure's achievement to reduction in morbidity (Harris et al., 2015) and readmission rates.

0004 Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (National Committee for Quality Assurance)

Measure Steward/Developer Representatives at the Meeting

- Kristen Swift
- Junqing Liu

Standing Committee Votes

- Evidence: H-7; M-11; L-0; I-0
- Performance Gap: H-10; M-8; L-0; I-0
- Reliability: H-2; M-16; L-0; I-0
- Validity: H-1; M-17; L-0; I-0
- Feasibility: H-10; M-7; L-1; I-0
- Use: Pass-18; No Pass-0
- Usability: H-4; M-13; L-1; I-0

Standing Committee Recommendation for Endorsement: Yes-18; No-0

The Standing Committee recommended the measure for continued endorsement. New and previous evidence was determined to support the measure's relevance to quality. Discourse between the developer and Committee revealed the following salient points:

- Measure has newly added evidence and also newly included pharmacotherapy and telehealth encounters in the denominator
- Same-day-as-diagnosis events are counted in the numerator for initiation, but a day lag is necessary for engagement.
- Patient refusals are not recorded in any way, thereby reducing sensitivity to attempts by care providers.
- Opioid vs. alcohol rates differ and interact with insurance type. The developer does not presently understand why this is, thus it remains a point of future investigation.
- Multimodal (drug and talk) therapies are not assessed specifically—instead either type can yield credit for the numerator. This point compromises measure validity somewhat, but not enough to hold up endorsement.
- At least one Committee member suggested "woodwork" penalties for entities that screen aggressively, whereas a second member noted that empirical studies actually demonstrate that higher initiation and engagement rates positively correlate with higher screening rates. This was a risk-benefit concern, but it did not prevent endorsement.
- At least one Committee member commented that incentives for providers may be necessary to see that encounters pertinent to this measure are documented. This was a feasibility concern, but not one that prevented endorsement.

Public Comment

One public comment was received for measure 0004 during the pre-commenting period, which began November 29 and ended January 18. The comment shared support for the measure, but noted a limitation in that it excludes multiple ASAM residential treatment levels of care. The

commenter suggested this observation be considered during the next update. No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF will post the draft technical report on March 11, 2019 for public comment for 30 calendar days. The continuous public comment with member support will close on April 9, 2019. NQF will re-convene the Standing Committee for the post-measure evaluation web meeting on February 5, 2019 and post-comment web meeting on May 3, 2019.