The National Quality Forum

National Voluntary Consensus Standards for Patient Outcomes

Summary of the Mental Health Steering Committee meeting
November 16-17, 2009

A two-day meeting of the Patient Outcomes-Mental Health Steering Committee (SC) took place on November 16-17, 2009, at the Hyatt Regency Hotel in Washington DC.

Steering Committee members present: Jeffrey Susman, MD, (co-chair); Tricia Leddy, MS (co-chair); Richard Goldberg, MD, MS; Sheila Botts, PharmD, BCPP; Eric Goplerud, MD; Maureen Hennessey, PhD, CPCC; Katie Maslow, MSW; Darcy Jaffe, ARNP; Luc Pelletier, MSN, APRN, FAAN; Anne Manton, PhD, APRN, FAAN; Harold Pincus, MD; Robert Roca, MD, MPH, MBA; Joel Streim, MD; George Wan; PhD, MPH, Carol Wilkins, MPP (Day-2 only)

Steering Committee members participating via conference call: William Golden, MD (Day-1 only); Daniel Kaufer, MD, FAAN

NQF Staff members present: Helen Burstin, MD, MPH; Reva Winkler, MD, MPH; Ian Corbridge, MPH, RN; Bonnie Zell, MD, MS; Ashley Morsell, MPH; Emma Nochomovitz, MPH

The Committee co-chairs, Tricia Leddy and Jeff Susman, opened the meeting with introductions and requested that the Steering Committee members provide a brief background of their interests and experience and disclose any specific activities pertaining to outcome measures for Mental Health.. After the introduction of the Committee members, National Quality Forum (NQF) staff also introduced themselves.

<u>Orientation to NQF</u>

Dr. Helen Burstin, Senior Vice-President for Performance Measurement made introductory comments, stressing the importance of the multi-stakeholder Steering Committee and how each Committee member was selected for their diverse array of background and knowledge in the mental health field.

Dr. Reva Winkler, NQF Project Consultant and the outcomes project advisor, oriented the group to NQF's mission, strategic goals, and current activities with the National Priorities Partnership and Health Information Technology. She reviewed NQF's processes for reviewing and endorsing performance measures. Quality measurement was discussed with regard to the forces that drive measure development, such as the needs to address gaps in performance in measurement and providing a foundation for pay-for-performance programs. Outcome measures, as well as measurement at the individual physician level, disparities-sensitive measurement, cross-cutting areas and care across multiple settings were identified as key gap areas in performance measurement.

<u>Orientation to the Outcomes Project</u>

Dr. Winkler explained NQF's contract with the Department of Health and Human Services, and the project-specific goals:

- identify, evaluate and endorse additional outcome measures for Mental Health; and
- identify gaps in existing outcome measures and make recommendations to fill those gaps.

Ian Corbridge explained the project's goals relative to mental health. Dr. Winkler explained that the Mental Health aspect is part of a larger Patient Outcomes project that includes two additional Steering Committees (a main SC and child health SC),

Dr. Winkler advised that NQF's main goals for this two day meeting, included:

- orienting the Steering Committee to NQF current and future activities;
- describing the Steering Committee role to reach project goals;
- defining mental health outcome measures and scope of this project; and
- discussing the measure evaluation process.

Further context for the project was provided through an explanation of the NQF Consensus Development Process (CDP) with regard to the role of the Steering Committee (SC) and the role of the NQF staff. The role of SC includes being a proxy for membership, assisting staff in achieving project goals; evaluating candidate measures and making recommendations for endorsement; responding to comments submitted during the review period; and responding to questions from the CSAC.

Additional information provided in the orientation to the project included a brief explanation of the online submission form, and NQF's standard measure evaluation criteria, which was revised in August 2008.

Steering Committee discussion

In response to the NQF and project orientation, the Committee members discussed at length identifying a framework for mental health outcomes, defining mental health outcomes, highlighting measurement and data sources, and identifying gaps where further measures are needed. In addition, the Committee also noted the need to reach out to new measure developers while identifying new stakeholders to engage. The Committee was encouraged to assist staff in drafting the Scope of activities for the Call for Measures for this part of the Outcomes project.

Framework for Mental Health Outcomes

The Committee reviewed/discussed current measures, research, interventions, policies and health trends in the mental health arena as a way of beginning to identify what should be consider in a "mental health outcome framework." The Committee identified important characteristics when approaching mental health outcomes including:

- the impact of improved management of mental diseases on the effects of co-morbidities
- the promotion of healthy behaviors and environment in relation to mental health;

- the use of non-traditional measures (homelessness and interaction with the justice system) as domains of measurement;
- consumer, patient, family and caregiver satisfaction.
- access to data and the role it plays in examining settings of care; and
- the multi-dimensional aspects of mental health that require a multi-disciplinary approach to care.

Defining the Scope of the Mental Health Outcomes project
In an effort to define the scope of this project, the Committee discussed the definition of an outcome measure at length starting with Donabedian's classic construct: "outcome refers to changes (desirable and undesirable) in individuals and populations that are attributed to healthcare."

Starting from a draft list of types of outcomes offered by NQF staff, the Committee delved further into discussions around what "mental health outcomes" encompass in their efforts to develop a framework The Committee discussed the importance of having *symptoms (including signs observed by a clinician), function*, and *quality of life* as their own individual domains for evaluating outcomes. Another focal point of the discussion was around the role of populations and population health. The Committee identified population level health measures as critical for improving quality in the mental health arena due to the nature of mental illnesses, interventions, and the need for the continuity of care across systems and into the community. In addressing the broader spectrum of mental health, the Committee also addressed the issue substance use. The Committee agreed substance use outcomes should be considered outcome components as part of co-morbid issues, but felt substance use would be to expansive to addresses outside of a co-morbidity perspective. The discussion concluded with agreement that coordination of care and seamless transitions in care is cross-cutting. The Committee generated an extensive list of mental health outcomes and examples. When refined, this table will form the basis of the Call for Measures.

PATIENT, CAREGIVER, & POPULATION OUTCOMES	**EXAMPLES**
Symptoms	Improvement or remission of pain, anxiety, depression, psychosis, unhealthy use of alcohol or other substances; Symptom, frequency, severity, and longitudinal trajectory; Sleep disorders; medical and other co-morbidities (e.g., smoking, metabolic syndrome, and cardiovascular disorders)
Function	Improvement in or maintenance of ability/disability ; Basic and instrumental activities of daily living and ability to function in social roles (work, school, play, family and social interaction);
Health Related Quality of Life/Global Well-being	Improvement or change in objective psychometrically sound symptom checklists
Change in Health Related Behaviors	Patient self-management use of advanced directives; Medication adherence; physical activity and nutrition; Smoking cessation;

	decrease in unhealthy alcohol or substance use; Improved health decision-making; enhanced willingness or readiness to change; Change in high-risk behaviors
Social Determinants of Health / Built Environment (effects on populations & individuals)	Decrease in homelessness and improved housing stability; enhanced foster care / out-of-home placement; absence of violence in the home-setting; stable and age-appropriate (e.g. with family or independent) home environment; improved social support and network; ability to engage in safe recreation; access to affordable, culturally appropriate food; improved promotion of social engagement; reduction in legal consequences / incarceration; positive changes in absenteeism / presenteeism
Service Utilization (appropriate & inappropriate use)	Emergency Department (ED) visits and hospitalizations (both medical and psychiatric); visits to primary care provider; use of sobering/detox centers; improved continuity of care (hand-offs between providers) and care coordination; use of evidence-based care; care for medical conditions
Direct Physiologic Measures	Drug screening and therapeutic drug monitoring; blood glucose, lipid level, blood pressure, renal and liver function; body mass index (BMI) according to patients health needs and appropriate waist circumference
Patient/Caregiver Experience	Satisfaction/perceptions of care; health literacy; cultural competency; Understanding of treatment changes/transitions; understanding of potential hazards to patient; care giver burden/distress/health status and outcomes
Patient Safety /Adverse Events	Medication side effects/complications/errors; suicide attempts/completions and self-harm; restraint; elopements; injury, violence and motor vehicle crashes; falls and wandering; delirium; pain medication management
Non-mental Health Medical Outcomes (general medical)	Management of co-morbidities; preventive care medical outcomes associated with mental health treatment and enhanced outcomes of medical illnesses; disability; oral health
Mortality	Suicide and alcohol/drug mortality; change in life expectancy
Recovery	Recovery model specific elements; shared decision-making; enhanced perception of hopefulness/optimism; patients meeting self-directed wellness goals; absence of disease or reduction in disease status and patient reported happiness
Incidence/Prevalence of Mental & Substance Use Conditions	Longitudinal prevalence and incidence on conditions at a population level; screening in medical populations; improved treatment rates
End of Life/Palliative Care	Use of hospice and advanced directives; pain control and well-being; patient perception of self-efficacy/control
Composite Measures	Combined medical, mental health, dental, and other health outcome measures

Another important factor the Committee wishes to convey to measure developers is the importance of measuring broadly and to elicit those areas where there is "dual accountability"- the idea of both the community & providers assuming responsibility for their contributions to patient outcomes in the mental health arena.

Gap Areas
One of the major responsibilities of the Steering Committee is to help identify areas where mental health outcome measures are needed. The Committee identified four areas: social determinants of health/built environment (foster care placement, incarceration, and academic attainment), patient and caregiver reported outcomes, composite measures and behavior change outcomes as highly desirable but unlikely to have current measures.

Population Health
Dr. Bonnie Zell, NQF, Senior Director, Population Health provided an overview on population health and it's relation to mental health. She charged the Committee with the question: How can we connect performance measures in healthcare with activities in the community setting, where are there areas of duel accountability (both healthcare and the community assuming responsibility for influencing mental health at the population level)? In line with earlier discussions, the Committee agreed a majority of mental health issues are influenced by factors outside the healthcare setting. The Committee agreed that the final Call for Measures must target/solicit measures at all levels of care and settings. Another point discussed was the scope of population health, which can ultimately be defined and redrawn across a multitude of boundaries (disease status, provider group or the greater community). The committee agreed this scope of population health critical in determining one's method of measurement, and has huge influence of the nature of the outcome observed. Dr. Zell further broke down the separation between healthcare and population health by emphasizing that population health is only individual health aggregated to a population level. Ultimately, to achieve health and well-being across a continuum, both healthcare and health enhancing services must be targeted at the individual and population level.

Identifying and Evaluating Candidate Outcomes Measures
Dr. Winkler oriented the Committee to NQF's Measure Evaluation process. In addition, the Committee was asked to consider whether they are aware of additional resources for seeking out existing outcome measures, not including those identified by NQF in their environmental scan. The following resources were suggested as potential avenues for seeking out additional measures:

- National Institute of Mental Health (NIMH)
- National Institute on Alcohol Abuse and Alcoholism (NIAA)
- American Academy of Pediatrics (AAP) – Mental Health Division
- International agencies where Committee members may have affiliations

Members of the group were asked to help solicit the submission of measures appropriate to this project when the "Intent to Submit Measures" and the Call for Measures" are release in December - January. NQF staff explained that measure developers have incentive to submit their measures to NQF given that NQF endorsement initiates a certain amount of authority, increases the likelihood that a measure will be more widely used, and allows a measure to be recognized at the national level.

Next steps
Dr. Winkler and Mr. Corbridge outlined the next activities for the Steering Committee:

1. Dissemination of the draft version of the Call for Measures to the Committee for final revisions.
2. Determine specific dates for the April in-person Steering Committee in Washington, DC.

There was discussion of mental health issues becoming significant within the child population so the Child Health Steering Committee may need to collaborate with Mental Health Steering Committee to discuss cross-cutting issues. The co-chair stressed the importance for the Steering Committee members to be present in person for the spring meeting.