The National Quality Forum

Comments on National Voluntary Consensus Standards for Mental Health Outcomes Phase III, 2010

Comments reviewed and discussed by the Mental Health Steering Committee on July 29, 2010.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
64	M-Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	General Comments	The American Nurses Association (ANA) concurs that to achieve quality healthcare across a full continuum of conditions, settings, and structures of care, there is a need for additional measures which specifically address various outcomes of mental health and substance use (MHSU) care provided in the nation's healthcare system and their impact on physical illnesses. ANA applauds NQF's efforts to endorse additional outcome measures with an emphasis on high impact (high volume, high morbidity, high cost) conditions and cross-cutting areas. NQF's efforts in that regard are laudable.	Thank you for your comments.
65	M-Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	General Comments	Furthermore, ANA agrees with the five important characteristics to consider in a mental health outcome framework: Mental health issues, including substance use patterns, should be included in any effort to broadly assess population health. Assessing consumer appraisal, feedback and satisfaction with mental health treatment and services is essential in a broad evaluation of treatment efficacy and quality. Obtaining this feedback from the varying perspectives of the patient, patient's family and relevant caregivers is very helpful. ANA concurs with the strategic approach of promotion of health behaviors and environment in persons afflicted by a MHSU disorders. This is consistent with the recognition that mental health and health-related behaviors and choices are inextricably linked. Real-life non-traditional measures like homelessness, job performance or legal system involvement are critical to assess in evaluating treatment or intervention effectiveness. Care coordination and post hospitalization follow-up in addition to patient patterns of recidivism are critical components in promoting accountability in mental health system.	

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66	M-Health Professional Council	Rita Munley Gallagher, PhD, RN, American Nurses Association	General Comments	The American Nurses Association (ANA) supports the broad range of outcomes that were considered. Many of these are patient-centered and the primary focus of treatment efforts) e.g. changes in symptoms, and symptom intensity (severity), and frequency). In addition ANA appreciates the focus on functional measures including change in health-related behaviors e.g. compliance with medication regimes, self-management efforts. The focus of the patient outcomes should include valid, reliable, and easy to administer measures of depression with a low level of respondent burden. The Patient Health Questionnaire 9 meets all of these criteria. However, consideration should be given to other important directions in outcome assessment: service utilization; social determinants of health (e.g. homelessness, stability in work or family relationships, etc.); and, patent outcomes assessing specifically chemical dependency/substance abuse. Finally, The American Nurses Association (ANA) respectfully suggests that the scope of the mental health outcomes project be expanded to the acute care settings. Registered nurses on standard medical-surgical units care for significant percentages of patients who are also being treated for depression, anxiety, or substance use issues.	NQF Staff Response: The Steering Committee and NQF agree with the ANA in that a broad perspective must be taken when considering mental health outcome measures. The Steering Committee made a concerted effort to integrate the larger determents of health (environment, socioeconomic status, etc) into the Mental Health Project framework (refer to Table A in the draft report). While the project received no outcome measures addressing the larger determinants of health, the Committee did address this pertinent topic matter in the gaps analysis. NQF anticipates the submission of outcome measures relevant to the larger determinants of health in the future. As noted, depression, anxiety, or substance abuse is not limited only to mental health care facilities. The Mental Health Outcomes project was not limited to any care setting. The Steering Committee and NQF encourage the development of measures which span a broad spectrum of care arenas.
67	M-Health Plan Council	Rebecca Zimmermann, AHIP	General Comments	AHIP appreciates the opportunity to provide comments on the Mental Health Outcomes measures. After discussing with our member health plans, we offer the following comments. General Comments While we support the use of outcomes measures to assess the effectiveness of quality interventions for patients, it is important to note that in the area of mental health care evaluating improvement in health outcomes has limitations. For patients with Alzheimer's and dementia an improvement in mental health outcomes is noted by marginal changes in cognitive skills and can be very subjective and intermittent. Measurement of these populations may be useful to the physician as they track the decline in a patient's health status, but may be of limited use in assessing the improvement in the quality of care provided. As more mental health measures are developed and reviewed by NQF, improvement should be	NQF Staff Response: The outcomes for certain diseases, such as Alzheimer's, are not necessarily the traditional outcomes such as improvement. The recommendation in the report has been expanded to suggest the types of outcome measure that might be appropriate for Alzheimer's such as patient safety and appropriate use of healthcare resources.

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				measured using both process and outcomes measures.	
70	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	General Comments	GENERAL COMMENTS NQF importantly recognizes that its portfolio of measures includes few outcome measures specific to mental health and substance use (MHSU) and seeks to fill this gap. Improving outcomes for patients with MHSU disorders is critical. MHSU disorders strain the mental, social and economic well-being of the person. They also affect the person's family and friends, the community, and society as a whole. Mental illness is widespread with approximately one in four Americans 18 years and older suffering from some sort of mental illness. We enthusiastically support the delineation of categories of mental health outcomes in Table A (the MHSU outcome framework) and commend the Steering Committee for developing this framework. Given the framework, we consider the set of four measures being recommended as a good start, but note that NQF is very far from being able to offer a comprehensive set of measures per the grid in Table A. NQF should develop a plan for how it will fill in the grid over some reasonable period of time.	NQF Staff Response: The Steering Committee noted that performance measures for mental health lag far behind measures in other fields and hopes that this work will prompt greater attention to development of measures in the mental health community. NQF will be soliciting new measures in varying mental health areas on a regular basis to enhance the portfolio of mental health measures.

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71	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	General Comments	GENERAL COMMENTS We understand that there were difficulties in getting measures submitted. For example, the Steering Committee noted, no outcome measures for Alzheimer's or other dementias were submitted for their consideration. With as many as 2.4 million to 5.1 million Americans with Alzheimer's disease, the most common form dementia, NQF should consider having a separate steering committee to endorse measures (including measures of outcomes) for this condition. Alzheimer's is also one of the top Medicare condition priorities. We also encourage NQF to consider how it can improve its measure submission process to better support and reach out to measure developers, particularly those with limited resources. We are disappointed by the absence of measures addressing substance abuse outcomes. This is a significant issue for employers and Medicaid programs, among others, and we would expect NQF to assign high priority for measure development and endorsement in this area, similar to the recommendation on measures for Alzheimers/dementia.	NQF Staff Response: The Mental Health Steering Committee and NQF acknowledge the importance of identifying and endorsing outcome measures pertaining to Alzheimer's and substance abuse. The Steering Committee made a concerted effort to integrate Alzheimer's and substance abuse outcomes into the framework of the project while the Committee and NQF staff made extensive efforts to identify and solicit Alzheimer's and substance abuse outcomes measures. Unfortunately, despite considerable outreach efforts by staff and Steering Committee members, no measures for Alzheimer's disease could be identified for consideration in this project. While no Alzheimer's measures were submitted to the project, NQF staff did work with developers of substance abuse measures and anticipate their submission at a later date once developers have finalize testing. With Alzheimer's as one of the top twenty Medicare priorities condition, NQF anticipates future projects related to Alzheimer's and welcomes any dialogue with key stakeholders to help move measure development forward.
72	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	General Comments	GENERAL COMMENTS We generally agree with the Steering Committee's additional recommendations, in particular those that address the measure development pipeline. The steering committee encourages measure developers in the MHSU arena to: Develop outcome measures so that they can be applied across different care settings Support efforts to develop Alzheimer's and dementia outcome measures The additional recommendations also encourage the mental health community to align their efforts in performance measurement with those underway at NQF and National Priorities Partnership. The work of the Steering Committee additionally underscores the need to improve the availability of data to support the feasibility of MHSU outcomes measures – which was a reoccurring challenge in this effort -- in a variety of areas such as readmissions.	Thank you for your comment.

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73	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	General Comments	GENERAL COMMENTS We are concerned about the set of measures that were not recommended for endorsement due to issues around scientific acceptability and testing. Some of these measures appear to be quite relevant and potentially valuable in addressing mental health outcomes. While we understand the Steering Committee's declining to take action on these measures at this time, we hope that NQF demonstrates a commitment to follow-up with developers of these potentially valuable measures to determine whether some of the issues around these measures have been resolved. NQF could for example create a process whereby the measures can be resubmitted and reconsidered at any time that the developers have completed the additional validation work that was recommended. Such has not been the case with NQF's focused and time-limited project orientation in the past.	NQF Staff Response: The measure developers participated in the discussion of the measures and were made aware of the issues that prevented the measures from being recommended. NQF is just beginning a new approach to measures evaluation where all topic areas are revisited every 3 years for maintenance of endorsed measures and evaluation of new measures that might be added to the portfolio.
74	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	General Comments	GENERAL COMMENTS A similar comment pertains to the recommendations to broaden certain measures in the current NQF-endorsed measure set e.g., readmissions to include mental health patients. While we agree with this approach, we request confirmation from NQF that it has a process to achieve this result in a reasonable period of time. Also, given that many patients are treated for mental health conditions in free-standing psychiatric facilities, we do not understand why measures that are specific to such facilities should be turned down due to the need to fold them in with similar measures in the broader hospital domain. Therefore, we recommend reconsideration of the readmission, fall rate, and adverse event measures for application in those settings that are dedicated to the treatment of mental health conditions for which there are no such measures at this time. Additionally, there were two assessment measures that were deemed "out of scope". It wasn't clear to us from their titles whether they were true outcome measures (i.e., report the actual results of care) or process measures (e.g., if an assessment was administered). Our concerns arise from the fact that process measures should not to be	NQF Staff Response: In an effort to integrate mental health into other specialty areas, the Steering Committee made a concerted effort to ensure measures had the broadest applicability. The Committee noted that measures which only focused on psychiatric settings, but were applicable in other care arenas would ultimately perpetuate the isolation of the mental health field. Free standing facilities are not excluded from broader measures, rather the Committee wanted to ensure the broadest integration of psychiatry into other care areas. Two process measures were deemed to be out of scope for this outcomes project.

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				mislabeled as outcome measures.	
91	M-Health Professional Council	Janet Leiker, on behalf of the AAFP Commission on Quality and Practice, American Academy of Family Physicians	General Comments	General Comments: Support the NQF scope of patient outcomes framework, which includes measurement of functional outcomes, such as reduction in homelessness and increase in self-care. Recommend that the NQF continue to seek outcomes measures to evalute the effectiveness of mental health treatments (medications in particular) and if they actually make a difference in society.	NQF Staff Response: NQF acknowledges that there are still some areas in the mental health field that allows for further work to be done. The table of types of outcome measures highlight the gaps in current measures. NQF will be soliciting new measures in varying mental health areas on a regular basis to enhance the portfolio of mental health measures.

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99	M-Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	General Comments	The American Medical Association (AMA) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) Patient Outcome Measures: Mental Health report. The AMA strongly believes that outcome measures are essential for improving the quality of care and we appreciate NQF's continued focus on such measures. However, the AMA continues to have reservations about the endorsement of outcome measures, especially those that focus on individual clinician accountability, when there is no risk adjustment methodology employed, or when the risk adjustment methodology is not available for review.	The Steering Committee reviewed all of the comments and again discussed at length the need for risk-adjustment for these measures. The Steering Committee has re-voted to recommend the measures. MD Response: Thank you for your comments. We are developing a risk adjustment model in conjunction with the University of MN and the MN Department of Health to adjust for severity of depression based on the initial PHQ-9 score. Other considerations for future risk adjustment variables, which would require further study, include insurance product as a proxy for socioeconomic status, age, and psychiatric and medical co-morbidities like substance abuse, double depression, diabetes, acute MI.
112	M-QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement ®	General Comments	The Physician Consortium for Performance Improvement® (PCPI) is pleased to have the opportunity to comment on the National Quality Forum's (NQF) Patient Outcome Measures: Mental Health report. The PCPI strongly believes that outcome measures are essential for improving the quality of care and we appreciate NQF's continued focus on such measures. However, the PCPI continues to have reservations about the endorsement of outcome measures, especially those that focus on individual clinician accountability, when there is no risk adjustment methodology employed, or when the risk adjustment methodology is not available for review.	See response to comment #99.
60	P	Kay Jewell, CCH	Not Recommended	My sincere apologies - Awhen I last looked for the transcripts and audio files to discuss the measures - they were not on the website but I just checked and they have been added. Thank you - I will still go over them. My comments about the measure specifications for those note recommended still stand.	Refer to comment #56 Thank you for your response.
78	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	Not Recommended	Fall rate per 1,000 patient days (OT3-008-10)was not recommended for endorsement as the steering committee sought to encourage the use of two existing NQF endorsed fall-related measures (both of which do not currently capture mental health care). The committee recommended that two existing NQF measures of fall rates and falls with injury be expanded to include psychiatric settings. The measure developer of these currently endorsed measures indicated a willingness to expand the measure to include inpatient mental health settings. We believe NQF should assign a timeline for this work to ensure that the measures are retooled as soon as possible.	NQF Staff Response: NQF has initiated discussions with the measure steward and anticipates the steward to address the inclusion of MHSU settings at the time of measure maintenance.

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88	M-Health Plan Council	Catherine MacLean, WellPoint	Not Recommended	General comments: WellPoint is concerned about the focus on outcome measures for dementia patients. Current diagnosis and treatment do not allow for confident selection of outcome measures relevant to dementia in the elderly. Although the predominant type of dementia in the elderly is associated with the pathology described by Alois Alzheimer over one hundred years ago, perhaps one in three cases of dementia will have alternative or additional findings to explain the diagnosis of dementia. Within the group of patients experiencing senile dementia of the Alzheimer's type, there are multiple areas (cognitive function, performance of activities of daily living, presence or absence of psychosis and caregiver distress) that contribute to outcome. Global measures of disease progression (eg, Clock Drawing) are sensitive to some areas affecting outcome but not others. Furthermore, there is little reason to believe that current treatment, medication or otherwise (exercise, physical or mental, for example) alters course. The research does show that outcomes are negative, and that they are difficult to influence. A proxy that is often used is timing of placement in a nursing home. However, this measure is also problematic, as there are many reasons why a patient with Alzheimer's or dementia may be placed in care (eg, financial reasons, lack of familial and social support, etc.); these reasons may not be changed by interventions from health plans or other health organizations.	NQF Staff Response: The Mental Health Steering Committee and NQF acknowledge the importance of identifying and endorsing measures pertaining to Alzheimer's and dementia. While the contractor (Department of Health and Human Services was interested in Alzheimer's and dementia measures the scope of the project with focused on outcome related measures. The Committee and NQF staff made extensive efforts to identify and solicit Alzheimer's and dementia outcomes measures, however, the lack of such measures submitted to the projects indicates a gap in measure development and represents a key priority area to address. With Alzheimer's as one of the top twenty Medicare priorities condition, NQF anticipates future projects related to Alzheimer's and welcomes any dialogue with key stakeholders to help move measure development forward.
89	M-Health Plan Council	Catherine MacLean, WellPoint	Not Recommended	General comments continued: We believe that it would be appropriate for measure developers to create process measures for this patient population; however, until the research indicates that there are interventions that may improve outcomes, it is not appropriate to create outcome measures for patients with Alzheimer's or dementia. WellPoint would like to suggest another topic for measure endorsement and clinical application: traumatic brain injury (TBI) in adults. There appears to be an emerging scientific consensus on sensitive methods of measuring outcome after TBI. It is thus plausible to seek application of these measures in clinical practice. Application of TBI outcome measures offers possible synergy with other interested parties such as the Veterans Administration and the Department of Defense. TBI outcome measures seem to meet the standards set forth by NQF more readily than	See response to comment #88. NQF Staff Response: NQF promotes the development of quality measures in all areas of the health arena and would welcome dialogue on new topic areas.

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				dementia outcome measures.	
92	M-Purchaser Council	Edward Garcia, CMS	Not Recommended	OT3-003-10 30 Day readmissions (Western Psychiatric Institute and Clinic of UPMC Presby Shadyside) OT3-004-10 7 Day readmissions (Western Psychiatric Institute and Clinic of UPMC Presby Shadyside) OT3-006-10 48 hours readmissions (Western Psychiatric Institute and Clinic of UPMC Presby Shadyside) CMS Comment: The Committee recommended current NQF measures should consider expanding the types of readmissions to include mental health and substance use conditions at the time of maintenance review and that measures that delineate specific care settings inevitably create a conceptual barrier, limiting measurement and broad adoption. We believe NQF should adopt a policy regarding whether psychiatric diagnoses should or should not be included in readmission measures. When NQF endorsed other readmission measures, it was then recommended that psychiatric admissions be excluded. Similarly, NQF requested that the psychiatric population be removed from the ED throughput measures due to significant differences for this population as compared to other included populations. Consistency in policy is requested.	NQF Staff Response: The stakeholders in NQF are constantly evolving their thinking and approaches to measurement. As seen in the recent report "The Prioritization of High-Impact Medicare Conditions and Measure Gaps (May 2010) NQF's Measure Prioritization Advisory Committee (MPAC) recommended measures sets that are applicable across populations. The handling of mental health population is not a matter of policy but a reflection of the evolution in thinking of NQF Committees and members.

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49	M- Provider Organization Council	Stacey Drubner, JD, MSW, MPH, Partners Psychiatry and Mental Health	OT3-011-10	Concerns about PHQ-9 as an outcomes measure: Patient-related factors may complicate measurement of remission goal-score<5; There could be significant consequences if used for contracting, evaluation of providers/ public reporting of hospitals, without risk adjustment. Medical/psychiatric co-morbidity, treatment refractoriness, and disadvantaged socio-economic status, would predict poor likelihood of remission. Higher baseline scores would also predict low likelihood of remission. These factors would need to be measured in conjunction with the PHQ-9. Concomitant administration of additional tools, (HADS-anxiety; ATRQ for treatment refractoriness) is required. 20% of patients (the most severely ill) will be available for reassessment of outcome, profoundly underestimating performance of the provider/clinic. There is little precedent/established methodological foundation for the use of this diagnostic tool for outcomes measurement of psychotherapy. Sensitivity/relevance for psychotherapy outcomes has yet to be established. There are no non-patient norms, so many common psychotherapy outcome measures, (reliable change/clinically significant improvement), cannot be conducted. Outcomes language (50% symptom reduction) is less relevant to psychotherapy providers. If adopted as a national outcome benchmark, the PHQ- 9 could place psychotherapy providers at a substantial disadvantage in demonstrating effectiveness of care. We support and encourage NQF's attention to addressing the complex issue of screening and outcomes measurement in mental health. While PPMH has concerns regarding the use of the PHQ-9 as an outcomes measure, we do look forward to searching together for solutions to improve the care of our patients and their families who suffer greatly with depression and its wide-reaching effects.	(continued from #48) See response to comment #48

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52	P	Michael Trangle, Healthpartners/Re	OT3-011-10	Please see my comments on the 6 month remission rate - all of which apply here. In addition, the 12 remission rate forces providers and clinics into dealing with the tremndously high "drop out/lost to follow-up" rates for depressed patients.This forces clinics to be as creative as possible to stay in touch with patients so they do not stop treatment prematurely and to be available should patients begin to relapse. Eventually it forces clinics to maximize their partnersips with patients to live reasonably balanced supportive lifestyles, to practice their cogintive/behavioral practices, and to stay on their meds long enough to stay euthymic.	Thank your for your comment.
54	P	Janny Brust, MN Council of Health Plans	OT3-011-10	MN Council of Health Plans (MCHP) supports NQF's commitment to the development and endorsement of outcome measures that strive to improve function, reduce symptoms, decrease pain and improve well being for patients with depression. MCHP strongly supports the scientific community process that MN Community Measurement and Institute for Clinical Systems Improvement used to measure remission at six and twelve months measures.	Thank your for your comment.

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61	P	Indira Jevaji, MD., MSL, ORWH/NIH	OT3-011-10	The Office of Research on Women?s Health (ORWH) serves as the focal point for women's health research at the National Institutes of Health (NIH). ORWH advances its mission in partnership with the NIH Institutes and Centers and supports innovative research on women?s health and the role of sex and gender in health and disease. The ORWH is pleased to have the opportunity to comment on the proposed four mental health outcome standards recommended for endorsement. The ORWH recommends that the NQF routinely collect report and conduct analyses for possible differences or similarities in quality of care patient outcomes by sex /gender and race/ethnicity to provide research based evidence for related outcomes.	NQF Staff Response: NQF does not collect data nor report measure results. NQF's measure evaluation criteria include evaluation of how a measure handles disparities. NQF expects measures to have the capability of measuring disparities and recommends that developers or entities using the measures to address disparities. It is at the discretion of the measure developer to report to NQF any findings based on the stratifications suggested, and this information will be provided to NQF at the time of update for the candidate standard. MD Response: Thank you for your comments. In Minnesota, we capture this information from the medical groups through a direct data submission process, and frequently this is an extraction from an EHR which has clinical and demographics information. Gender, race/ethnicity, primary language and country of origin are fields that we collect for each patient and can be used for analysis and stratification.
68	M-Health Plan Council	Rebecca Zimmermann, AHIP	OT3-011-10	Comments on Specific Measures OT3-012-10: Depression remission at six months (Minnesota Community Measurement) OT3-011-10: Depression remission at twelve months (Minnesota Community Measurement) OT3-022-10: Depression utilization of the Patient Health Questionnaire (PHQ-9) tool Minnesota Community Measurement) The Patient Health Questionnaire (PHQ-9) is a commonly used, statistically validated tool to assess depression and depression severity. The measures above utilize this tool to assess the effectiveness of treatment in achieving and maintaining depression remission. AHIP supports the endorsement of these measures and this tool. However, other tools with an equal evidence base also exist and endorsement of these measures should not preclude the use of other tools or survey instruments.	SC discussion: The SC noted that the PHQ-9 is widely and accepted. Measurement requires some standardization for comparability. MD Response: Thank you for your comments. Our suite of measures for the depression population are all based on the PHQ-9 score; for remission it is an absolute score of less than five. The PHQ-9 has been widely adopted by primary care providers in the state of Minnesota and is gaining traction with behavioral providers as well. We understand that there are other tools that can be used to assess depression, some of which are proprietary, require significant clinician time or are difficult to score. Using many tools to define remission will reduce the reliability and validity of the outcome measure itself. Using a standardized tool ensures that each patient's depression symptoms are being assessed in the same way. We do not have plans to incorporate other tools into the definition of remission.

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75	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	OT3-011-10	Depression remission at six months and Depression remission at 12 months (OT-012-10 and OT3-011-10) We believe that these measures provide critical information on whether providers have helped patients with depression achieve the best possible outcome. The desired end result in the treatment of depression has become remission. These two measures capture whether a patient with depression has achieved remission at the six month marker and at the 12 month marker, and they both rely on PHQ-9 results. These two measures are identical except for their variations in timeframes assessing depression remission. These measures also promote standardization by requiring the use of the PHQ-9 to assess whether a patient has achieved remission. Use of a standard tool facilitates comparison across providers, a critical issue for consumers and purchasers. We also appreciate that these measures reflect the patient perspective. However, we believe that it will be important that both measures be reported by a provider to encourage monitoring of a patient's status over time. We also suggest that NQF address the significant challenges posed by the lack of standardized approaches of gathering patient reported outcomes data. There should be an increasing movement toward developing the electronic infrastructure to collect and submit patient reported outcomes data.	NQF Staff Response: Thank you for your comment. In a continued effort to improve performance measurement within the broader health care sector, NQF actively supports building the foundation and support systems to move quality measurement to a real-time electronic platforms. NQF is working on re-tooling currently NQF endorsed® quality measures for electronic format and will stipulate that future quality measures be integrated into an EHR system. NQF's HIT projects are anticipating patient reported outcome measures - fields exist in the QDS for values of the results of PRO tools and the upcoming measure authoring tool will have the capability to handle patient reported outcome measures.

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81	M-Purchaser Council	Gaye Fortner, HC21	OT3-011-10	I believe that this measure provides critical information on whether providers have helped patients with depression achieve the best possible outcome. The desired end result in the treatment of depression has become remission. This measure captures whether a patient with depression has achieved remission at the 12-month marker, and relies on PHQ-9 results. This measure is promotes standardization by requiring the use of the PHQ-9 to assess whether a patient has achieved remission. Use of a standard tool facilitates comparison across providers, a critical issue for consumers and purchasers. We also appreciate that this measure reflects the patient perspective. However, I believe that it will be important that this measure be reported by a provider to encourage monitoring of a patient's status over time. I also suggest that NQF address the significant challenges posed by the lack of standardized approaches of gathering patient reported outcomes data. There should be an increasing movement toward developing the electronic infrastructure to collect and submit patient reported outcomes data.	See response to comment #75
84	M-Health Plan Council	Catherine MacLean, WellPoint	OT3-011-10	OT3-012-10, OT3-011-10, and OT3-022-10: WellPoint believes that these measures are a good starting point for standardizing how depression remission is documented. However, what response is envisioned if a practitioner chooses a widely accepted tool (there are many the Beck Depression Inventory or BDI and the Montgomery Asberg Depression Rating Scale or MADRS are widely used examples) other than the PHQ-9? We also question whether documentation of these measures will be implemented outside of P4P programs because of provider reluctance to assume what is perceived as additional work.	MD Response: Thank you for your comments. Our suite of measures for the depression population are all based on the PHQ-9 score; for remission it is an absolute score of less than five. The PHQ-9 has been widely adopted by primary care providers in the state of Minnesota and is gaining traction with behavioral providers as well. We understand that there are other tools that can be used to assess depression, some of which are proprietary, require significant clinician time or are difficult to score. Using many tools to define remission will reduce the reliability and validity of the outcome measure itself. Using a standardized tool ensures that each patient's depression symptoms are being assessed in the same way. We do not have plans to incorporate other tools into the definition of remission.
96	M-Purchaser Council	Edward Garcia, CMS	OT3-011-10	CMS supports the recommendation for endorsement of this measure.	Thank your for your comment.

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100	M-Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-011-10	Risk Adjustment While the AMA believes that these two depression measures, each paired with OT3-022-10, are of reasonable intent, it is difficult to fully assess their viability as outcome performance measures without information regarding the risk adjustment methodology that will be employed in their eventual execution. The submission documents provided by MN Community Measurement indicate that they will be developing a risk adjustment methodology in the Spring of 2010. We agree that risk adjustment is essential for these measures. However, we are concerned that such information has not been publically made available. As such, we believe the endorsement of these measures is premature and we recommend that these measures be made available for public comment only when the risk adjustment methodology is finalized and available to the public. Furthermore, we have noted that the lack of risk adjustment was among the reasons cited for several other measures being not recommended for endorsement. This criterion should be applied uniformly across all candidate measures. -Success rate The AMA notes that the success (remission) rates reported in the submission documents for the 6- and 12-month measures are quite low (in the 4-5% range). Given that the denominator is patients with depression, the low success rate may discourage clinicians from diagnosing and treating patients with depression if they perceive a high remission rate to be unattainable.H79	NQF Staff Response: 10. The PHQ-9 is publically available and is free of charge. The instrument was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. MD Response: Thank you for your comments. MN Community Measurement has been publicly reporting unadjusted ambulatory outcome rates for several years dating back to 2004. We have been comfortable with unadjusted rates because 1) we use a stringent population definition with a denominator certification process that ensures that all groups are collecting data in the same way, 2) believe that some patient variables are equally distributed among the clinics, for example diabetic patient compliance with self care or diabetics who additionally have cardiovascular disease, and 3) a large percentage of clinics reporting full population lends to the strength of the unadjusted rate. As our state began moving towards utilizing cost and quality measures to demonstrate value (provider peer grouping) and utilizing these measures for incentive based payment and tiering by health plans, we began to explore risk adjustment of measures used for these purposes. Working with our partners at the University of Minnesota, we are working through the logistics for risk adjustment and understanding the potential use of risk adjustment going forward. For the depression remission measures, the proposed plan is to use severity of depression (as measured by first PHQ 9 score) as a variable for risk adjustment when follow-up PHQ-9 rates improve with a minimum follow-up rate of 50%. Other considerations for future risk adjustment variables for depression, which would require further study, include insurance product as a proxy for socioeconomic status, age, and psychiatric and medical co-morbidities like substance abuse, double depression, diabetes, acute MI.

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102	M-Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-011-10	Practitioner burden While it is reasonable to believe that these measures are feasible for physicians or group practices that utilize electronic health records (EHR) systems, we are concerned that those without such systems will face a prohibitive burden in reporting on these measures. Should these measures become mandatory the administrative burden of reporting multiple PHQ-9 scores can be significant.	NQF Staff Response: The SC discussed the feasibility of collecting the data with the measure developer and noted that using the PHQ-9 is common practice. MD Response: Thank you for your comments. We agree that the data collection burden is greater for clinics that have not yet implemented an EHR. This measure was designed with for use with EHR systems as the planned source of information; however it is possible to abstract the needed data from paper charts.
108	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-011-10	Please see our comments on OT3-012-10 (remission at six months), which also apply to this measure.	MD Response: Please see all the responses for (OTC-012-10) remission at six months as they apply to the twelve month remission measure as well.
109	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-011-10	The identical remission rates (approximately 5%) reported for the 6- and 12-month measures in testing are counterintuitive. Regardless of the treatment approach, there should be a greater percentage of patients who have achieved remission by 12 months. One cannot distinguish if these results are reflective of consistent collection/reporting of the PHQ-9 (a process issue) or are an accurate reflection of depression remission rates (outcome).	MD Response: Thank you for your comments. As with the six month remission measure, one of the reasons that the remission rates are so low is related to the process of obtaining a follow-up PHQ-9 at twelve months +/- 30 days, currently at 20%.
110	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-011-10	A population that may not be accounted for in this measure is patients who achieved remission at 6 months, but relapsed before the 12 month follow-up. It would be inappropriate to penalize clinicians for this natural course of illness.	MD Response: Thank you for your comments. The reverse is true as well; patients who are not in remission at six months have the chance of achieving remission at twelve months. Although rates are collected and calculated at a patient level, rates are currently reported at a clinic site level in aggregate. It is our goal that these measures support processes that improve the patient's symptoms of depression and enhance the patient provider relationship.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
113	M-QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement ®	OT3-011-10	Risk Adjustment While the PCPI believes that these two depression measures, each paired with OT3-022-10, are of reasonable intent, it is difficult to fully assess their viability as outcome performance measures without information regarding the risk adjustment methodology that will be employed in their eventual execution. The submission documents provided by MN Community Measurement indicate that they will be developing a risk adjustment methodology in the Spring of 2010. We agree that risk adjustment is essential for these measures. However, we are concerned that such information has not been publically made available. As such, we believe the endorsement of these measures is premature and we recommend that these measures be made available for public comment only when the risk adjustment methodology is finalized and available to the public. Furthermore, we have noted that the lack of risk adjustment was among the reasons cited for several other measures being not recommended for endorsement. This criterion should be applied uniformly across all candidate measures. Success rate The PCPI notes that the success (remission) rates reported in the submission documents for the 6- and 12-month measures are quite low (in the 4-5% range). Given that the denominator is patients with depression, the low success rate may discourage clinicians from diagnosing and treating patients with depression if they perceive a high remission rate to be unattainable.	See response to comment #100.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
114	M-QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement ®	OT3-011-10	Risk Adjustment While the PCPI believes that these two depression measures, each paired with OT3-022-10, are of reasonable intent, it is difficult to fully assess their viability as outcome performance measures without information regarding the risk adjustment methodology that will be employed in their eventual execution. The submission documents provided by MN Community Measurement indicate that they will be developing a risk adjustment methodology in the Spring of 2010. We agree that risk adjustment is essential for these measures. However, we are concerned that such information has not been publically made available. As such, we believe the endorsement of these measures is premature and we recommend that these measures be made available for public comment only when the risk adjustment methodology is finalized and available to the public. Furthermore, we have noted that the lack of risk adjustment was among the reasons cited for several other measures being not recommended for endorsement. This criterion should be applied uniformly across all candidate measures. Success rate The PCPI notes that the success (remission) rates reported in the submission documents for the 6- and 12-month measures are quite low (in the 4-5% range). Given that the denominator is patients with depression, the low success rate may discourage clinicians from diagnosing and treating patients with depression if they perceive a high remission rate to be unattainable.	(continued from 113) See response to comment #100.
115	M-QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement ®	OT3-011-10	While it is reasonable to believe that these measures are feasible for physicians or group practices that utilize electronic health records (EHR) systems, we are concerned that those without such systems will face a prohibitive burden in reporting on these measures. Should these measures become mandatory the administrative burden of reporting multiple PHQ-9 scores can be significant.	See response to comment #102.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
48	M- Provider Organization Council	Stacey Drubner, JD, MSW, MPH, Partners Psychiatry and Mental Health	OT3-012-10	PPMH has concerns about endorsing the PHQ-9 as an outcomes measure for several reasons outlined below. First, several patient-related factors may complicate standardized measurement of the remission goal (score<5). Given the wide and often mandatory application of measures endorsed and adopted by NQF, there could be significant consequences if the PHQ-9 is used as part of contracting, or ranking/evaluation of providers and public reporting of hospital quality, in the absence of feasible, careful measurement standards and processes. At the very least, deliberative and complex risk adjustment is necessary to ensure accurate results. The presence of medical co-morbidity, psychiatric co-morbidity (especially anxiety disorders), treatment refractoriness, and disadvantaged socio-economic status, would predict poor likelihood of remission. Higher baseline scores would also predict low likelihood of remission (it is easier to lower a score from 12 to 4, than from 22 to 4). Each of these factors would need to be measured in conjunction with the PHQ-9. Information on these components is generally not available in the medical record, or billing data, and would therefore require concomitant administration of additional tools, such as the HADS for anxiety and the ATRQ for treatment refractoriness. Additionally, there will be primarily patients with high acuity eligible for follow-up milestone time periods. NQF acknowledges that approximately 20% of patients will be available at the 6 and 12 month follow-up points for reassessment of outcome. It is likely that these will represent the most severe cases, which will profoundly underestimate actual performance of the provider or clinic. These nuances may not be clearly understood by those using this instrument as a performance barometer.	Steering Committee Response: The Steering Committee explicitly discussed the measures absence of any risk adjustment methodology. While the Committee affirmed the need for most outcome measures to employ some degree of risk adjustment, the Committee believed the PHQ-9 Depression Remission measures as currently written meet NQF's measure evaluation criteria. The Committee elected to revote on the three PHQ-9 Depression Remission measures in response to public and member comments . The Committee reviewed past deliberations and documentation provided by the measure developer. The Steering Committee re-voted to recommend the measures. MD Response: Thank you for your comments. MN Community Measurement has been publicly reporting unadjusted ambulatory outcome rates for several years dating back to 2004. We have been comfortable with unadjusted rates because 1) we use a stringent population definition with a denominator certification process that ensures that all groups are collecting data in the same way, 2) believe that some patient variables are equally distributed among the clinics, for example diabetic patient compliance with self care or diabetics who additionally have cardiovascular disease, and 3) a large percentage of clinics reporting full population lends to the strength of the unadjusted rate. As our state began moving towards utilizing cost and quality measures to demonstrate value (provider peer grouping) and utilizing these measures for incentive based payment and tiering by health plans, we began to explore risk adjustment of measures used for these purposes. Working with our partners at the University of Minnesota, we are working through the logistics for risk adjustment and understanding the potential use of risk adjustment going forward. For the depression remission measures, the proposed plan is to use severity of depression (as measured by first PHQ 9 score) as a variable for risk adjustment when follow-up PHQ-9 rates improve with a minimum follow-up rate of 50%. Other considerations for future risk adjustment variables for depression, which would require further study, include insurance product as a proxy for socioeconomic status, age, and psychiatric and medical co-morbidities like substance abuse, double depression, diabetes, acute MI.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
51	P	Michael Trangle, Healthpartners/Re	OT3-012-10	This has been broadly adopted by a host of clinicians, medical groups, health plans, and employers throughout Mn as a key quality measure. It's the first example that we are aware of where psychiatrists, therapists, and primary care physicians all measure the same thing and transparently share results on the same website. This has spurred a tremendous amount of interdisciplinary collaborative improvement work.For most clinicians and groups in the mental health world it's helped to transform their paradigm into an evidence based approach and organizations into learning environments.	Thank your for your comment.
53	P	Janny Brust, MN Council of Health Plans	OT3-012-10	MN Council of Health Plans (MCHP) supports NQF's commitment to the development and endorsement of outcome measures that strive to improve function, reduce symptoms, decrease pain and improve well being for patients with depression. MCHP strongly supports the scientific community process that MN Community Measurement and Institute for Clinical Systems Improvement used to measure remission at six and twelve months measures.	Thank your for your comment.
62	P	Indira Jevaji, MD., MSL, ORWH/NIH	OT3-012-10	The Office of Research on Women?s Health (ORWH) serves as the focal point for women's health research at the National Institutes of Health (NIH). ORWH advances its mission in partnership with the NIH Institutes and Centers and supports innovative research on women?s health and the role of sex and gender in health and disease. The ORWH is pleased to have the opportunity to comment on the proposed four mental health outcome standards recommended for endorsement. The ORWH recommends that the NQF routinely collect report and conduct analyses for possible differences or similarities in quality of care patient outcomes by sex /gender and race/ethnicity to provide research based evidence for related outcomes.	NQF Staff Response: NQF does not collect, report, etc however, NQF does recommend that developers or entities collecting measures do address disparities. It is at the discretion of the measure developer to report to NQF any findings based on the stratifications suggested, and this information will be provided to NQF at the time of update for the candidate standard.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
80	M-Purchaser Council	Gaye Fortner, HC21	OT3-012-10	I believe that this measure provides critical information on whether providers have helped patients with depression achieve the best possible outcome. The desired end result in the treatment of depression has become remission. This measure captures whether a patient with depression has achieved remission at the six month marker, and relies on PHQ-9 results. This measure is promotes standardization by requiring the use of the PHQ-9 to assess whether a patient has achieved remission. Use of a standard tool facilitates comparison across providers, a critical issue for consumers and purchasers. We also appreciate that this measure reflects the patient perspective. However, I believe that it will be important that this measure be reported by a provider to encourage monitoring of a patient's status over time. I also suggest that NQF address the significant challenges posed by the lack of standardized approaches of gathering patient reported outcomes data. There should be an increasing movement toward developing the electronic infrastructure to collect and submit patient reported outcomes data.	MD Response: Thank you for your comments and support. See response to comment #75.
85	M-Health Plan Council	Catherine MacLean, WellPoint	OT3-012-10	OT3-012-10, OT3-011-10, and OT3-022-10: WellPoint believes that these measures are a good starting point for standardizing how depression remission is documented. However, what response is envisioned if a practitioner chooses a widely accepted tool (there are many the Beck Depression Inventory or BDI and the Montgomery Asberg Depression Rating Scale or MADRS are widely used examples) other than the PHQ-9? We also question whether documentation of these measures will be implemented outside of P4P programs because of provider reluctance to assume what is perceived as additional work.	See response to comment #84.
97	M-Purchaser Council	Edward Garcia, CMS	OT3-012-10	CMS supports the recommendation for endorsement of this measure.	Thank your for your comment.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
101	M-Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-012-10	Risk Adjustment While the AMA believes that these two depression measures, each paired with OT3-022-10, are of reasonable intent, it is difficult to fully assess their viability as outcome performance measures without information regarding the risk adjustment methodology that will be employed in their eventual execution. The submission documents provided by MN Community Measurement indicate that they will be developing a risk adjustment methodology in the Spring of 2010. We agree that risk adjustment is essential for these measures. However, we are concerned that such information has not been publically made available. As such, we believe the endorsement of these measures is premature and we recommend that these measures be made available for public comment only when the risk adjustment methodology is finalized and available to the public. Furthermore, we have noted that the lack of risk adjustment was among the reasons cited for several other measures being not recommended for endorsement. This criterion should be applied uniformly across all candidate measures. -Success rate The AMA notes that the success (remission) rates reported in the submission documents for the 6- and 12-month measures are quite low (in the 4-5% range). Given that the denominator is patients with depression, the low success rate may discourage clinicians from diagnosing and treating patients with depression if they perceive a high remission rate to be unattainable.	(continued from 100) See response to comment #100

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
103	M-Health Professional Council	Nancy H. Nielsen, MD, PhD, American Medical Association	OT3-012-10	Practitioner burden While it is reasonable to believe that these measures are feasible for physicians or group practices that utilize electronic health records (EHR) systems, we are concerned that those without such systems will face a prohibitive burden in reporting on these measures. Should these measures become mandatory the administrative burden of reporting multiple PHQ-9 scores can be significant.	(continued from #102) See response to comment #102

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
104	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-012-10	The lack of risk adjustment specifications in these measures is a serious concern, and the potential consequences suggest that endorsement should be delayed until these specifications have been developed and tested. Psychiatrists and other expert clinicians who are skilled at managing depression often treat the most challenging, treatment resistant patients. Without risk adjustment, these clinicians will conversely receive the lowest scores, because their patients may take longer to achieve and maintain remission.	Steering Committee Response: The Steering Committee explicitly discussed the measures absence of any risk adjustment methodology. While the Committee affirmed the need for most outcome measures to employ some degree of risk adjustment, the Committee believed the PHQ-9 Depression Remission measures as currently written meet all of NQF's measure evaluation criteria. The Committee elected to revote on the three PHQ-9 Depression Remission measures in response to public and member comments . The Committee reviewed past deliberations and documentation provided by the measure developer. The results of the revote are reflected in the updated draft report. MD Response: Thank you for your comments. MN Community Measurement has been publicly reporting unadjusted ambulatory outcome rates for several years dating back to 2004. We have been comfortable with unadjusted rates because 1) we use a stringent population definition with a denominator certification process that ensures that all groups are collecting data in the same way, 2) believe that some patient variables are equally distributed among the clinics, for example diabetic patient compliance with self care or diabetics who additionally have cardiovascular disease, and 3) a large percentage of clinics reporting full population lends to the strength of the unadjusted rate. As our state began moving towards utilizing cost and quality measures to demonstrate value (provider peer grouping) and utilizing these measures for incentive based payment and tiering by health plans, we began to explore risk adjustment of measures used for these purposes. Working with our partners at the University of Minnesota, we are working through the logistics for risk adjustment and understanding the potential use of risk adjustment going forward. For the depression remission measures, the proposed plan is to use severity of depression (as measured by first PHQ 9 score) as a variable for risk adjustment when follow-up PHQ-9 rates improve with a minimum follow-up rate of 50%. Other considerations for future risk adjustment variables for depression, which would require further study, include insurance product as a proxy for socioeconomic status, age, and psychiatric and medical co-morbidities like substance abuse, double depression, diabetes, acute MI.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
105	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-012-10	The extremely low average (approximately 5%) and narrow range of success rates for these measures reported in the measure submission documents and from an active implementation of these measures (see http://www.mnhealthscores.org/?p=our_reports&sf=clinic&category=4&sub_category=8&name_id=&compare=) raises additional concerns. Publicly reported outcomes measurement is intended to inform clinicians of their results in comparison to other clinicians, highlight actionable areas of improvement, and to inform patients' decisions about where to seek care. It is difficult to interpret a measure where virtually all reported scores are less than 10%. While the performance illustrates a clear opportunity for improvement, it likely also reflects systemic challenges of managing depression; underlying problems with the measure including how the outcome is defined; and process issues with capturing and/or reporting PHQ-9 scores correctly. It is not possible to distinguish between these types of issues with the measures as currently specified, and many of the causes are beyond the control of individual clinicians or groups. The opportunities to identify specific actions to realize improved quality, a key goal of performance measurement, are therefore limited. Further, patients who are viewing these low performance rates may inappropriately interpret the universally low remission rates and be discouraged from seeking treatment for depression in the first place.	MD Response: Thank you for your comments. We understand your concerns and agree that the low performance rate could be discouraging to both providers and patients. Currently, low rates are influenced by system process issues related to maintaining contact with the patient. The rate of obtaining a PHQ-9 score at six months +/- 30 days is 21%. Groups with the highest remission rates also have higher than average rates of obtaining follow-up PHQ-9 scores at six and twelve months. This is a relatively new measure for our community and medical groups needed to implement processes to enable them to maintain contact with their patients being treated for depression. We believe that changes to processes and care delivery can make a difference and the provider can influence appropriate follow up care. There is some variability among clinics with a range of 0% to 36%. It is true that our three publicly reported measures do not shed any light about the potential reasons why a remission rate is low or high, but we do provide seven additional measures to groups for their internal use and two of these measures are the rate of success in obtaining a PHQ-9 score at six and twelve months.
106	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-012-10	In the reported testing data, 97% of clinicians had access to an Electronic Health Record (EHR). This is not reflective of the average EHR adoption rate, which is considerably lower. Reporting frequent PHQ-9 scores will be more burdensome for clinicians who do not yet have an EHR. These measures as currently specified may therefore further discourage clinicians from identifying and managing depression and may inappropriately penalize clinicians for a process-based issue (not reporting PHQ-9 correctly) rather than reflecting the true outcome of their patients (depression remission rates).	MD Response: Thank you for your comments. It is true that the majority of clinics currently submitting data for this measure have an EHR. The approximate rate of EHR adoption in our state is 68%. We agree that the data collection burden is greater for clinics that have not yet implemented an EHR. This measure was designed with for use with EHR systems as the planned source of information; however it is possible to abstract the needed data from paper charts.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
107	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-012-10	A significant unintended consequence of the lack of risk adjustment; low reported success rates; and potential reporting burden is that clinicians, particularly those that are not experienced in depression treatment may be disincentivized from actively identifying depression. This would antithetically hinder the vital objectives of increasing recognition and management of depression in the general population. The lack of a companion measure that encourages screening for depression will likely be amplified this effect. Unrecognized depression represents a significant, foundational gap in care.	Steering Committee Response: The Steering Committee explicitly discussed the measures absence of any risk adjustment methodology. While the Committee affirmed the need for most outcome measures to employ some degree of risk adjustment, the Committee believed the PHQ-9 Depression Remission measures as currently written meet all of NQF's measure evaluation criteria. The Committee elected to revote on the three PHQ-9 Depression Remission measures in response to public and member comments . The Committee reviewed past deliberations and documentation provided by the measure developer. The results of the revote are reflected in the updated draft report.MD Response: Thank you for your comments. It is our philosophy that you cannot improve what you cannot measure. It has been our experience so far that groups are working on improving outcomes for their patients, not trying to avoid reporting. One example of this is another internal measure that we provide groups, the rate of the use of 311 Depression NOS. Some groups have had a very high rate of the use of 311 (60 to 70%) and are now working on appropriately diagnosing major depression. Groups with very high 311 rates have decreased their rates by 20% and the overall use of 311 for all groups reporting had dropped 9%. Although we are not capturing an overall population measure for screening for depression, the paired process measure (OT3-22-10) Depression Utilization of the PHQ-9 does provide information on how effectively practices are at administering the PHQ-9 to patients with a diagnosis of depression or dysthymia. MN Community Measurement has been publicly reporting unadjusted ambulatory outcome rates for several years dating back to 2004. We have been comfortable with unadjusted rates because 1) we use a stringent population definition with a denominator certification process that ensures that all groups are collecting data in the same way, 2) believe that some patient variables are equally distributed among the clinics, for example diabetic patient compliance with self care or diabetics who additionally have cardiovascular disease, and 3) a large percentage of clinics reporting full population lends to the strength of the unadjusted rate.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
116	M-QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement ®	OT3-012-10	While it is reasonable to believe that these measures are feasible for physicians or group practices that utilize electronic health records (EHR) systems, we are concerned that those without such systems will face a prohibitive burden in reporting on these measures. Should these measures become mandatory the administrative burden of reporting multiple PHQ-9 scores can be significant.	See response to comment #115
117	M-QMRI Council	Bernard M. Rosof, MD, MACP, Physician Consortium for Performance Improvement ®	OT3-012-10	Risk Adjustment While the PCPI believes that these two depression measures, each paired with OT3-022-10, are of reasonable intent, it is difficult to fully assess their viability as outcome performance measures without information regarding the risk adjustment methodology that will be employed in their eventual execution. The submission documents provided by MN Community Measurement indicate that they will be developing a risk adjustment methodology in the Spring of 2010. We agree that risk adjustment is essential for these measures. However, we are concerned that such information has not been publically made available. As such, we believe the endorsement of these measures is premature and we recommend that these measures be made available for public comment only when the risk adjustment methodology is finalized and available to the public. Furthermore, we have noted that the lack of risk adjustment was among the reasons cited for several other measures being not recommended for endorsement. This criterion should be applied uniformly across all candidate measures. Success rate The PCPI notes that the success (remission) rates reported in the submission documents for the 6- and 12-month measures are quite low (in the 4-5% range). Given that the denominator is patients with depression, the low success rate may discourage clinicians from diagnosing and treating patients with depression if they perceive a high remission rate to be unattainable.	See response to comment #100.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
41	M-Purchaser Council	Kris Soegaard, Buyers Health Care Action Group	OT3-022-10	Comments Supporting NQF Endorsement of Depression Remission at Six Months and Depression Utilization of the PHQ-9 Tool The Buyers Health Care Action Group (BHCAG) is a not-for-profit membership coalition of multi-stakeholders, the majority of which are private and public employers, located in Minnesota. The BHCAG agenda represents what is important to purchasers who pay for health care services. Through our advocacy work, we inform the market on what purchasers want and influence changes in the market to improve the performance of doctors, hospitals and health plans. BHCAG works collaboratively with health care organizations to insure Minnesota continues to be a leader in transforming the health care delivery system. BHCAG and its' members advocate for more rapid adoption of rational system reform focused on patient safety, health care quality and affordability. We identify value-added initiatives and implement them in Minnesota, giving our members the opportunity to participate in new approaches to improve health outcomes. We lead the effort to use consumer incentives and provider rewards to align incentives to deliver a higher quality health care. Members of BHCAG participate on boards, committees, task forces and focus groups to shape the future of health care. BHCAG staff represents our membership in both Minnesota-based and national efforts. BHCAG is a member of the National Quality Forum.	Thank your for your comment.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
42	M-Purchaser Council	Kris Soegaard, Buyers Health Care Action Group	OT3-022-10	(continued from above) BHCAG manages and administers the Minnesota Bridges to Excellence (MNBTE) program. Improving treatment protocols and outcomes for people with conditions like diabetes, vascular disease and depression is the focus MNBTE. This program, which has gained national recognition, provides financial rewards to providers who achieve optimal outcomes for patients with these conditions. In the process, more efficient and cost effective methods of care delivery are identified. BHCAG introduced MNBTE, a purchaser-led pay-for-performance program, in Minnesota in 2006 and continues to manage the program today. MNBTE was tailored specifically for the Minnesota marketplace, utilizing existing infrastructure – measures developed by the Institute for Clinical System Improvement (ICSI) and public reporting by Minnesota Community Measurement. The goals of MNBTE are to: Improve the quality of care for patients Raise the level of purchaser and consumer awareness about the variation in quality Encourage provider competition based on quality outcomes Fourteen private and public purchasers, who provide health care coverage to over 800,000 individuals, pay rewards for optimal performance in diabetes, vascular and depression care.	Thank you for your comments.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
43	M-Purchaser Council	Kris Soegaard, Buyers Health Care Action Group	OT3-022-10	(continued from above) The MNBTE depression care program utilizes the Depression Remission at Six Months measure administered by Minnesota Community Measurement to determine clinic-level performance and qualification for incentive payments and this measure incorporates utilization of the PHQ-9 tool. Our goals in implementing the depression care program were to: Encourage wide spread utilization of the PHQ-9 questionnaire as the assessment tool for identification of depression in a patient population and the level of a patient's depression, and signal the market to adopt a more focused approach to depression care management - one oriented towards accelerated improvement in outcomes for patients with depression. BHCAG and MNBTE believe that measure standardization is an essential element of quality improvement and public reporting. We strongly support endorsement of Depression Remission at Six Months and Depression Utilization of the PHQ-9 Tool measures under consideration for NQF endorsement.	(continued from 41 & 42) See response to comment #41

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
44	P	Linda Vukelich, Minnesota Psychiatric Society	OT3-022-10	The MN Psychiatric Society offered comments on Minnesota's plan to use the PhQ-9 as its standard quality measurement. The central ideas apply here as well, so those comments are submitted below: The Minnesota Psychiatric Society (MPS) is interested in commenting on the Minnesota Community Measurement Specification for Depression specifically the use of the PHQ-9 and data collection. We have the following comments: 1. The State of Minnesota has embarked on a process to collect data on PHQ-9 scores. MPS assumes that this process is going forward and that is the starting point for this discussion. Psychiatry has not opposed the idea of measurement and in fact, the DSM 5 work group has proposed the PHQ-9 as an option for rating the severity for Major Depression. 2. The diagnosis of Major Depression or Dysthymia is based on a clinical interview that requires the physician to assess the patient for other psychiatric and medical conditions. While we recognize that the MNCM specification states that the diagnosis of depression is a prerequisite for PHQ-9 screening, we have concerns that the screening instrument will be used as a diagnostic tool instead. There may be further confusion in that some of the literature supporting the use of the PHQ-9 also describes it as a diagnostic tool.	MD Response: Thank you for your comments. PHQ-9 tool being used for diagnostic purposes: The PHQ-9 tool has been validated for use both as a diagnostic and assessment tool as well as a reliable measure of depression treatment outcomes. [Kronke et al PHQ-9 Validity of a Brief Depression Severity Measure J GEN INT MED 2001], [Lowe et al Monitoring Depression Treatment Outcomes With the Patient Health Questionnaire-9 Medical Care 2004]. It is the intent that providers will use their clinical judgment in arriving at the diagnosis of major depression or dysthymia, and the diagnosis codes plus the elevated PHQ-9 score defines the denominator for measurement. Medication management quality measures with no psychotherapy or psychosocial intervention measures: This is not a requirement of the six month remission measure, nor is data captured for these variables. We are not dictating the intervention, only measuring the success of whatever interventions are deemed appropriate by the provider. Burden using the PHQ-9 tool: It is understandable that change is difficult. A study by Duffy [Systematic Use of Patient-Rated Depression Severity Monitoring: Is It Helpful and Feasible in Clinical Psychiatry? Psychiatric Services Oct 2008] demonstrated that the adoption of the PHQ-9 is feasible even in practices with limited resources and additionally that PHQ-9 scores influenced clinical decision making 93% of the time and resulted in a change in treatment for 40% of patient contacts. The data collection can be burdensome for clinics that have not yet implemented an electronic health record, however the administration of the PHQ-9 tool itself is found to be fairly quick (the patient answers the questions), easy to score, and then can be reviewed by the provider and often opens up discussion between the patient and provider.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
45	P	Linda Vukelich, Minnesota Psychiatric Society	OT3-022-10	3. There may be more valid indicators of improvement than the PHQ-9 score consistent with remission of depression. Actual studies of the sample population may be indicated to determine optimal improvement measures with this instrument. We recommend that the de-identified data be made available to researchers for further statistical analysis. We also recommend more specific studies of validity and factors affecting PHQ-9 scores. 4. The most recent MNCM Measure "Depression Remission at Six months"lists medication management quality measures with no psychotherapy or psychosocial intervention measures. This suggests that medication management is the preferred method of treating depression and has the potential for affecting treatment choices. 5. The administrative use of PHQ-9 scores specifically as a basis for "pay for performance" is an area of concern. There are potential unintended consequences of this type of methodology. The recognition, diagnosis, and treatment of depression in primary care settings is currently reimbursed at a low rate. There is concern that an additional burden introduced by PHQ-9 screening may actually discourage recognition of depression unless there is an appropriate financial offset. There is also a concern that physicians treating the most severe and treatment refractory cases of depression would be penalized unless additional criteria for improvement could be established. The Minnesota Psychiatric Society and its approximately 450 members is extremely interested in improving the treatment of depression in the state of Minnesota and would like to be a resource for the quality blueprint necessary to achieve that goal. Accuracy in measurement is the first step.	See response to comment #44

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
47	M-Provider Organization Council	Stacey Drubner, JD, MSW, MPH, Partners Psychiatry and Mental Health	OT3-022-10	PPMH supports the establishment of a process measure for general depression screening using the PHQ-9. It is a valid, reliable tool for screening of major depression, and is a reasonable option for confirming diagnosis and assessing the overall level of baseline severity for treatment planning purposes. Although PPMH support the use of the PHQ-9 as a screening tool, there is one caveat that warrants mention. The PHQ-9 is a copyrighted instrument owned by Pfizer. Although the instrument is available in the public domain, the Pfizer copyright must be reproduced on all copies of the instrument. The presence of the Pfizer logo on patient materials promoted and distributed by providers in academic psychiatry settings may portray the appearance of an inappropriate relationship between industry and psychiatry. This is a particular concern in the current climate of scrutiny about the influence of Pharma in the psychiatry setting. An assurance that no one with Pfizer connections participated in the selection process may mitigate this concern somewhat. Additionally, PPMH would support the use of an alternative, technically sound instrument, such as the QIDS-SR, a self-rated tool used in the Star*D project. The QIDS-SR has no direct link to the Pharma industry.	NQF Staff Response: 10. The PHQ-9 is publically available and is free of charge. The instrument was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. MD Response: Thank you for your comments. I understand about the concerns of linking to the pharmaceutical industry and you are correct that Pfizer was not involved in any way in the development of the depression measures. In terms of the Pfizer logo, we've seen many physical versions (not technical as they all need to contain the exact same questions, order and scoring) of the form in use by clinics and I've not yet seen a Pfizer logo as part of the form, though it could exist. Including the Pfizer logo has not been a requirement that we are aware of. There have recently been developments in terms of the copyright for the PHQ-9. In June of 2010, Pfizer turned over the copyright back to the developers Drs. Robert L. Spitzer, Janet B.W. Williams, and Kurt Kroenke. They only ask that in the footer of the PHQ-9 form contain the following statement "Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute." The PHQ-9 is now in the public domain with 79 language translations at www.phqscreeners.com.
50	P	Michael Trangle, Healthpartners/Re	OT3-022-10	This tool is valid, reliable, extraordinarily easy to use and quite helpful for ongoing clinical management as well as measurement purposes. We have been spreading it to both Behavioral Health and Primary Care clinics throughout MN (representating a variety of settings and resources). Except for some minor grousing about a few clinicians attempting to inappropriately use it to automatically diagnose a patient (without using their clinical judgement)and similiar quibbles about defining remission in patients with chronic medical conditions (such as pain. insomnia, fatigue) it's been universally accepted and adopted.	Thank your for your comment.
55	P	Janny Brust, MN Council of Health Plans	OT3-022-10	MN Council of Health Plans (MCHP) supports the use of the standardized assessment tool, the PHQ-9, which assesses the severity of depression symptoms. This tool which provides a measureable assessment of a patient's depression symptoms has been widely adopted by primary care providers in Minnesota and is gaining traction with behavioral health providers as well.	Thank your for your comment.

#	Member Council/ Public	Organization Contact	Topic	Comment	Response
63	P	Indira Jevaji, MD., MSL, ORWH/NIH	OT3-022-10	The Office of Research on Women?s Health (ORWH) serves as the focal point for women's health research at the National Institutes of Health (NIH). ORWH advances its mission in partnership with the NIH Institutes and Centers and supports innovative research on women?s health and the role of sex and gender in health and disease. The ORWH is pleased to have the opportunity to comment on the proposed four mental health outcome standards recommended for endorsement. The ORWH recommends that the NQF routinely collect report and conduct analyses for possible differences or similarities in quality of care patient outcomes by sex /gender and race/ethnicity to provide research based evidence for related outcomes.	See response to comment #62
76	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	OT3-022-10	We generally support this measure, although it is a process measure rather than an outcome measure. This measure captures whether a PHQ-9 tool was administered at least once every four months. This measure is to be paired with the measures of depression remission at six months and 12 months, providing these two measures with the data necessary to assess whether remission was achieved. However, it will be important that the results of these paired measures be reported separately (e.g., whether 6 months remission was achieved should not be compounded with information about whether the PHQ-9 was administered).	NQF Staff Response: The Steering Committee acknowledged that measure OT3-022-09 is a process measure, but is an important companion to the outcome measures. Paired measures do not imply any integration, just that both measures are performed and reported together. MD Response: Thank you for your comments. In Minnesota we do report this process measure separately. I believe that it is being presented as a paired measure because the process measure, utilization of the PHQ-9, serves as an intermediate step towards clinicians using the tool as part of an ongoing assessment and remaining in contact with the patient to enable measuring remission at six and twelve months. We report performance rates at a clinic site level, when the measures are viewed in tandem, it can help explain outcomes rates. Groups with very low utilization rates have very little chance of achieving remission targets and need to work on improving their processes.

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79	M-QMRI Council	Senka Hadzic, Institute for Clinical Systems Improvement	OT3-022-10	The Institute for Clinical Systems Improvement (ICSI) is a non-profit organization that brings together diverse groups to transform the health care system so that it delivers patient-centered and value-driven care. It is comprised of 59 medical groups and sponsored by six Minnesota and Wisconsin health plans. Since March 2008, ICSI has worked with 83 clinics to implement DIAMOND (Depression Improvement Across Minnesota, Offering New Direction) in primary care clinics. All 83 certified DIAMOND clinics have standardized the PHQ-9 as a required tool for reliable and standardized assessment,symptom management, treatment intensification/modification, patient engagement, and tracking outcomes for major depression. With more than 5,000 patients, the DIAMOND program is getting at least five times as many patients with depression into remission by six months compared to patients receiving typical primary care treatment for depression. Use of the PHQ-9 is a core component of the DIAMOND model because it is supported by quality and breadth of evidence from more than 600 published studies demonstrating its effectiveness in various clinical settings and patient populations. We strongly support endorsement of Depression Utilization of the PHQ-9 Tool, Remission at 6 and 12 months measures under consideration for NQF endorsement.	Thank your for your comment.

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82	M-Purchaser Council	Gaye Fortner, HC21	OT3-022-10	I generally support this measure, although it is a process measure rather than an outcome measure. This measure captures whether a PHQ-9 tool was administered at least once every four months. This measure is to be paired with the measures of depression remission at six months and 12 months, providing these two measures with the data necessary to assess whether remission was achieved. However, it will be important that the results of these paired measures be reported separately (e.g., whether 6 months remission was achieved should not be compounded with information about whether the PHQ-9 was administered).	NQF Staff Response: The Steering Committee acknowledged that measure OT3-022-09 is a process measure, but is an important companion to the outcome measures. Paired measures do not imply any integration, just that both measures are performed and reported together. MD Response: Thank you for your comments. In Minnesota we do report this process measure separately. I believe that it is being presented as a paired measure because the process measure, utilization of the PHQ-9, serves as an intermediate step towards clinicians using the tool as part of an ongoing assessment and remaining in contact with the patient to enable measuring remission at six and twelve months. We report performance rates at a clinic site level, when the measures are viewed in tandem, it can help explain outcomes rates. Groups with very low utilization rates have very little chance of achieving remission targets and need to work on improving their processes.
86	M-Health Plan Council	Catherine MacLean, WellPoint	OT3-022-10	OT3-012-10, OT3-011-10, and OT3-022-10: WellPoint believes that these measures are a good starting point for standardizing how depression remission is documented. However, what response is envisioned if a practitioner chooses a widely accepted tool (there are many the Beck Depression Inventory or BDI and the Montgomery Asberg Depression Rating Scale or MADRS are widely used examples) other than the PHQ-9? We also question whether documentation of these measures will be implemented outside of P4P programs because of provider reluctance to assume what is perceived as additional work.	See response to comment #84.
98	M-Purchaser Council	Edward Garcia, CMS	OT3-022-10	CMS supports the recommendation for endorsement of this measure.	Thank your for your comment.

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111	M- QMRI Council	Robert Plovnick, American Psychiatric Institute for Research and Education	OT3-022-10	Previous work with the PHQ-9 has demonstrated that its use in conjunction with a care manager has inevitably resulted in improved outcomes for patients. Clinicians have been encouraged to examine the response to treatment based on PHQ-9 scores and adjust their intervention strategies based on the feedback they get from the measure, and to use the care manager to query patients about their compliance with treatment protocols. There have not been studies that have assessed the benefits of using the PHQ-9 alone as an outcome measure to incentivize improved care. While process measures based on administering the PHQ-9 and use of depression care managers could lead to marked improvements in patient outcomes, using the PHQ-9 measure in isolation as a proxy for remission and outcome is extrapolating beyond existing research studies and is inconsistent with the previous use of these instruments.	MD Response: Thank you for your comments. I hope that I'm not misinterpreting your comments, but any tool used in isolation without clinical judgment is of no value. We have many clinics working on improving processes and outcomes without the benefit of a case manager and are inventing creative ways to stay connected with their patients. Use of the PHQ-9 has been studied as a tool to measure outcomes as well. [Monitoring Depression Treatment Outcomes With the Patient Health Questionnaire-9 Lowe et al Medical Care Volume 42, Number 12, December 2004]. Additionally, a study by Duffy [Systematic Use of Patient-Rated Depression Severity Monitoring: Is It Helpful and Feasible in Clinical Psychiatry? Psychiatric Services Oct 2008] demonstrated that the adoption of the PHQ-9 is feasible even in practices with limited resources and additionally that PHQ-9 scores influenced clinical decision making 93% of the time and resulted in a change in treatment for 40% of patient contacts.
69	M-Health Plan Council	Rebecca Zimmermann, AHIP	OT3-047-10	OT3-047-10: Inpatient Consumer Survey (ICS) (National Association of State Mental Health Program Directors Research Institute, Inc.) The Inpatient Consumer Survey (ICS) addresses multiple dimensions of the patient experience post-hospital discharge, such as patients' perceived outcomes, patient dignity and rights, and the facility environment. While the questions appear to be appropriate, additional information is needed on the results of measure testing using this specific tool. It is also unclear if this survey could be used in addition to HCAHPS. HCAHPS provides an opportunity for hospitals to compare performance among different departments. We would encourage the use of hospital psychiatric departments to utilize both surveys.	The Steering Committee compared a crosswalk of the ICS and HCAHPS. The ICS includes question specific to mental health patients and patient's perceptions of the effectiveness of their care which are not included in HCAHPS. MD Response: Analyses of psychometric properties currently being prepared for publications focus on a recent year (2008) of data: findings indicate reliability statistics by domain range from .72 - .87; all tests on psychometric properties have been run with good results. These values have been consistent since 2002 when the 28-item tool was first implemented (unpublished findings). It is a provider's option to use this tool in addition to HCAHPS, supported by the HCAHPS Fact Sheet. The initial clients for NRI were standalone inpatient psychiatric hospitals. HCAHPS had yet to be developed when development began on the ICS and there were no public domain tools that included free access to the scoring algorithms of measures. We also encourage hospitals to consider additional items that are relevant for their particular environment.
77	M-Purchaser Council	Christine Chen, Pacific Business Group on Health	OT3-047-10	This survey asks patients to evaluate their care. Five domains are included in the survey: outcome, dignity, rights, treatment, and environment. We believe that this measure will help consumers and purchasers better understand patients' experience of care.	Thank your for your comment.
83	M-Purchaser Council	Gaye Fortner, HC21	OT3-047-10	I believe that this measure will help consumers and purchasers better understand patients' experience of care.	Thank your for your comment.

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87	M-Health Plan Council	Catherine MacLean, WellPoint	OT3-047-10	OT3-047-10: WellPoint does not support this measure. We believe that available measures of patient experience during episodes of hospitalization should be more broadly applied to include the MHSU population, rather than creating a separate measure for the MHSU population. Broadening existing measures would increase parity for MHSU patients, and allows comparisons across hospital units (including behavioral health units) within the general hospital setting. Use of existing measures of patient experience also facilitates comparison between types of facilities. Using a separate measure for MHSU patients would not allow for such comparisons, potentially diminishing parity.	Steering Committee Response: While the Committee affirmed the need for measures to have a broad range of applicability, the Committee did identified unique components of the measure which would be irrelevant to other care settings. MD Response: Broadening existing measures requires tools to be re-tested, adding items increases complexity and may decrease response rate, and skip logic may be difficult for certain client populations. I would agree that comparisons across health populations is useful to determine if there are disparities by disease group, and system changes can be made to reduce disparities. However, I would argue that it is difficult to create a tool that will adequately serve all populations, just as an educational program needs to attend to different styles of learning so a consumer-oriented evaluation of care needs to attend to the interests of the various consumers. Psychiatric hospitals have indicated a medical model focus of most hospital survey tools undermines the client-centered recovery focus of psychiatric care. I do not see a relationship between cross-disease comparisons and parity. The reason for a consumer evaluation is to improve care practices for that disease.

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90	M- Provider Organization Council	Stacey Drubner, JD, MSW, MPH, Partners Psychiatry and Mental Health	OT3-047-10	NQF CONSENSUS STANDARDS FOR PATIENT OUTCOMES MEASURES: CHILD AND MENTAL HEALTH INPATIENT CONSUMER SURVEY MEASURE: OT3-047-10 PARTNERS PSYCHIATRY AND MENTAL HEALTH RESPONSE Partners Psychiatry and Mental Health (PPMH) supports standardized consumer experience measurement. In a recent system-wide quality survey of psychiatry clinicians/leadership, patient satisfaction was rated the most relevant to improving patient care. PPMH supports the proposed measures with the following observations/caveats: Key domains are covered in the measure. The number of items may be overwhelming for patients who are still psychiatrically symptomatic at the time of administration. We recommend risk adjustment, particularly around differentiating voluntary versus involuntary admissions. Paper-based measures are not as efficient/user-friendly for administration, data collection and reporting; We recommend an allowance for electronic technologies. Where feasible, we favor standardization of survey approach/question format across clinical services; We recognize that not all mainstream survey components are appropriate for all patient populations. We concur with AHRQ CAHPS philosophy endorsing patient experience (versus traditional satisfaction) surveys, as they elicit information that allows for more specific feedback, which is objective, understandable, actionable. We recommend using a measure available in the public domain versus a proprietary one, in the interest of cost mitigation.	MD Response: The 2-page instrument is designed to be used at discharge (before the client leaves the hospital) or annual review. Survey response is voluntary and all clients are given the opportunity to respond; low response rates or missing items remove the client from a measure calculation. We have suggested to hospitals that they track the reasons for low response rates and incomplete surveys as these could illuminate quality improvement activities. Risk adjustment is one option for benchmarking; NRI provides its hospitals with stratified reports for legal status on admission and age group. Stratified reports ensure that disparities are open and can be addressed. NRI's hospitals have preferred stratified reports. Future public reports may incorporate stratifications. Paper-based or electronic technologies can be used to administer the survey. NRI developed a paper-based tool for patients. A couple of NRI's client hospitals developed "touch screen" tools for patients that follow the same format as the paper version. NRI developed an Access database to facilitate data entry and reporting. We also favor a standard survey approach across all clinical specialties. All patients should be given the opportunity to provide evaluation of their care; however, some tools ask only a sample of patients and some do not begin the process until after discharge is completed. There are considerable missed opportunities and potential for selection bias in the respondents. The ICS is given to all clients once a discharge date has been determined. NRI tool is available for use without fee (i.e. public domain), however, it is labeled as proprietary (copyright) to ensure that no user edits or changes the instrument. The integrity of the ICS and comparability of measures results cannot be maintained if users change the tool. Users are given the option to add items to the end, not the beginning of the tool; a practice also noted in the HCAHPS. The tool is 2 pages. NRI also provides full instructions for compiling domain scores to any provider on request, without fee.

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93	M-Purchaser Council	Edward Garcia, CMS	OT3-047-10	The target denominator population includes adolescents age 13-17 years and adults age 18 years and older but the reliability testing does not cite results from the 13-17 age group. Were these included in the testing? The sampling strategy only included state psychiatric hospitals and it would have been preferable to have data from other types of inpatient providers ensuring a more representative sample.	MD Response: Adolescents were not included in the pilot. After the tool was reduced to 28 items, the reading level was checked and minor wording changes were made to reduce the reading level to grade 5.2. Reliability testing was completed on for responses from adolescent in 2005 when there was a significant response rate from that group. Current research (publication in development) indicates scales validate at a slightly lower reliability alpha statistic for all domains for youth compared to responses from adults (alpha ranges from .63 to .84 for youth and .72 - .87 for adult) (unpublished findings). The tool was initially developed for existing hospital clients of NRI to meet accreditation requirements of The Joint Commission. State psychiatric hospitals providing both acute and long term care services to person with a variety of diagnoses volunteered to test the instrument. Since its implementation, several private hospitals have contacted NRI to request permission to adopted the tool and receive the instructions; other private hospitals simply download the free tool from the website.
94	M-Purchaser Council	Edward Garcia, CMS	OT3-047-10	Requiring completion of only 2 domains seems limiting. More data analysis could be obtained with encouraging more domains scored.	MD Response: Clarification: A client's domain score is an average of the ratings for the items in the domain. Client must complete 2 items to have a domain score calculated. Hospitals are required to use the instrument in it full form without any deletions. Clients are thus permitted to respond to all items. Hospitals are encouraged to select all domains for scoring. Additionally, hospitals are provided analysis for all individual items.
95	M-Purchaser Council	Edward Garcia, CMS	OT3-047-10	Health outcomes and subjective perceptions are likely to affect the patient's survey responses, thus raising questions about the value of the measure scoring.	MD Response: The ICS includes a domain for (mental) health outcomes. Regardless of the ultimate health outcome, client's evaluation of their care provides direct feedback to the healthcare provider on the nature of the interactions between the healthcare provider and the client (rights, dignity, and participation). Correlation among the outcomes domain (dealing with one's illness) and the other domains suggests that addressing issues stemming from the quality of the interactions can support client's learning to deal with and recover from one's illness.