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Primary Care and Chronic Illness, Fall 2021 Cycle: CDP Report

TECHNICAL REPORT
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Executive Summary

Primary care functions as an initial access point to medical care and is generally the most common point of encounter between providers and patients. Primary care is intended to offer care that is optimally accessible, comprehensive, and preventive in nature. Chronic illness is characterized by persistent symptomology that is exhibited by a patient and ameliorated by ongoing intervention. In addition to the treatment of chronic illness, primary care also aids in health promotion and disease prevention.[1] The National Quality Forum's (NQF) Primary Care and Chronic Illness (PCCI) Standing Committee oversees a portfolio of quality measures that address primary care and the management of chronic disease, along with additional disease processes that present the need for continuous quality care. The portfolio includes measures on ears, nose, throat, and eye care; endocrinology; infectious disease; musculoskeletal care; pulmonology; and other chronic conditions.

The PCCI Standing Committee evaluated two newly submitted measures and one measure undergoing maintenance review against NQF's standard evaluation criteria. The Standing Committee recommended two measures for endorsement but did not recommend the remaining measure for endorsement. The Consensus Standards Approval Committee (CSAC) upheld the Standing Committee's recommendations.

The Standing Committee endorsed the following measures:

- NQF #3332 Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) (Massachusetts General Hospital [MGH])
- NQF #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma (College of American Pathologists [CAP])

The Standing Committee did not endorse the following measures:

- NQF #3667 Days at Home for Patients With Complex, Chronic Conditions (Centers for Medicare & Medicaid Services [CMS]/Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation [Yale CORE])

Brief summaries of the measures and their evaluations are included in the body of the report; detailed summaries of the Standing Committee's discussions and ratings of the criteria for each measure are in Appendix A.

Introduction

Primary healthcare focuses on the patient's overall health needs, including health promotion, disease prevention, and diagnosis and treatment of chronic disease.[1] Because primary healthcare providers are the most common point of contact with patients in the health system,[1] measuring the quality of healthcare provided becomes even more important. Measuring quality allows providers to determine how well they are performing and provides them with an opportunity to improve the overall care they provide to their patients. Three measures were reviewed during the PCCI Standing Committee's fall 2021 measure evaluation meeting; these measures focused on monitoring patients' days at home and out of the hospital, biomarker genetic testing of surgical pathology reports in some cancers, and behavioral health assessments in children. Each cycle, the PCCI Standing Committee convenes a unique expert pool of members based on the measures under review. Experts from the Cancer and Behavioral Health and Substance Use (BHSU) Standing Committees were added to the fall 2021 PCCI Standing Committee, as full voting members, to provide clinical expertise and input during the evaluation of the measures.

Patients' Days at Home

Medicare enrollment is projected to increase by more than 50 percent, from 54 million beneficiaries in 2015 to more than 80 million in 2030.[2] A growing focus on complex, chronically, and seriously ill Medicare patients necessitates care that reflects the system's responsiveness to patient preferences. In addition, the need for innovative approaches designed to empower beneficiaries to engage in their own care can potentially decrease overuse of acute and long-term institutional care.[3] Research shows that patients prefer to be at home and not in the hospital.[4–8] Therefore, improving care coordination will allow patients to spend more time at home, decrease unnecessary hospitalizations, improve clinical outcomes, and decrease costs.[7,9–13]

Surgical Pathology Biomarker Testing in Cancer

Cancer constitutes 21 percent of all deaths in the United States (U.S.).[14] Characterized as a collection of diseases with specific heterogeneous genetic profiles,[15] biomarker testing of cancer and its evolving etiology continually guide providers on immuno-oncologic therapies and treatment decisions for patients. Increased precision and the ability to target genetic markers are important for patients whose previous cancer modalities have failed and their cancer continues to progress.

Pediatric Behavioral Health Assessment

It is estimated that about 12 percent of children and adolescents experience psychosocial problems, which are often unrecognized by their pediatrician.[11,16,17] Routine psychosocial screening and subsequent early detection of psychosocial problems during preventive child healthcare services can improve the acknowledgement, counsel, and potential referral of behavioral health services for pediatric patients.[18] Children who are screened for psychosocial problems are also more likely to receive outpatient mental health services than those who are not.[19–21]

NQF Portfolio of Performance Measures for Primary Care and Chronic Illness Conditions

The PCCI Standing Committee (Appendix C) oversees NQF's portfolio of PCCI measures (Appendix B), which includes measures on ears, nose, throat, and eye care; endocrinology; infectious disease; musculoskeletal care; and pulmonology. This portfolio contains 59 measures: 45 process measures, five outcome measures, one patient-reported outcome performance measure (PRO-PM), three intermediate outcome measures, two composite measures, and three trial use measures.

Other measures related to Primary Care and Chronic Illness have been assigned to other portfolios. These include functional status measures (Patient Experience and Function), opioid use measures (Patient Safety, BHSU), diabetes-related admission rate measures (Prevention and Population Health), and a variety of condition- or population-specific measures (Cardiovascular, Geriatrics and Palliative Care, etc.).

Primary Care and Chronic Illness Measure Evaluation

On February 11, 2022, the PCCI Standing Committee evaluated two new measures and one measure undergoing maintenance review against NQF's standard measure evaluation criteria.

Table 1. Primary Care and Chronic Illness Measure Evaluation Summary

Measure	Maintenance	New	Total
Measures under review for endorsement	1	2	3
Measures endorsed	1	1	2
Measures not endorsed	0	1	1
Reasons for not endorsing	*	Scientific Acceptability – 1	*

* Indicates the table cell is empty

Scientific Methods Panel Measure Evaluation

Prior to the Standing Committee's review, the Scientific Methods Panel (SMP) reviewed one complex measure in this topic area. The SMP passed this measure on reliability but did not reach consensus on validity during its measure evaluation. The Standing Committee also reviewed this measure.

A meeting summary detailing the SMP's measure evaluation for the fall 2021 cycle is available on the SMP webpage.

Comments Received Prior to Standing Committee Evaluation

NQF accepts comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments for a continuous 16-week period during each evaluation cycle via an online tool located on the project webpage. For this evaluation cycle, the commenting period opened on November 30, 2021, and pre-meeting commenting closed on January 12, 2022. As of January 12, 2022, four comments were submitted and shared with the Standing Committee prior to the measure evaluation meeting (Appendix F).

Comments Received After Standing Committee Evaluation

The continuous 16-week public commenting period with NQF member support closed on April 25, 2022. Following the Standing Committee's evaluation of the measures under review, NQF received 11 comments from seven organizations (including five member organizations) and individuals pertaining to the draft report and the measures under review (Appendix G). All comments for each measure under review have also been summarized in Appendix A. These comments were sent to the Standing Committee and discussed during the post-comment meeting.

NQF members had the opportunity to express their support ("support" or "do not support") for each measure submitted for endorsement consideration to inform the Standing Committee's recommendations during the pre-meeting commenting period. One NQF member expressed "do not support" and two NQF members expressed "support" for NQF #3667. One member expressed "do not support" for NQF #3661.

Summary of Measure Evaluation

The following brief summaries of the measure evaluation highlight the major issues that the Standing Committee considered. Details of the Standing Committee's discussion and ratings of the criteria for each measure are included in Appendix A.

Pediatric Behavioral Health Assessment

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

Description: Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit; **Measure Type**: Process; **Level of Analysis**: Health Plan; Clinician: Group/Practice; Clinician: Group/Practice; Population: Regional and State; Population: Regional and State; Population: Regional and State; Facility; Facility; **Setting of Care**: Outpatient Services; **Data Source**: Paper Medical Records; Claims; Electronic Health Records: Electronic Health Records; Electronic Health Data

This health plan-level measure was originally endorsed in 2017. It is currently used in the Commonwealth of Massachusetts' Children's Behavioral Health Initiative (CBHI) payment program. The measure is also part of the American Board of Pediatrics (ABP) Maintenance of Certification program. The Standing Committee agreed that the updated evidence further supported the measure and passed it on the evidence criterion. Moving to performance gap, the Standing Committee requested more information on racial disparities. The developer explained that large racial and ethnic disparities were not observed in this measure. However, the Standing Committee noted that the measure shows variable performance in care and a clear performance gap overall. Therefore, the Standing Committee passed the measure on the performance gap criterion.

The Standing Committee asked the developer why an outcome or a PRO-PM had not been developed yet. The developer emphasized that the screening tool's primary function is to optimize the number of encounters in which pediatricians engage their patients in this screen and the propensity for pediatricians to take care of their patients; the developer also emphasized that every patient encounter does not and should not necessarily warrant a referral. The developer continued to explain that the

screening tool has built capacity for providers to counsel, manage, and refer children with behavioral health issues and either provide them with or direct them to the right care. Although the Standing Committee expressed a desire for further development of the measure towards increased assessment of patient-related outcomes and integration of care models, it acknowledged that the measure has proven to be successful in its core purpose. Moving to the evaluation of scientific acceptability (i.e., reliability and validity), the Standing Committee noted that for both the 2017 billing code data and 2021 electronic warehouse data, the intercoder agreement, at over 90 percent, is high and well within the range of acceptability. The Standing Committee expressed no further commentary and passed the measure on the reliability subcriterion. The Standing Committee noted that the validity testing at both the patient/encounter and accountable-entity levels was strong, and the measure was able to identify meaningful differences in provider performance. The Standing Committee expressed no concerns with validity and passed the measure on both reliability and validity.

The Standing Committee passed the measure on feasibility, noting that the measure is feasible and well integrated into practice. The Standing Committee also acknowledged that the measure is in use but expressed concerns about potential unintended consequences, such as taking away time from other concerns and overburdening of referral resources. Despite these concerns, the Standing Committee recognized that the measure's benefits outweigh the perceived barriers. It agreed that the measure is usable and passed the measure on use and usability. The Standing Committee did not raise any additional concerns prior to the vote for overall suitability and stated that the measure is suitable for endorsement. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

Surgical Pathology Biomarker Testing in Cancer

NQF #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma (College of American Pathologists): Endorsed

Description: Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice; Clinician: Individual; **Setting of Care**: Outpatient Services; **Data Source**: Electronic Health Data; Other (specify)

This individual and group clinician-level measure was newly submitted for endorsement. The measure is publicly reported nationally in the Quality Payment Program's (QPP) Merit-Based Incentive Payment System (MIPS). The Standing Committee reviewed the presented evidence: It agreed that it supports the measure and that the measure is meaningful to patients. The Standing Committee noted that a performance gap was present and passed the measure on the evidence and performance gap criteria. The Standing Committee reviewed the reliability data, which were reported and analyzed at the individual level, with a mean reliability score of 0.96. Group level analysis was not performed, and the Standing Committee noted that the measure was reported at the individual and group levels. The developer explained that their individual results were excellent and aggregating the data and repeating the analysis at the group level would only make the reliability better. Therefore, group level analysis was not performed. The Standing Committee chose to vote at the group and individual levels for reliability

separately, and the measure passed at both levels. Validity testing was conducted via face validity; no threats to validity were found, and the measure is not risk-adjusted. The Standing Committee passed the measure on validity.

During the feasibility discussion, the Standing Committee highlighted one concern: This is an audit-based measure, and it may not be feasible. The Standing Committee discussed the concern and agreed that the measure was feasible, regardless of the additional need to audit the results. The measure has been in use since 2021 in the MIPS program, but it is not publicly reported. Performance scores have increased from 2020 to 2021 from 78.3 to 86.5, respectively, suggesting that the measure is usable. The Standing Committee passed the measure on feasability, use, and usability. The Standing Committee also passed the measure on overall suitability for endorsement and recommended the measure for initial endorsement. The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement. No appeals were received.

Patients' Days at Home

NQF #3667 Days at Home for Patients With Complex, Chronic Conditions (Yale CORE): Not Endorsed

Description: This is a provider group-level measure of days at home or in community settings (that is, not in acute care such as inpatient hospital or emergent care settings or post-acute settings such as Skilled Nursing Facilities (SNFs)) among adult (age 18 years or older) Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating provider groups. The measure includes risk adjustment for differences in patient mix across provider groups, with an adjustment based on patients' risk of death. An additional adjustment that accounts for patients' risk of transitioning to a long-term nursing home is also applied to encourage home- and community-based care in alignment with CMS's policy goals. A higher risk-adjusted score indicates better performance; **Measure Type**: Outcome; **Level of Analysis**: Clinician: Group/Practice; Accountable Care Organization; **Setting of Care**: Inpatient/Hospital; Post-Acute Care; **Data Source**: Claims

This accountable care organization (ACO)-level measure was newly submitted for endorsement. The measure has not yet been implemented in a federal program. The Standing Committee noted that the evidence supports the measure but questioned whether the denominator would capture patients with substantial disease. The developer clarified that patients must have a Hierarchical Condition Category (HCC) composite risk score of greater than or equal to 2.0, which would include a wide cohort with a variety of chronic conditions. The Standing Committee did not have any further questions and passed the measure on evidence. The Standing Committee also noted that substantial variation was present in time spent at home and that an opportunity to improve care was available; however, the Standing Committee had concerns about the disparities data, considering the analysis used Medicare ACO data, while the measure was specified for all Medicare patients. Both the Standing Committee and developer further clarified that 20 percent of all Medicare patients are represented in ACOs. No further conversation took place regarding this point. The Standing Committee also questioned whether variability among ACOs truly indicated a national performance gap due to the lack of inclusion of social determinants of health (SDOH) in the developer's analysis. The developer stated that during their analysis, they could not identify a strong link related to SDOH factors. The Standing Committee ultimately passed the measure on performance gap.

The SMP reviewed this measure, prior to the Standing Committee meeting, and passed it on reliability but did not reach consensus on validity. The Standing Committee reviewed the major reliability concerns the SMP addressed, which mainly focused on the measure's specifications. The Standing Committee also requested clarification as to whether the measure was only meant to be used in ACOs or whether it could be used more broadly at the clinician-group level. A few Standing Committee members also questioned whether days at home could be considered a valid surrogate for care coordination. The developer clarified that the terms *ACO* and *clinician group* are considered synonymous in this measure, and a clinician group would encompass any entity that is committed to providing care with a focus on care coordination. The developer acknowledged that directly measuring care coordination is challenging, and based on the developer's research, days at home could be used to signal good care coordination. The Standing Committee did not have any further questions or concerns and voted to accept the SMP's rating of reliability.

The Standing Committee noted that the developer conducted face validity and construct validity testing. The face validity testing indicated the measure may be valid. The construct validity testing found that the correlation between NQF #3667 and two of the six other measures was weak. The developer emphasized that the lack of correlation may be due to the other measures having smaller sample sizes and not being risk-adjusted. The correlation with the four other measures was noted as moderate in strength. The Standing Committee highlighted that the SMP's main concerns with validity pertained to the risk adjustment models, measure exclusions, and meaningful differences in performance. The Standing Committee once again expressed concerns with SDOH factors not being included in the risk adjustment model. The developer noted that a national standardized approach to addressing SDOH factors does not exist. However, the developer stated that the most accepted method is to utilize dual eligibility, which is what the developer did within the risk adjustment model. The Standing Committee believed that dual eligibility did not do enough to account for these factors. The Standing Committee also raised concerns with the exclusions, specifically with low outliers and how the developer attributed them to an unintended consequence of the measure's construct, as the measure itself attempts to balance days at home with other unintended consequences. Due to these concerns, the Standing Committee did not pass the measure on validity.

Because validity is a must-pass criterion, the Standing Committee did not discuss NQF #3667 any further and did not recommend this outcome measure for initial endorsement. During the post-comment meeting, seven comments were received for this measure. Two commenters expressed support for the Standing Committee's decision to not recommend the measure for endorsement, while three commenters expressed support for endorsing the measure. The developer also submitted a comment clarifying aspects of the measure and requested feedback on potential enhancements to the measure. The Standing Committee provided recommendations on how the measure could be improved. The CSAC upheld the Standing Committee's decision to not recommend the measure for endorsement.

Measures Withdrawn From Consideration

One measure previously endorsed by NQF was either not resubmitted for maintenance of endorsement or was withdrawn during the endorsement evaluation process. Endorsement for this measure has been removed.

Table 2. Measure Withdrawn From Consideration

Measure	Reason for withdrawal
NQF #3086 Population Level HIV Viral Load Suppression	Developer requested to retire the measure.

References

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Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable

National Quality Forum (NQF) ensures that quorum is maintained for all live voting. Quorum is 66 percent of active Standing Committee members minus any recused Standing Committee members. There were no Standing Committee recusals. Quorum (14 out of 20 Standing Committee members) was reached and maintained during the full measure evaluation meeting on February 11, 2022. Vote totals may differ between measure criteria and between measures, as Standing Committee members may have joined the meeting late, stepped away for a portion of the meeting, or had to leave the meeting before voting was complete. The vote totals listed below reflect Standing Committee members present and eligible to vote at the time of the vote. Voting results are provided below.

A measure is recommended for endorsement by the Standing Committee when greater than 60 percent of voting members select a passing vote option (Pass, High and Moderate, or Yes) on all must-pass criteria and overall suitability for endorsement. A measure is not recommended for endorsement when less than 40 percent of voting members select a passing vote option on any must-pass criterion or overall suitability for endorsement.

Measures Endorsed

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

Measure Worksheet | Specifications

Description: Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

Numerator Statement: Number of patients with documentation that the PSC tool was administered as part of the well child visit

Denominator Statement: Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit

Exclusions: No exclusions

Adjustment/Stratification: No additional risk adjustment analysis included

No risk adjustment or stratification

N/A

Level of Analysis: Health Plan, Population: Regional and State, Facility

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

Measure Steward: Massachusetts General Hospital

STANDING COMMITTEE MEETING [February 11, 2022]

1. Importance to Measure and Report:

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total votes-19**; **H-N/A**; **M-14**; **L-5**; **I-0** 1b. Performance Gap: **Total votes-19; H-3**; **M-16**; **L-0**; **I-0**

Rationale:

- The Standing Committee reviewed prior evidence from the 2017 measure submission, as well as submitted updated evidence. The Standing Committee voiced a concern regarding the absence of a systemic review but recognized the high level of evidence from the multiple randomized controlled trials (RTCs) and agreed that the evidence supports routine screening with the PSC.

- The Standing Committee noted a clear performance gap based on the wide distribution (8.21% to 85.65% with a median of 64.53%) of screening across states within a decade of assessment.
- The Standing Committee expressed some concerns with the lack of data on racial disparities; however, the developer advised that the identification of racial gaps, with this measure, is not appropriate or necessary. Additionally, the developer explained that the patient population is characterized by low socioeconomic status and that no clear or large racial/ethnic disparities have been observed.
- Ultimately, the Standing Committee noted that disparities are more likely to arise during the examination of patient outcomes and less likely during the examination of processes.
- The Standing Committee expressed no further concerns and passed the measure on evidence and performance gap.

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Total votes-19; H-N/A**; **M-18**; **L-1**; **I-0**; 2b. Validity: **Total votes-19; H-4**; **M-12**; **L-3**; **I-0**

Rationale:

- The SMP did not review the measure because this is a noncomplex measure.
- The Standing Committee expressed concern with the overuse of process measures and desire to see movement toward patient-reported outcome measures (PROMs). The developer acknowledged the Standing Committee's concern but advised that this process measure is integral to screening patients for depression, prior to implementing treatments. The Standing Committee expressed understanding of the next step in this measure, which is to develop outcome measures that will determine whether screenings are working to improve the diagnosis and treatment of depression.
- The Standing Committee noted the reliability testing was conducted at the patient/encounter level using inter-rater reliability. The Standing Committee agreed that the inter-rater reliability results of over 90% for the 2017 and 2021 data demonstrated high reliability.
- The Standing Committee noted the high indications of the measure's validity and agreed that the Current Procedural Terminology (CPT) code used to bill for screening corresponded with evidence that a PSC had been given. The Standing Committee noted that the sensitivity of the coding versus chart review was 86%, and the specificity was 100% with an overall level of agreement of 91%.
- The Standing Committee passed the measure on the reliability and validity criteria.

3. Feasibility: Total votes-19; H-4; M-15; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee noted that the data elements are abstracted from a record by someone other than the person documenting the original information.
- The Standing Committee recognized that the measure has no proprietary elements in its implementation as well as no fees.
- The Standing Committee noted indication of more than a dozen newly published PSC papers since the developer's last submission, which have demonstrated the feasibility of screening.
- The Standing Committee passed the measure on feasibility.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Total votes-19**; **Pass-19; No Pass-0**; 4b. Usability: **Total votes-19; H-4; M-13; L-2; I-0**

Rationale:

- The Standing Committee noted that the measure is used by the Commonwealth of Massachusetts' Children's Behavioral Health Initiative (CBHI) payment program and the American Board of Pediatrics (ABP) Maintenance of Certification program.
- The Standing Committee expressed concern that the burden of completing the screening tool will take time away from clinicians to address other important medical or social concerns. Additionally, the overburdening and lack of referral resources in rural areas were voiced.
- Although the Standing Committee held these concerns, it ultimately acknowledged the importance of the measure and that screening using the PSC tool has increased by over 30% in the past decade.
- The Standing Committee passed the measure on usability and use.

5. Related and Competing Measures

- This measure is related to the following measures:
    - NQF #2801 Use of First-Line Psychosocial Care for Children and Adolescents
    - NQF #0576 Follow-Up After Hospitalization for Mental Illness (FUH)
    - NQF #0108 Follow-Up Care for Children Prescribed ADHD Medication (ADD)
    - NQF #0710e Depression Remission at 12 Months
    - NQF #0711 Depression Remission at Six Months
    - NQF #0712 Depression Assessment With PHQ-9 / PHQ-9M
    - NQF #1884 Depression Response at Six Months – Progress Towards Remission
    - NQF #1885 Depression Response at 12 Months – Progress Towards Remission

- The Standing Committee had a brief discussion on the unintended consequences of overassessment and redundancy in depression screening, particularly concerning NQF #3332 versus NQF #0712. Ultimately, the Standing Committee distinguished the Patient Health Questionnaire (PHQ)-9 depression screening assessment instrument as one that objectifies the degree of depression severity and stated that NQF #3332 encompasses more of a broad array of psychosocial issues.

6. Standing Committee Recommendation for Endorsement: **Total votes-19; Yes-17**; **No-2**

7. Public and Member Comment

- No pre-evaluation comments were received for this measure.
- One post-evaluation comment was received for this measure. The commenter noted opposition to NQF #3332 because their organization's physicians do not find the form to be as helpful as others and that it is too long to be useful at a well-child visit. The developer responded to these comments by noting that the commenter did not have empirical evidence to support the claim and cited data from a recently published paper that showed the tool's usefulness and feasibility.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes- 8; Yes-8; No-0 (July 26, 2022: Endorsed)

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received.

NQF #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

Measure Worksheet | Specifications

Description: Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both.

Numerator Statement: Surgical pathology reports that contain impression or conclusion of or recommendation for testing of MMR by immunohistochemistry, MSI by DNA-based testing status, or both

Denominator Statement: All surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection

Exclusions: (1) Patients with an existing diagnosis of Lynch Syndrome (2) Squamous cell carcinoma of the esophagus

Adjustment/Stratification:

No risk adjustment or stratification

N/A--not risk stratified. As this is a process measure, risk stratification was deemed inappropriate for this measure. Additionally, pathologists are non-patient-facing clinicians and as such do not have access to most patient data needed for any stratification or adjustment. This issue was identified while specifying the Exclusions and Exceptions and addressed via feasibility testing.

Level of Analysis: Clinician: Individual, Clinician: Group/Practice

Setting of Care: Outpatient Services

Type of Measure: Process

Data Source: Other (specify), Electronic Health Data

Measure Steward: College of American Pathologists

STANDING COMMITTEE MEETING [February 11, 2022]

1. Importance to Measure and Report:

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total votes-18**; **H-4**; **M-13**; **L-1**; **I-0**; 1b. Performance Gap: **Total votes-19; H-11**; **M-8**; **L-0**; **I-0**

Rationale:

- The Standing Committee considered the evidence presented for the measure, which included a systematic review of 103 studies and three clinical practice guidelines. The Standing Committee expressed that the literature was strong to support the use of this measure, and the graded evidence was of high quality, quantity, and consistency. The Standing Committee did not identify any concerns with the presented evidence and passed the measure on the evidence criterion.
- The Standing Committee considered the performance gap information presented for the measure. The mean measure performance was 78.3, with a standard deviation of 29 and score ranges from 40-100%. Based on the data through October 2021, the mean performance on the measure improved to 86.5. Multiple studies also showed low reporting from 20% to 50%, indicating a wide range in performance.
- The Standing Committee requested further information regarding disparities and expressed a concern regarding whether disparity data can be tracked via pathology reports. The developer noted that disparities data are not readily available in laboratory information systems; however, literature shows that White, non-Hispanic patients were more likely to receive testing than Black, non-Hispanic patients. Studies also show lower testing rates are found in patients with Medicare, Medicaid, and no insurance, compared to patients with private/commercial insurance. The Standing Committee agreed that while disparities are involved, they are not a target of this measure.
- The Standing Committee did not identify any concerns on performance gap and passed the measure on the performance gap criterion.

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability (Group): **Total votes-18; H-7**; **M-11**; **L-0**; **I-0**; 2a. Reliability (Individual): **Total votes-19; H-8**; **M-11**; **L-0**; **I-0** 2b. Validity: **Total votes-19; H-N/A**; **M-19**; **L-0**; **I-0**

Rationale:

- The Standing Committee questioned why a pathologist would not automatically order this testing for patients, and the developer explained that the testing, in the past, had not been recognized as a national standard; however, it is becoming more regularly used, and providers are aware of the importance of testing. Additionally, the Standing Committee questioned the cost of testing and agreed that the test is now universally reimbursed.
- Reliability testing was performed using a signal-to-noise analysis with a beta-binomial method at the individual level at both academic medical center practices and private practices.
- The Standing Committee questioned why only reliability testing at the individual level was reported when the measure is also reported at the group practice level. The developer explained that they did not report or analyze data at the group level because the results at the individual level were good and aggregating the data and repeating testing at the group level would only make the reliability better; thus, updated testing at the group level was not needed.
- The Standing Committee accepted this rationale and passed the measure at the group and individual levels for reliability.
- The Standing Committee considered the validity testing for the measure. Face validity testing was performed by way of a discussion with 40 different clinical experts, who agreed the measure was valid, and no threats to validity were identified. The Standing Committee did not identify any concerns with the validity testing and passed the measure on validity.

3. Feasibility: Total votes-19; H-6; M-13; L-0; I-0

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

Rationale:

- The Standing Committee noted that the measure data elements are collected in defined fields.
- The Standing Committee highlighted one concern regarding the audit-based measure, noting that this may add burden to organizations and may not be feasible because additional staff are needed to audit and highlight the discrepancies between actual practice and the standard of care. The Standing Committee discussed this concern and agreed that even with this potential burden, the measure is feasible to implement.

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use**: Total votes-19; Pass-19; No Pass-0**; 4b. Usability: **Total votes-19**; **H-11; M-8; L-0; I-0**

Rationale:

- This measure has been used in the MIPS since 2021, and the average score has increased from 78.3 in 2020 to 86.5 in 2021, suggesting that the measure is usable.
- The Standing Committee discussed the potential unintended consequence of performing generic or genomic testing and discerned a small risk of this testing potentially resulting in discrimination when applying for health insurance or employment. The Standing Committee agreed that this is not a reason to say the measure is not appropriate to use, and no other evidence of unintended consequences was found.

5. Related and Competing Measures

- No related or competing measures were noted.

6. Standing Committee Recommendation for Endorsement: **Total votes-19; Yes-17**; **No-2**

7. Public and Member Comment

- One pre-evaluation comment was submitted, which included clarification from the developer regarding the Standing Committee's pre-evaluation feedback.

- Three post-evaluation comments were submitted. Two commenters supported the measure, while the one commenter wrote in opposition to NQF #3661. The commenter stated that the guidelines only recommend testing for patients with concern of familial cancer and that clinical data do not show that extending the testing to all patients will improve outcomes. Additionally, the commenter expressed concern that the reliability testing was conducted only at the individual level despite the measure being specified at both group/practice and individual levels. The Standing Committee noted that it previously discussed this concern and accepted the updated guidelines the developer provided and the developer's rationale for not conducting testing at the group/practice level.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes- 8; Yes-8; No-0 (July 26, 2022: Endorsed)

- The CSAC upheld the Standing Committee's decision to recommend the measure for endorsement.

9. Appeals

- No appeals were received.

Measures Not Endorsed

NQF #3667 Days at Home for Patients With Complex, Chronic Conditions

Measure Worksheet

Description: This is a provider group-level measure of days at home or in community settings (that is, not in acute care such as inpatient hospital or emergent care settings or post-acute settings such as Skilled Nursing Facilities (SNFs)) among adult (age 18 years or older) Medicare FFS beneficiaries with complex, chronic conditions who are aligned to participating provider groups. The measure includes risk adjustment for differences in patient mix across provider groups, with an adjustment based on patients' risk of death. An additional adjustment that accounts for patients' risk of transitioning to a long-term nursing home is also applied to encourage home- and community-based care in alignment with CMS's policy goals. A higher risk-adjusted score indicates better performance.

Numerator Statement: The outcome measured for each eligible beneficiary is days spent "at home," adjusted for clinical and social risk factors, risk of death, and risk of transitioning to a long-term nursing home.

Denominator Statement: Eligible beneficiaries aligned to participating provider groups.

Exclusions: Not applicable. There are currently no denominator exclusions or exceptions for the measure. All patients meeting the denominator inclusion criteria are included.

Adjustment/Stratification:

Statistical risk model with risk factors (specify number of risk factors)

Level of Analysis: Accountable Care Organization

Setting of Care: Post-Acute Care, Inpatient/Hospital

Type of Measure: Outcome

Data Source: Claims

Measure Steward: Centers for Medicare & Medicaid Services (CMS)

STANDING COMMITTEE MEETING [February 11, 2022]

1. Importance to Measure and Report:

(1a. Evidence, 1b. Performance Gap)

1a. Evidence: **Total votes-18; Yes-14; No-4**; 1b. Performance Gap: **Total votes-18; H-1**; **M-10**; **L-2**; **I-5**

Rationale:

- The Standing Committee reviewed the evidence the developer submitted, noting that the evidence appears to indicate that days spent at home lead to improved quality of care.
- The Standing Committee also noted that the evidence showed that patients prefer to spend time at home or in their community rather than an acute-care setting; therefore, the measure was created to reflect patient preferences.

- The Standing Committee questioned whether providers have one action they can do to improve care, further stating that it is unclear whether evidence exists of distinct actions that can be taken to make a difference in whether someone had more days of care or less. Despite raising this concern, the Standing Committee agreed that the evidence was strong otherwise and supported the need for the measure.
- The Standing Committee noted that substantial variation in time was spent at home (the average was 330.4 days, and the range was 291–345.9 days), and an opportunity to improve care was also present. Concerns about the strength of the disparities data and the lack of clarity regarding whether the variability among ACOs provides a similar performance gap were also discussed. The Standing Committee stated that the dual-eligibility population has differences, which could be related to socioeconomic status; however, the indicators for social risk factors were not found to be statistically significant or of modest impact. Therefore, the Standing Committee could not conclude what the differences in the population were attributed to. The Standing Committee did acknowledge, however, that these types of data are difficult to obtain because there is no standardized approach to capturing these types of factors. Despite these concerns, the Standing Committee agreed that a performance gap exists.
- The Standing Committee passed the measure on evidence and performance gap.

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity)

2a. Reliability: **Total votes-19; Yes-14; No-5**; 2b. Validity: **Total votes-18; H-0**; **M-3**; **L-7**; **I-8**

Rationale:

- The SMP reviewed this measure and passed it with a rating of moderate on reliability **(Total votes-11; H-5, M-6, L-0, I-0)** but did not reach consensus on validity **(Total votes-10; H-0, M-4, L-5, I-1).**
- The Standing Committee reviewed the major reliability concerns the SMP addressed, which mainly focused on the measure's specifications. The Standing Committee requested clarification on whether the measure was only meant to be used in ACOs or whether it could be used more broadly at the provider group level. The developer clarified that the terms *ACO* and *provider group* are considered synonymous in this measure and that *provider group* would encompass any entity that is committed to providing care with a focus on care coordination.
- The Standing Committee questioned whether the measure was applicable to the entire population, considering the analysis only used Medicare ACO data, while the measure was specified for all Medicare patients. If the measure is not applicable to the entire Medicare population, then the measure is not specified appropriately. Despite this concern, the Standing Committee agreed that the measure was reliable.
- A few Standing Committee members also questioned whether days at home could be considered a valid surrogate for care coordination. The developer acknowledged that directly measuring care coordination is challenging, and based on the developer's comparison to measures that did measure care coordination, days at home could be used to signal good care coordination.
- The Standing Committee questioned whether the denominator would capture patients with substantial disease. The developer clarified that patients must have a Hierarchical Condition Category (HCC) composite risk score of greater than or equal to 2.0, which would include a wide cohort with a variety of chronic conditions.
- A Standing Committee member stated that a lot of the work to keep a person at home is done by nonphysicians. They questioned whether this measure gives credit to physicians when families may be the ones performing the care coordination. According to the developer, the hope is that the measure will take some of the burden from patient/family caregivers and give that responsibility to the ACO.

- The Standing Committee asked the developer to clarify whether reliability was tested in non-ACO settings, to which the developer replied no. The Standing Committee ultimately voted to accept the SMP's rating on reliability.
- The Standing Committee noted that the developer conducted face validity and construct validity testing. The face validity testing indicated the measure may be valid (19 out of 21 Technical Expert Panel [TEP] members agreed that the measure can be used to distinguish between better and worse performance at ACO or provider group levels). The construct validity testing found that the correlation between NQF #3667 and the two of the six measures was weak while the other four measures' correlations with NQF #3667 were moderate in strength (Pearson's rank correlation ranged from 0.549 to 0.048). The developer emphasized that the lack of correlation may be due to the other measures having smaller sample sizes and not being risk-adjusted.
- The Standing Committee highlighted that the SMP's main concerns with validity pertained to the risk adjustment models, measure exclusions, and meaningful differences in performance.
- The Standing Committee highlighted that the SMP's concerns with the exclusions regarded the low outliers and how the developer attributed them to an unintended consequence of the measure's construct as the measure attempts to balance days at home with other unintended consequences. The Standing Committee agreed that these concerns were significant enough to threaten the validity of the measure.
- The Standing Committee highlighted the SMP's concerns with meaningful differences in performance and the use of the measure for quality improvement purposes, specifically questioning whether the measure should be used to identify differences in patient function or health-related quality of life. The Standing Committee agreed that these concerns were significant enough to threaten the validity of the measure.
- The Standing Committee expressed concern with SDOH factors not being included in the risk adjustment model. The Standing Committee emphasized that without these data, there is no way to know whether the testing results are due to differences in performance or other confounding factors. The developer once again noted that no national standardized approach to addressing SDOH factors exists. However, the most accepted method is to utilize dual eligibility, which is what the developer did within the risk adjustment model. The Standing Committee felt that dual eligibility did not do enough to account for these factors.
- Additionally, the Standing Committee expressed concern that the measure could disincentivize good care, especially for primary care providers who use value-based contracting. The developer cited this concern as the reason why they adjusted for transitions into long-term care so that they could guard against unintended consequences, such as this one.
- Ultimately, the Standing Committee did not pass the measure on validity based on the above concerns.

3. Feasibility: Vote Not Taken

(3a. Clinical data generated during care delivery; 3b. Electronic sources; 3c. Susceptibility to inaccuracies/ unintended consequences identified; 3d. Data collection strategy can be implemented)

4. Usability and Use:

(Used and useful to the intended audiences for 4a. Accountability and Transparency; 4b. Improvement; and 4c. Benefits outweigh evidence of unintended consequences)

4a. Use: Vote Not Taken; 4b. Usability: Vote Not Taken

5. Related and Competing Measures

- This measure is related to the following measure:
    - NQF #2888 Risk-Standardized Acute Admission Rates for Patients With Multiple Chronic Conditions

- The measure did not pass on validity; therefore, the Standing Committee did not discuss the related measure.

6. Standing Committee Recommendation for Endorsement: Vote Not Taken

7. Public and Member Comment

- Three pre-evaluation public comments were submitted. One NQF member did not support the measure. The other two comments were clarifications regarding the SMP's feedback that the developer submitted following the SMP's review.
- Seven post-evaluation comments were submitted. Two commenters expressed support for the Standing Committee's decision to not recommend the endorsement of NQF #3667, while three commenters expressed support for the Standing Committee's decision to recommend the endorsement of NQF #3667. One of the commenters who was in support of the measure also noted that challenges exist within operationalizing the measure, such as access to care, perceived lack of control to make changes by those being held accountable, and the ability of claim-based measures to make reactive actions effective.
- The developer also submitted a comment clarifying aspects of the measure and requested feedback on potential enhancements to the measure. The Standing Committee responded to the developer's request for feedback during the post-comment meeting by recommending the following: (1) Introduce a survey instrument or a PROM that would assess factors, which may affect the quality of care and feasibility of care being provided at home; (2) Focus the assessment of the measure on the continuum of care versus location of care (i.e., home); and (3) Identify alternative factors to accurately represent SDOH factors, given dual-eligibility risk identifier is not an accurate capture of SDOH factors. Not all patients who are able to receive care at home are dual-eligible, and this could penalize the provider. Additionally, there are significant policy variations in Medicaid from state-to-state, which impacts the entity-level SDOH factor.

8. Consensus Standards Approval Committee (CSAC) Endorsement Decision: Total votes- 8; Yes-8; No-0 (July 26, 2022: Not Endorsed)

- The CSAC upheld the Standing Committee's decision to not recommend the measure for endorsement.

Appendix B: Primary Care and Chronic Illness Portfolio—Use in Federal Programs*

NQF	Title	Federal Programs (Finalized or Implemented)
0046	Screening for Osteoporosis for Women 65-85 Years of Age	Healthcare Effectiveness Data and Information Set (HEDIS) Quality Measure Rating System Merit-Based Incentive Payment System (MIPS) Program Physician Compare
0047	Asthma: Pharmacologic Therapy for Persistent Asthma	None
0053	Osteoporosis Management in Women Who Had a Fracture	HEDIS Quality Measure Rating System Medicare Part C Star Rating Merit-Based Incentive Payment System (MIPS) Program
0055	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	HEDIS Quality Measure Rating System Marketplace Quality Rating System (QRS) Medicare Part C Star Rating)
0056	Comprehensive Diabetes Care: Foot Exam	None
0057	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	HEDIS Quality Measure Rating System
0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	None
0059	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	HEDIS Quality Measure Rating System Medicaid Medicare Shared Savings Program Merit-Based Incentive Payment System (MIPS) Program
0061	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	HEDIS Quality Measure Rating System
0062	Comprehensive Diabetes Care: Medical Attention for Nephropathy	HEDIS Quality Measure Rating System Medicare Part C Star Rating
0069	Appropriate Treatment for Children With Upper Respiratory Infection (URI)	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program Marketplace Quality Rating System (QRS) HEDIS Quality Measure Rating System
0086	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	Physicians Compare

NQF	Title	Federal Programs (Finalized or Implemented)
0086e	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	None
0087	Age-Related Macular Degeneration: Dilated Macular Examination	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
0088	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	None
0088e	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	None
0091	COPD: Spirometry Evaluation	Physicians Compare HEDIS Quality Measure Rating System
0102	COPD: Inhaled Bronchodilator Therapy	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
0118	Anti-Lipid Treatment Discharge	None
0405	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	None
0409	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis	None
0416	Diabetic Foot & Ankle Care, Ulcer Prevention – Evaluation of Footwear	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
0417	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
0541	Proportion of Days Covered (PDC): Three Rates by Therapeutic Category	Marketplace Quality Rating System Medicare Part D Star Rating

NQF	Title	Federal Programs (Finalized or Implemented)
0563	Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 15% or Documentation of a Plan of Care	Merit-Based Incentive Payment System (MIPS) Program
0565	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
0565e	Cataracts: 20/40 or Better Visual Acuity Within 90 Days Following Cataract Surgery	None
0566	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	None
0575	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Control (<8.0%)	HEDIS Quality Measure Rating System Marketplace Quality Rating System (QRS))
0577	Use of Spirometry Testing in the Assessment and Diagnosis of COPD	None
0653	Acute Otitis Externa: Topical Therapy	Physicians Compare
0654	Acute Otitis Externa: Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
0655	Otitis Media With Effusion: Antihistamines or Decongestants – Avoidance of Inappropriate Use	None
0657	Otitis Media With Effusion: Systemic Antimicrobials – Avoidance of Inappropriate Use	Merit-Based Incentive Payment System (MIPS) Program
0729	Optimal Diabetes Care	Physicians Compare
1800	Asthma Medication Ratio	HEDIS Quality Measure Rating System Marketplace Quality Rating System Medicaid

NQF	Title	Federal Programs (Finalized or Implemented)
2079	HIV Medical Visit Frequency	Physicians Compare Merit-Based Incentive Payment System (MIPS) Program
2080	Gap in HIV Medical Visits	None
2082	HIV Viral Load Suppression	Medicaid Merit-Based Incentive Payment System (MIPS) Program
2083	Prescription of HIV Antiretroviral Therapy	None
2522 (Approved for Trial Use)	Rheumatoid Arthritis: Tuberculosis Screening	None
2523	Rheumatoid Arthritis: Assessment of Disease Activity	Merit-Based Incentive Payment System (MIPS) Program Physician Compare
2524e	Rheumatoid Arthritis: Patient-Reported Functional Status Assessment	None
2525e (Approved for Trial Use)	Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy	None
2797	Transcranial Doppler Ultrasonography Screening Among Children With Sickle Cell Anemia	None
2811e	Acute Otitis Media - Appropriate First-Line Antibiotics	None
2856	Pharmacotherapy Management of COPD Exacerbation	Medicare Shared Savings Program Physician Compare
3059e (Approved for Trial Use)	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	None
3166	Antibiotic Prophylaxis Among Children With Sickle Cell Anemia	None
3209e	HIV Medical Visit Frequency	None

NQF	Title	Federal Programs (Finalized or Implemented)
3210e	HIV Viral Load Suppression	None
3211e	Prescription of HIV Antiretroviral Therapy	None
3294	STS Lobectomy for Lung Cancer Composite Score	None
3332	Psychosocial Screening Using the Pediatric Symptom Checklist-Tool (PSC-Tool) [+]	None
3475e	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	Medicaid Promoting Interoperability Program for Eligible Professionals Merit-Based Incentive Payment System (MIPS)
3532	Discouraging the Routine Use of Occupational and/or Supervised Physical Therapy After Carpal Tunnel Release	None
3568	Person-Centered Primary Care Measure PRO-PM	None
3595	Hydroxyurea Use Among Children With Sickle Cell Anemia	None
3599	Pediatric Asthma Emergency Department Use	None
3617	Measuring the Value-Functions of Primary Care: Provider Level Continuity of Care Measure	None
3661	Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma[^]	None

* CMS Measures Inventory Tool last accessed on August 11, 2022.

[+] Measure reviewed this cycle, but the measure resides in the Behavioral Health portfolio.

[^] Measure reviewed this cycle, but the measure resides in the Cancer portfolio.

Appendix C: Primary Care and Chronic Illness Standing Committee and NQF Staff

STANDING COMMITTEE

Dale Bratzler, DO, MPH (Co-Chair)
Chief COVID Officer, Professor and Associate Dean, College of Public Health, University of Oklahoma
Oklahoma City, OK

Adam Thompson, BA (Co-Chair)
Consultant, Center for Quality Improvement and Innovation (CQII)
Regional Partner Director – NECA AETC SNJ
New York, NY

Lindsay Botsford, MD, MBA, CMQ, FAAFP
Market Medical Director, Iora Health
Houston, TX

William Curry, MD, MS
Professor, Departments of Family and Community Medicine and Public Health Sciences, Penn State College of Medicine
Hershey, PA

Kim Elliott, PhD
Executive Director, Health Services Advisory Group, Inc.
Phoenix, AZ

V. Katherine Gray, PhD
President, Sage Health Management Solutions, Inc.
Minneapolis, MN

David Lang, MD
Chair, Department of Allergy and Clinical Immunology, Respiratory Institute, Cleveland Clinic
Cleveland, OH

Esther Babady, PhD
Director of the Microbiology Service Clinical Operations, Memorial Sloan Kettering Cancer Center
New York, NY

Anna McCollister
Co-Founder, Galileo Analytics
Washington, DC

William Glomb, MD, FCCP, FAAP
Senior Medical Director, Superior HealthPlan
Austin, TX

Harold Pincus, MD
Professor and Vice Chair of Psychiatry and Co-Director of the Irving Institute for Clinical and Translational Research at Columbia University
New York, NY

Jeffrey Susman, MD
Dean and VPHA, Emeritus, Northeast Ohio Medical University, Northeast Ohio Medical University
Rootstown, OH

Vitka Eisen, MSW, EdD
President and Chief Executive Officer, HealthRIGHT 360
San Francisco, CA

Brooke Parish, MD
Executive Medical Director, Health Care Service Corporation – Blue Cross Blue Shield of New Mexico
Albuquerque, NM

Raquel Mazon Jeffers
Senior Director, The Community Health Acceleration Partnership (CHAP)
Newark, NJ

Karen Fields, MD
Medical Director, Clinical Pathways Department and Value-Based Cancer Care, Moffitt Cancer Center
Tampa, FL

Shelly Fuld Nasso, MPP
CEO, National Coalition for Cancer Survivorship
Washington, DC

Jette Hogenmiller, PhD, MN, APRN/ARNP, CDE, NTP, TNCC, CEE
Oncology Nurse Practitioner
Idaho Springs, CO

Jennifer L. Malin, MD, PhD
Staff Vice President, Clinical Strategy, Anthem, Inc.
Thousand Oaks, CA

Heidi Floyd
Patient Advocate
Hoschton, GA

NQF STAFF

Kathleen F. Giblin, RN
Senior Vice President, Emerging Initiatives and Program Operations
Acting Senior Vice President, Measurement Science and Application *(Former)*

Elizabeth Drye, MD, SM
Chief Scientific Officer, Measurement Science and Application

Tricia Elliott, DHA, MBA, CPHQ, FNAHQ
Senior Managing Director, Measurement Science and Application

Matthew K. Pickering, PharmD
Senior Director, Measurement Science and Application

Poonam Bal, MHSA
Senior Director, Measurement Science and Application

Paula Farrell, MSHQS, BSN, RN, CPHQ, LSSGB
Director, Measurement Science and Application

Mike DiVecchia, MBA, PMP
Senior Project Manager, Program Operations

Adam Vidal, PMP
Project Manager, Program Operations *(Former)*

Erica Brown, MHA, PMP
Project Manager, Program Operations

Oroma Igwe, MPH
Manager, Measurement Science and Application

Gabrielle Kyle-Lion, MPH
Analyst, Measurement Science and Application

Matilda Epstein, MPH
Temp Associate, Measurement Science and Application

Appendix D: Measure Specifications

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

STEWARD

Massachusetts General Hospital

DESCRIPTION

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

TYPE

Process

DATA SOURCE

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records In medical record (paper or electronic):

If patient age => 3.0 & age =< 17.99; claim for well child visit (99382 or 99383 or 99385 or 99392 or 99393 or 99394), assess progress note, templated note, flowsheet, scanned in PSC, for evidence that screen was administered. In systems like the state of Massachusetts where billing for the screen as well as screening itself is required, the source for data about screening can be claims data.

In both our 2021 and 2017 submissions we stated that paper medical records were a possible source of measure information for which evidence was available. Data source 2 was based on a review of ~4000 (in some comparisons ~ 6000) paper medical records. Some information about the use of this sample to assess ethnicity and regional differences in the statewide CBHI program is provided above in section 2a.08. As described in the Savageau, et al 2016 paper, the reliability and validity of this method was established in the following way: “An experienced medical record review (MRR) vendor conducted a retrospective MRR of the sample’s ~4000 children/adolescents. Three registered nurses used a chart abstraction tool developed by one of the researchers and a panel of practicing physicians. Before implementation of the MRR, nurse abstractors had to pass Gold Standard Testing and attain interrater reliability scores of 95% or higher. The abstraction tool was piloted in a large community-based

practice. From chart notes and documentation, nurse abstractors determined the presence of standardized BH screening, screening results, and referrals. They also detailed the presence of non-MassHealth approved screening tools and notations of informal screening/surveillance without a specific tool. Where both formal and informal screens were conducted and abstracted, subsequent analyses prioritized results from the formal screening. In addition, abstractors recorded charted notes and documentation on BH referrals (made at the time of the WCV), patient demographics (ie, age, sex, ethnicity, and primary language spoken at home), interpreter use during the WCV, and use of a non-English BH screening tool

LEVEL

Health Plan, Population: Regional and State, Facility

SETTING

Outpatient Services

NUMERATOR STATEMENT

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NUMERATOR DETAILS

Patients passing this quality measure are identified through a review of the medical record. In a chart review, the presence of a PSC score or PDF scan of it in the progress note, or score shown in the visit template or flowsheet documents the completion of the screen on the same day of the WCV. To receive credit, progress notes must indicate the name of the specific measure and actual score (eg, PSC given, score = not at risk). In pediatric settings in which the PSC is completed electronically (eg, over the internet or on an iPad in the waiting room), item- and subscale scores are filed and available in defined fields in the EHR (such as flowsheet or visit note template) and the numerator is established by checking these fields for data on the date of the WCV.

There are four versions of the PSC in wide clinical use: the original 35 item form that is filled out by parents, a 17 item version of this, and 35 and 17 item versions of a youth report version. All four of these versions have the same 17 items at their core and the same subscale scores. Credit for administering the screen is given if any of the four have been used.

In Massachusetts (and possibly in other locations which require routine screening), providers who conduct well child visits with patients covered by Medicaid are required to bill for each screen using CPT code 96110 or 96127 so that officials can ascertain whether a screen was given. Therefore, in the Massachusetts program, the presence of CPT code 96110 or 96127 (in the billing data or in the EHR) can be used to identify patients in the numerator with the denominator being all cases with a CPT code for a WCV for a given time period (eg, calendar year) and entity (eg, specific provider, health center, health plan, etc.).

DENOMINATOR STATEMENT

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

DENOMINATOR DETAILS

Cases are identified from administrative data for site. Number of unique patients ages 3.00 to 17.99 seen for a well-child visit (CPT 99381-99394) in a defined evaluation period, often a year.

EXCLUSIONS

No exclusions.

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No additional risk adjustment analysis included

No risk adjustment or stratification

N/A

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion

Better quality = Higher score

ALGORITHM

Step 1. Count number of children aged 3-17 seen for a well child visit in state, region, clinic or other group during defined period (often, one year) using administrative data (CPT 99381-99394). N=total population. This is the denominator.

Step 2. Assess whether PSC was administered as a part of WCV, for the eligible population, using the chart for indicator status. Pass if documentation that screen was given on the day of the WCV is present.

Step 3. Compute numerator = count of patients with completed PSC.

Step 4. Calculate clinic or other entity rate as numerator/denominator. No risk adjustment.

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NQF #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

STEWARD

College of American Pathologists

DESCRIPTION

Percentage of surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection, that contain impression or conclusion of or recommendation for testing of mismatch repair (MMR) by immunohistochemistry (biomarkers MLH1, MSH2, MSH6, and PMS2), or microsatellite instability (MSI) by DNA-based testing status, or both.

TYPE

Process

DATA SOURCE

Other (specify), Electronic Health Data
Currently in use in the Pathologists Quality Registry QCDR

LEVEL

Clinician: Individual, Clinician: Group/Practice

SETTING

Outpatient Services

NUMERATOR STATEMENT

Surgical pathology reports that contain impression or conclusion of or recommendation for testing of MMR by immunohistochemistry, MSI by DNA-based testing status, or both

NUMERATOR DETAILS

This measure requires that immunohistochemistry (IHC) for the four MMR proteins (MLH1, MSH2, MSH6 and PMS2); or MSI by DNA-based testing; or both are addressed in the surgical pathology report for biopsy or resection specimens with primary or metastatic colorectal carcinoma and surgical pathology report for biopsy or resection specimens with primary or metastatic endometrial carcinoma are present. A short note can be made in the final report, such as or combination of:

- No loss of nuclear expression of MMR proteins
- Loss of nuclear expression of MMR proteins (intact expression)
- Microsatellite instability (MSI)
- Microsatellite instability high (MSI-H)
- Microsatellite instability low (MSI-L)
- Microsatellite stable (MSS)
- MMR, MSI, or both previously performed
- MMR, MSI, or both recommended
- MMR, MSI, or both cannot be determined

MMR/MSI status may be derived from either the primary or a reference laboratory, but the specific results (as noted above) need to be included within the final pathology report.

DENOMINATOR STATEMENT

All surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, biopsy or resection

DENOMINATOR DETAILS

CPT: 88305, 88307, 88309

AND

ICD-10:

- C18.0: Malignant neoplasm of cecum
- C18.2: Malignant neoplasm of ascending colon
- C18.3: Malignant neoplasm of hepatic flexure
- C18.4: Malignant neoplasm of transverse colon
- C18.5: Malignant neoplasm of splenic flexure
- C18.6: Malignant neoplasm of descending colon
- C18.7: Malignant neoplasm of sigmoid colon
- C18.8: Malignant neoplasm of overlapping sites of colon
- C18.9: Malignant neoplasm of colon, unspecified
- C19: Malignant neoplasm of rectosigmoid junction
- C20: Malignant neoplasm of rectum
- C54.1 Malignant neoplasm of endometrium
- C54.3 Malignant neoplasm of fundus uteri
- C54.8 Malignant neoplasm of overlapping sites of corpus uteri
- C54.9 Malignant neoplasm of corpus uteri, unspecified
- C55 Malignant neoplasm of uterus, unspecified
- C15.3: Malignant neoplasm of upper third of esophagus
- C15.4: Malignant neoplasm of middle third of esophagus
- C15.5: Malignant neoplasm of lower third of esophagus
- C15.8: Malignant neoplasm of overlapping sites of esophagus
- C15.9: Malignant neoplasm of esophagus, unspecified
- C16.0: Malignant neoplasm of cardia
- C16.1: Malignant neoplasm of fundus of stomach
- C16.2: Malignant neoplasm of body of stomach
- C16.3: Malignant neoplasm of pyloric antrum
- C16.4: Malignant neoplasm of pylorus
- C16.5: Malignant neoplasm of lesser curvature of stomach, unspecified
- C16.6: Malignant neoplasm of greater curvature of stomach, unspecified
- C16.8: Malignant neoplasm of overlapping sites of stomach
- C16.9: Malignant neoplasm of stomach, unspecified
- C17.0 Malignant neoplasm of duodenum
- C17.1 Malignant neoplasm of jejunum
- C17.2 Malignant neoplasm of ileum
- C17.3 Meckel's diverticulum, malignant
- C17.8 Malignant neoplasm of overlapping sites of small intestine
- C17.9 Malignant neoplasm of small intestine, unspecified
- C26.0 Malignant neoplasm of intestinal tract, part unspecified.

EXCLUSIONS

1. Patients with an existing diagnosis of Lynch Syndrome
2. Squamous cell carcinoma of the esophagus

EXCLUSION DETAILS

Existing diagnosis of Lynch syndrome ICD-10 codes: ICD-10-CM Z15.0, Z15.04, Z15.09, Z80.0

RISK ADJUSTMENT

No risk adjustment or stratification

N/A--not risk stratified. As this is a process measure, risk stratification was deemed inappropriate for this measure. Additionally, pathologists are non-patient-facing clinicians and as such do not have access to most patient data needed for any stratification or adjustment. This issue was identified while specifying the Exclusions and Exceptions and addressed via feasibility testing.

STRATIFICATION

N/A Measure is not risk stratified

TYPE SCORE

Rate/proportion

Better quality = Higher score

ALGORITHM

1. Identify all surgical pathology reports for primary colorectal, endometrial, gastroesophageal or small bowel carcinoma, including biopsy or resection specimens, and reports with other samples (i.e. resection specimen with lymph nodes)

2. Remove cases positively identified as squamous cell carcinoma of the esophagus and cases where patient has an existing diagnosis of Lynch syndrome, regardless of how Lynch syndrome was diagnosed

3. Identify cases from that population that have documentation of mismatch repair (MMR) testing by immunohistochemistry for all four of the MMR proteins (MLH1, MSH2, MSH6 and PMS2) OR microsatellite instability testing by DNA-based methods (PCR, next-generation or whole genome sequencing, multi-plex sequencing) OR documentation that such a test was recommended, ordered, or previously performed--the Met population

4. From the remaining cases that do not have documentation of MMR/MSI testing status, remove any for which there is documentation of one of the following:

1. Insufficient tissue for testing or tissue is necrotic

2. Specimen contains metastatic carcinoma (not a primary neoplasm)

3. No residual tumor (post treatment)

4. Patient is not a candidate for checkpoint inhibitor therapy

5. Remaining cases that do not have documentation of one of those medical reasons are considered Not Met for this measure

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N/A

Appendix E: Related and Competing Measures

Comparison of NQF #3332 and NQF #2801

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

National Committee for Quality Assurance

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Percentage of children and adolescents 1-17 years of age who had a new prescription for an antipsychotic medication, but no U.S. Food and Drug Administration primary indication for antipsychotics, and had documentation of psychosocial care as first-line treatment.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Children and adolescents 1-17 years of age who had psychosocial care as first-line treatment prior to (or immediately following) a new prescription of an antipsychotic without a U.S. Food and Drug Administration primary indication for antipsychotic use.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Children and adolescents 1-17 years of age as of December 31 of the measurement year who had a new prescription of an antipsychotic medication for which they do not have a U.S. Food and Drug Administration primary indication for antipsychotics.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Populations at Risk, Children

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Process

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Claims

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Health Plan

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #2801 USE OF FIRST-LINE PSYCHOSOCIAL CARE FOR CHILDREN AND ADOLESCENTS ON ANTIPSYCHOTICS

Outpatient Services

Comparison of NQF #3332 and NQF #0576

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

National Committee for Quality Assurance

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e. January 1 to December 1) for members 6 years and older.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Populations at Risk, Children, Elderly

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Process

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Claims

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Health Plan

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQWF #0576 FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS (FUH)

Inpatient/Hospital, Outpatient Services

Comparison of NQF #3332 and NQF #0108

Steward

NQF#3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

National Committee for Quality Assurance

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.

An Initiation Phase Rate and Continuation and Maintenance Phase Rate are reported.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Among children newly prescribed ADHD medication, those who had timely and continuous follow-up visits.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Children 6-12 years of age newly prescribed ADHD medication.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Children

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Process

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Claims

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Health Plan

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #0108 FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION (ADD)

Outpatient Services

Comparison of NQF #3332 and NQF #0710e

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

MN Community Measurement

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score greater than 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Populations at Risk: Populations at Risk

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Outcome: PRO-PM

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Other, Paper Medical Records, Electronic Health Records: Electronic Health Records

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Facility, Clinician: Group/Practice

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #0710E DEPRESSION REMISSION AT TWELVE MONTHS

Outpatient Services

Comparison of NQF #3332 and NQF #0711

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

MN Community Measurement

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score greater than 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.

This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Populations at Risk: Populations at Risk

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Outcome: PRO-PM

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Other, Electronic Health Records: Electronic Health Records, Paper Medical Records

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Clinician: Group/Practice, Facility

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #0711 DEPRESSION REMISSION AT SIX MONTHS

Outpatient Services

Comparison of NQF #3332 and NQF #0712

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

MN Community Measurement

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during the four month measurement period.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Adult patients age 18 and older with the diagnosis of major depression or dysthymia.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Populations at Risk: Populations at Risk

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Process

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Other, Paper Medical Records, Electronic Health Records: Electronic Health Records

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Clinician: Group/Practice, Facility

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #0712 DEPRESSION ASSESSMENT WITH PHQ-9/ PHQ-9M

Outpatient Services

Comparison of NQF #3332 and NQF #1884

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

MN Community Measurement

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score greater than 9 who demonstrate a response to treatment at six months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Elderly

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Outcome: PRO-PM

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Instrument-Based Data, Electronic Health Records: Electronic Health Records, Registry Data, Other, Paper Medical Records

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Clinician: Group/Practice

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #1884 DEPRESSION RESPONSE AT SIX MONTHS- PROGRESS TOWARDS REMISSION

Outpatient Services

Comparison of NQF #3332 and NQF #1885

Steward

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Massachusetts General Hospital

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

MN Community Measurement

Description

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Percentage of children from 3.00 to 17.99 years of age seen for a pediatric well child visit who have a Pediatric Symptom Checklist (PSC) Tool administered as a component of that visit.

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score greater than 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.

Numerator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients with documentation that the PSC tool was administered as part of the well child visit.

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.

Denominator Statement

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Number of patients aged 3.00 to 17.99 seen for a pediatric well-child visit.

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.

Target Population

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Children (Age < 18)

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Elderly

Type

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Process

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Outcome: PRO-PM

Data Source

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Claims, Paper Medical Records, Electronic Health Records, Electronic Health Records: Electronic Health Records

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Paper Medical Records, Other, Registry Data, Electronic Health Records: Electronic Health Records, Instrument-Based Data

Level

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Health Plan, Population: Regional and State, Facility

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Clinician: Group/Practice

Setting

NQF #3332 PSYCHOSOCIAL SCREENING USING THE PEDIATRIC SYMPTOM CHECKLIST-TOOL (PSC-TOOL)

Outpatient Services

NQF #1885 DEPRESSION RESPONSE AT TWELVE MONTHS- PROGRESS TOWARDS REMISSION

Outpatient Services

Appendix F: Pre-Evaluation Comments

Comments received as of January 12, 2022.

#3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma

Comment 1 by: College of American Pathologists

For reliability testing, the CAP only performed testing at the individual level. This was for two reasons: first, since the testing we did (signal to noise with a beta-binomial model) is dependent on the number of measured entities, we started with the testing that would yield the lower reliability value, which is testing at the individual level. Given that our individual-level reliability was very high, we did not proceed to group level testing. Second, for purposes of MIPS reporting (which is the only program this measure is for), the group score is simply the sum of the individual scores, there is no separate method of calculating a group score. So calculating "group" reliability doesn't have an independent meaning.

#3667 Days at Home for Patients With Complex, Chronic Conditions

Comment 1 by: American Medical Association

The American Medical Association (AMA) appreciates the opportunity to comment on #3667, Days at Home for Patients with Complex, Chronic Conditions. We note that while the submission form indicates that the measure is intended to be used at the Accountable Care Organization (ACO) level, the wording, "provider groups", is used frequently throughout the submission. We request clarification on whether the measure is intended to be used for ACO reporting only or if it would also be applied to other levels such as clinician groups. Based on the specifications and testing completed, we do not believe that it would be appropriate to be applied to any other level but the submission is not clear on its intent. In addition, The AMA strongly supports the inclusion of individuals with dual eligibility status in the risk model but remains concerned that CMS continues to test social risk factors after the assessment of clinical and demographic risk factors and it is unclear why this multi-step approach is preferable. On review of the Evaluation of the NQF Trial Period for Risk Adjustment for Social Risk Factors report, it is clear that the approaches to testing these data should be revised to strategies such as multi-level models or testing of social factors prior to clinical factors and that as access to new data becomes available, it may elucidate more differences that are unrelated to factors within an entity's control. Additional testing that evaluates clinical and social risk factors at the same time or social prior to clinical variables rather than the current approach with clinical factors prioritized should be completed. References: National Quality Forum. Evaluation of the NQF Trial period for Risk Adjustment for Social Risk Factors. Final report. July 18, 2017. Available at: https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=85635. Last accessed January 8, 2022.

#3667 Days at Home for Patients With Complex, Chronic Conditions

Comment 2 by: Jake Miller

Yale/CORE clarifications to the methods panel evaluation summary (1 of 2):

Specifications:

In their preliminary analyses, a few SMP members found the specifications confusing and occasionally arbitrary. Some members expressed concerns about the potential misalignment of concept presentations within the submission and noted the denominator statement appeared to lack an explanation of the target population, conditions, settings, and other pertinent measure constructs information. They were also concerned that several concepts included in the submission were not documented as exclusions in the specifications, which both threatens the measure's validity and may incentivize under-treatment of conditions potentially outside the locus of control of the accountable entity, including very low outliers that can never reach the expected performance gains, permanent nursing home residents

NQF Clarification: Please note that the issues noted here were raised by some but not all SMP members and that the summary should clearly reflect these as individual opinions, not the consensus of the entire SMP. Over 60% of subgroup members voted to support this measure on both reliability and validity in the preliminary analysis, indicating they were able to follow the information we provided in the submission. In the final vote after the SMP discussion of these issues, 4 of 10 SMP members still supported the measure validity and voted to pass the measure. It is important not to base this summary solely on the views of a few individual SMP members.

Clarification: The Days at Home measure is population-based and intended to capture performance broadly across eligible beneficiaries. The target population is patients with complex, chronic conditions (who have higher risk for needing complex care) as defined by the inclusion criteria. **This is clearly documented in the submission and should not be noted as lacking**. There are intentionally no denominator exclusions – all beneficiaries meeting the inclusion criteria are included in the denominator because conceptually all are at risk for days in care, and any further exclusions would lack face validity. Some members of the committee may have been confusing the cohort (included beneficiaries) and outcome (days in care that count in the model). We clarify the outcome below. However, it is not accurate to present the measure as "not documenting exclusions."

Clarification: The description of the SMP evaluation seems to reference comments related both to the cohort of included patients (as addressed above) and in the outcome definition of days in care (as clarified here). The measure uses a broad definition of "days in care" consistent with feedback from the Technical Expert Panel (TEP) and aligned with previous work by the Medicare Payment Advisory Commission (MedPAC), reflecting that patients tend to view any time in settings such as inpatient hospitals and facilities as disruptive to their daily life. The consensus recommendation of the TEP was to maintain a broad conception of days in care, so that no types of hospital admission were counted as "days at home." Such a broad definition is not intended to suggest every admission is avoidable, but instead to represent a patient-centered outcome definition which allows for flexibility in improvement strategies. The goal is not to achieve zero days in care, but to reduce the total days in care compared to expectation for a given case mix.

Clarification: It is not accurate to say that "very low outliers" or "permanent nursing home residents" are categorically "outside the locus of control of the accountable entity." Clinical groups and ACOs do have capacity to impact days in acute care for these populations (for example, through more proactive preventive care and improved care coordination to avoid preventable admissions) as confirmed by the TEP.

The SMP also questioned whether the consideration of exclusions included (i.e., patients treated in emergency departments, admitted to acute care settings, and days after a death occurs), indicated low-quality care. Another SMP member expressed concerns with adjusting for transitions to the nursing home, which purports that moving from home to a nursing home, is always negative. Other concerning date elements included permanent nursing home admissions requiring skilled nursing care, which may include personal and community resources that are not be modifiable by the accountable entity.

Clarification: As noted above, the Days at Home measure does not conceptually assume that *all* days in an included setting indicate low-quality care, and the goal is not to achieve zero days in these settings. Rather, the goal is to encourage providers to explore home-based options or other feasible means so that their patients can spend *fewer* days in these settings. Moreover, days after a death occurs are not counted as either days at home or days of acute care, but rather as unmeasured days. **Clarification:** The goal of adjusting for nursing home transitions is to encourage providers to explore care options, such as providing home-and community-based care, preventive care services, or improved care coordination, that relieve some of the burden on their patients (and family/caregivers) while allowing patients to remain in their home and community longer. While in some cases a transition to nursing home is the best outcome for a patient, the TEP and CMS agreed this outcome is more often less desirable than remaining in the community setting and that the measure should not have the unintended consequence of rewarding providers who are quicker to transition patients to nursing homes. The adjustment is designed to have a modest effect on measure scores in those cases where there are much higher rates of transition than expected given the case-mix of patients. The current approach was developed as a compromise between counting days in a nursing home as "acute care days" and counting them as "days at home," both options that include notable drawbacks as discussed by the TEP.

Clarification: While most long-term nursing home residence days are considered "days at home," days in which **skilled** nursing care is utilized *do* count as "days in care."

SMP members also noted that the unit of analysis reported in the measure vacillates between accountable care organizations (ACOs) and provider group.

Clarification: The measure is intended for use in different settings in which accountable entities comprise groups of individual providers, including provider groups and ACOs; the specifications have used the general term "provider group" to capture these different organizations. The term "ACO" is used only in documentation pertinent to the *testing* of the measure, which used a dataset of 2017-2018 Shared Savings Programs ACOs and aligned beneficiaries.

One SMP member questioned whether this measure, which combines multiple risk models calculations into a single overall score, should be considered a cost composite measure.

Clarification: Days at Home is not a composite measure; it measures a single outcome. The mortality and nursing home transition component models are not standalone measures, nor are they intended to capture different outcomes. These component models are included as a means of safeguarding against potential adverse consequences for the measure that were identified in conversation with CMS, the TEP, and other experts. The only outcome is days at home, which is adjusted for multiple risk factors, as well

as for unexpectedly high mortality or nursing home transition rates. This is demonstrated empirically in test results as noted in the additional comments in the final measure submission; the quality signal of the measure is dominated by the Days in Care component and the additional adjustments result in modest changes for a small number of ACOs.

Validity:

The developer conducted construct validity with Pearson correlations to six other ACO-level measures hypothesizing that quality conceptually relates to excess days in care (EDIC) for patients with complex chronic diseases.

Pearson's correlations did not correlate well, ranging between -0.549 and +0.048 resulting in a high inverse correlation for unplanned admissions (expected), moderate correlation with other measures, no correlation with fall risk, and an unexpected inverse correlation with patient experience.

The developer explained that this is possibly due to endogeny of the hospital admissions and readmissions measures. The developer also reported the poor correlations may result from testing against measures using smaller sample sizes and which were not risk adjusted for clinical variables.

Clarification: This summary does not accurately reflect the developer's explanation. We documented the expected modest correlations in a direction that was pre-specified. The measures with significant correlation in the expected direction have key and notable differences in cohort (the patients included and the time period for measurement) and outcome (the settings included and the outcome metric) from Days at Home, despite some overlap. These measures were intended to assess construct validity because they measure similar aspects of quality in distinctly different way. These results do not undermine the validity of the measure as we would expect similar results across providers between similar measures.

#3667 Days at Home for Patients With Complex, Chronic Conditions

Comment 3 by: Jake Miller

Yale/CORE clarifications to the methods panel evaluation summary (2 of 2):

Risk-Adjustment:

The SMP members had concerns with the model construction, which they agreed lacked vital adjustment and consideration for many variables without theoretical or empirical justifications and used arbitrary measure weighting. The developers acknowledge these were not empirically assessed, but rather are subjective and based solely on TEP recommendation.

Clarification: The Days in Care statistical count model includes an offset for days alive, so that "mortality days" are not counted in either the numerator nor denominator of the main measure component ("excess days in care" or EDIC). The Days in Care measure does incorporate an adjustment to EDIC for the excess mortality risk of the measured provider groups, as well as the excess risk of transition to nursing home. These adjustments are made by multiplying the EDIC by a standard mortality ratio (SMR) and by 0.5 times a standard nursing home transition ratio (SNHR). The SNHR is scaled to have the same

distribution as SMR and then given a relative weight of 0.5, to accommodate feedback received from the TEP that nursing home transition as an outcome is less severe than death but should still be reflected in performance scores. Both the SMR and SNHR adjustments have a minor impact on the overall score, except in the case of extreme differences from the average provider group risk of mortality or nursing home transition.

Clarification: The "nursing home start date of January 1" refers to the classification of beneficiaries; those already in a nursing home on January 1 are not considered for a nursing home transition during the measurement period. This start date aligns exactly with the specified performance period for the measure of January 1 to December 31 (the calendar year).

A few SMP members discussed the effect of specific chronic conditions on the risk model, such as cancer, dementia, and congestive heart failure that increase EDIC by nature of the disease states.

Clarification: The measure includes risk adjustment to account for differences in case mix between providers, including for these stated factors. While these conditions may result in more observed (unadjusted) days in care for patients, risk adjustment accounts for this increased risk and these patients will not necessarily have more *excess* days in care.

The greatest concern for the risk adjustment model expressed from the SMP members was the development approach for days at home, and the mortality and nursing models. The SMP noted that formulas in the approach may include doubling the EDIC estimates for enrolled ACOs and negative impacts to the penalty schematic

Clarification: It is unclear what "faulty formulas" are being referenced here, what "doubling" is described, or how the specifications compromise the validity of the measure. The formulas used were endorsed by the TEP, which included members with expertise in measure development who had reviewed the approach and results in great detail. Performance on the measure is driven by the Days in Care model, which is a conventional risk adjustment model. The score is then modified such that only provider groups with both outlying performance in Days in Care and nursing home transitions and/or mortality are noticeably impacted. It is not true that this results in "doubling the estimates" for some providers. It is also not clear what "negative impacts to the penalty schematic" means in this statement or what "fault" in the specifications is proposed to give rise to that. Without more detail, it is difficult to further address the challenges being put forward.

Exclusions:

The SMP questioned the process-outcome pathway that resulted in increased, rather than decreased, days in care, and the lack of exclusions for long-term nursing home residents prior to a measurement period, who have no chance of "at home" days defined in the specifications.

Clarification: This is not an accurate description of the methodology. **Patients who reside in long-term nursing homes are considered "at home" for purposes of the Days in Care model.** For example, a nursing home resident on January 1 with no other care use during the year would be considered "at home" for the full 365 days. Similarly, for patients who transition to a nursing home during the

performance year, all subsequent days in the nursing home with no other care use are counted as “days at home.”

SMP members indicated the discrimination and calibration were generally acceptable but had concerns related to the low outliers. The developer described this as an unintended consequence of the measure construct as the measure attempts to balance days at home with other unintended consequences.

Clarification: The measure does not have a strict definition of outliers, nor is it proposed to report outliers. In clarification of results the SMP may be referring to, certain ACOs observed in testing with scores much lower than average did not arise as a result of "attempting to balance days at home with other intended consequences." These ACOs in the test dataset already had substantially more days in care than expected, based on the Days in Care model results even before accounting for nursing home transitions and mortality, and their low performance is unrelated to the additional adjustments. The nursing home and mortality adjustments simply have the greatest *potential* impact for provider groups that are already outliers (either high or low) in Excess Days in Care. The measure was designed to ensure that it is extremely difficult for a provider group with near-average Excess Days in Care to become a very high or very low performer due solely to outlying performance in the nursing home or mortality models.

Meaningful Differences:

A few SMP members questioned the presence of meaningful differences in performance and the use of the measure for quality improvement purposes, and whether the measure could be used to identify differences in patient function or health-related quality of life.

Clarification: While scores are reported as “days at home” to align with the conceptual focus of the measure, *differences* in performance should be considered relative to days *in care* which are the basis of the main Days in Care model. As noted in the measure submission, the interquartile range of 3.0 days at home (329.1 – 332.1) reflects that patients of a provider at the 25th percentile of performance can each expect to spend on average 3.0 days *more* in care than they could expect at a provider at the 75th percentile of performance. As the average patient in the cohort spends 12.8 days in care, 3 days more or fewer represents a meaningful amount of time for each patient who, as noted above, strongly prefer to minimize time in these care settings when possible.

Appendix G: Post-Evaluation Comments

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

Stephanie Collingwood, UnityPoint Health; Submitted by Stephanie Collingwood

Comment ID#: 7971 (Submitted: 04/25/2022)
Council / Public: PRO
Level of Support: N/A

Comment

UnityPoint Health respectfully offers comments in opposition to measures 3661 as outlined below. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 32,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 8.4 million patient visits. Within our organization, a handful of physicians utilize PSC17 but don't find it as helpful as other screenings. Our physicians find it too long to be useful as a screening form in a well child visit and deliver results that are too vague to be useful in a focused mental health encounter. The pediatric symptom checklist is an even longer version (35 questions) plagued by the same problems. Typically, basic history taking indicates whether a more specific and sensitive screen or diagnostic tool is indicated or in the setting of a well visit whether a follow up visit dedicated specifically to mental health is needed. A standard set of psychosocial screening questions is certainly helpful but if the end point of those questions is to just indicate the need for additional assessment, as is the case with the PSC, then those first questions need to be very brief, and that additional assessment deserves dedicated time outside of a well visit. Furthermore, identifying more kids with problems without any infrastructure to support them will be stressful for providers and not helpful to our patients. At this time UnityPoint Health feels this measure, as proposed, is too cumbersome for use in daily practice and would not recommend the measure move forward.

Developer Response

Writing on behalf of UnityPoint Health, Stephanie Collingwood has commented that, in their opinion, NQF measure #3332, "Psychosocial screening with the Pediatric Symptom Checklist Tool (PSC-Tool") should not move forward for endorsement because it is "too cumbersome for use in daily practice". Our reply is that although this may be UnityPoint's opinion, they do not support it with anything but the claim that within their organization, "a handful of physicians utilize PSC17 but don't find it as helpful as other screenings". Beyond this assertion based on very small number of unspecified cases, the commentator does not reference any studies that would support this opinion. Contrast this with a recent paper (Murphy et al, 2020) that showed that in the first year of a best practice commitment to using the PSC-17 in a network of 18 suburban outpatient pediatric practices whose patients were covered predominantly with commercial insurance, 89.3% of the 35,237 well child visits in their organization had been screened with the PSC and that even in the second year of the program, the rate was 77.9%. Other evidence of the feasibility (lack of

cumbersomeness) of using the PSC in actual practice are reports from the statewide Massachusetts Children's Behavioral Health Initiative for children with Medicaid (CBHI; Kuhlthau, 2011; Murphy et al, 2020) now in its fifteenth year. The PSC is the primary screening measure for 4-17 year old children and, according to data on a state website, the rate of psychosocial screening has averaged about 67% over the entire time and has not dropped below 60% (MassHealth Quarterly Screening Report, 2021 [use https://www.mass.gov/info-details/childrens-behavioral-health-initiative-cbhi-data-reports]) since it started, again providing strong evidence for feasibility/lack of cumbersomeness. The UnityPoint Health commentator goes on to note that: Our physicians find it too long to be useful as a screening form in a well child visit and deliver results that are too vague to be useful in a focused mental health encounter. The pediatric symptom checklist is an even longer version (35 questions) plagued by the same problems Again the commentator provides no empirical support for the opinion expressed on this point and, in contrast, the CBHI program website and findings from the empirical papers cited above (and more than 200 other papers that used the PSC) document the feasibility of using the PSC in the real world. With regard to the comment about the length of the PSC-35, it may be important to note that even after fifteen years, the state of Massachusetts continues to approve the use of the PSC-35 as well as the PSC-17 (MassHealth - Learn about the Approved Screening Tools [use https://www.mass.gov/info-details/learn-about-the-approved-masshealth-screening-tools]).To our knowledge, there are no published studies of the UnityPoint approach. The commentator next provides a snapshot of the approach that UnityPoint uses: Typically, basic history taking indicates whether a more specific and sensitive screen or diagnostic tool is indicated or in the setting of a well visit whether a follow up visit dedicated specifically to mental health is needed. A standard set of psychosocial screening questions is certainly helpful but if the end point of those questions is to just indicate the need for additional assessment, as is the case with the PSC, then those first questions need to be very brief, and that additional assessment deserves dedicated time outside of a well visit. Although the brief outline of the UnityPoint system described in the comment may sound like a less cumbersome approach, the comment does not describe in any detail its alternative approach (which would permit a reader to assess whether it does indeed seem less cumbersome). Again, there no evidence of the feasibility and effectiveness of an alternative system, and no data comparing the approach outlined by UnityPoint to a PSC-based system. As for the comment's implication that the PSC takes too long and is not brief enough, it is important to note that all versions of the PSC are filled out prior to the well child visit, so there is no burden on pediatricians at all and even the burden on the parent or youth who completes the PSC is very light. The PSC-35 takes only about 5 minutes to complete, and the PSC-17 takes only two minutes. It is hard to see how, even if the implied briefer UnityPoint screen took only one minute, this time saving would be experienced as significantly less cumbersome. Although the commentator does not give enough details for the reader to be sure, it sounds like their approach may actually be to do away with first stage screening entirely, skipping right to diagnosis-specific measures if the pediatrician becomes aware of a specific problem (e.g. child seems anxious during the well child visit). This kind of approach flies in the face of dozens of studies over several decades showing that, in the absence of a policy that endorses routine psychosocial screening, pediatricians often fail to detect problems during the well child visit and therefore would lose the chance to administer diagnosis-specific measures. All of this is not to imply that current PSC screening systems are perfect or that other approaches which might prove

to be more effective might not exist now or in the future. Quite the contrary, the literature shows that there are other ways to screen, although systematic comparisons usually favor the PSC (Pourat et al, 2017). For example, the second most frequently used brief psychosocial screen is the Strengths and Difficulties Questionnaire, which, as its name suggests, includes an assessment of strengths as well as problems. The SDQ's authors believed that adding some questions about strengths would make the SDQ superior to a questionnaire like the PSC that only screened for difficulties…but there are, to our knowledge, no studies that investigate this hypothesis. The SDQ was originally endorsed by Massachusetts CBHI, but was removed after several years due to its infrequent usage (MassHealth - Learn about the Approved Screening Tools [use https://www.mass.gov/info-details/learn-about-the-approved-masshealth-screening-tools]). Other researchers have explored whether greater screening accuracy can be obtained by using the PSC in tandem with a second brief screen (like the PHQ-9; Jellinek et al, 2021), with longer and shorter screens like the CBCL and SDQ (Young and Takala, 2018), or when both parent and youth complete a PSC (Montano, 2011). Although each of these screening alternatives undoubtedly has some plusses, they undoubtedly also have some minuses and there has been no empirical research that demonstrates a more effective way to screen in the real world than by using a single PSC measure. The UnityPoint comment concludes by stating that "…identifying more kids with problems without any infrastructure to support them will be stressful for providers and not helpful to our patients." While, again, this assertion might be true in general, it confounds a number of issues. Although identifying children and adolescents with psychosocial problems without providing ways to respond to them is unethical as well as pointless, the published research provides evidence that this is not what happens in the real world. For example, numerous studies by Hacker and her associates (2014a, 2014b, and 2016) have documented that after the implementation of the CBHI screening program, thousands of additional referrals were made and there were substantial increases in the number of children and adolescents who actually received outpatient mental health services. Screening mandates do not in and of themselves guarantee a greater access to mental health services, but they do appear to create pressures within healthcare systems to find ways to help the children and adolescents who are newly identified. In conclusion, although the UnityPoint commentator has not provided evidence that should lead NQF to withdraw its endorsement of the PSC, the UnityPoint comment outlines its own alternative approach which might, over time, be able to provide evidence of its feasibility and effectiveness so that it could be compared to similar evidence from the PSC. Until that time, NQF's continued endorsement of psychosocial screening with the PSC-tool will keep encouraging providers to use a screen with proven feasibility and effectiveness and, thereby, to facilitate research that can sharpen a more complete understanding of the most important aspects of routine screening in pediatrics.
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NQF Response

Thank you for your comment. It has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

NQF #3661 Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma (Recommended)

Anna Kim, American Geriatrics Society; Submitted by Anna Kim

Comment ID#: 7958 (Submitted: 04/25/2022)
Council / Public: HPR
Level of Support: Member Does Support

Comment

The AGS does not support Measure #3661: Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma. The guidelines recommend testing for patients with concern of familial cancers and we were not able to find clinical data that suggests outcomes will improve if the recommendation is broadened to all patients. Furthermore, the analysis was only on an individual basis without support from a group-level analysis.

Developer Response

Thank you for your comments. To clarify, we are not suggesting that every patient is a candidate for MMR or MSI testing. However, recent guidelines broaden recommendations beyond familial cancers to include patients being considered for checkpoint inhibitor therapy (see https://www.cap.org/protocols-and-guidelines/cap-guidelines/current-cap-guidelines/mismatch-repair-and-microsatellite-instability-testing-for-immune-checkpoint-inhibitor-therapy). This is the reason for the Exception category "patients not a candidate for checkpoint inhibitor therapy". With the FDA's approval of pembrolizumab for any advanced tumor that is microsatellite instable or mismatch repair deficient, it is increasingly important to consider not only familial occurrences of these genetic changes such as those found in Lynch syndrome but spontaneous as well. We also appreciate the concern regarding individual vs group level analysis. As noted by NQF staff, this was addressed to the satisfaction of the reviewers. However, we continue to collect data on this measure (which was in use in 2021 and is in use in 2022) at the clinician and group level so that further testing can be performed to ensure complete reliability.

NQF Response

N/A

NQF Committee Response

Thank you for your comment. The Standing Committee accepted the updated guideline which was submitted by the developer to support the broadening of the measure population to assist in therapeutic decision making and thus to include all patients being considered for checkpoint inhibitor therapy. Further, the Standing Committee evaluated the measure as specified by the College of American Pathologists, with the level of analysis at the group/practice level and individual level. At the meeting, the developer stated that the analysis results at the individual level demonstrated sufficient reliability and that aggregating at the group level would only improve the reliability. The Standing Committee accepted this rationale and found reliability testing sufficient for both the individual and group levels.

Leslie Narramore, American Gastroenterological Association; Submitted by Leslie Narramore, Leslie Narramore

Comment ID#: 7952 (Submitted: 04/07/2022)
Council / Public: Public
Level of Support: N/A

Comment

AGA supports NQF Measure 3661. Mismatch repair (MMR) and microsatellite instability (MSI) are key biomarkers in colorectal cancer (CRC) and other GI tumors, with crucial diagnostic, prognostic, and predictive implications. Gastroenterologists and other clinicians order testing for MMR/MSI during screening for Lynch syndrome and/or prognostic stratification for patients with CRC or with a personal history of colon and rectal cancer. Gastroenterologists and other ordering clinicians depend on pathologists' interpretations of and any recommendations for tests in order to provide quality patient care. If the status of genetic testing is not indicated in each pathology report, important tests may be missed or unnecessary repeat testing may be performed leading to

inappropriate treatment and/or increasing cost. Having a quality measure would provide a strict framework for management with the multi-specialty team managing the patient's oncology care. This is a measure that is applicable to several specialties and fits the larger paradigm of cross-cutting measure, which are particularly relevant. Measure 3661 represents a crucial step in the care process by promoting effective communication of critical information for the purpose of care coordination and efficient use of resources.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

Stephanie Collingwood, UnityPoint Health; Submitted by Stephanie Collingwood

Comment ID#: 7970 (Submitted: 04/25/2022)
Council / Public: PRO
Level of Support: N/A

Comment

UnityPoint Health respectfully offers comments in support of measures 3661. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 32,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 8.4 million patient visits. It was noted that the tumor type for the numerator should specify "adenocarcinoma" or include an additional exclusion for "neuroendocrine carcinoma." Though uncommon, MMR testing is not currently indicated for neuroendocrine carcinomas. From an operational perspective, concern was raised regarding the ability to capture results of MMR testing performed on the biopsy when a resection is received. Sometimes the biopsy is read at a different institution and there may not be an efficient mechanism to determine whether MMR testing was performed and what the results were. However, the metric is written broadly enough that it would be satisfied by mentioning the need to correlate with biopsy MMR testing or recommending that MMR testing be requested if not performed on the biopsy.

Developer Response

Thank you for your comments. We appreciate the careful consideration of the details of the measure specification and will consider whether an exclusion is needed for neuroendocrine carcinoma in the future. At the moment, scientific evidence does not definitely rule out MSI testing on poorly differentiated neuroendocrine colorectal carcinoma, so we did not exclude this from the

measure completely (see 2019 ESMO recommendations found here: https://www.annalsofoncology.org/article/S0923-7534(19)31269-4/fulltext). However, we will continue to engage with stakeholders and monitor scientific consensus to determine whether additional clarification is needed. We also appreciate the difficulty in determining whether MMR testing was previously performed on a biopsy. As noted, we wrote the measure broadly to account for such circumstances and to discourage repeat testing by allowing "recommended" or "previously performed" as Met conditions.

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

NQF #3667 Days at Home for Patients with Complex, Chronic Conditions (Not Recommended)

Anna Kim, American Geriatrics Society; Submitted by Anna Kim

Comment ID#: 7957 (Submitted: 04/25/2022)
Council / Public: HPR
Level of Support: Member Does Support

Comment

The AGS supports this measure and believes it is important to managing patients at home, particularly as it is patient-centered and one that patients care about deeply. It is critical to capture patients with substantial disease(s) and have specific measures for complex, chronic conditions to do so effectively. The measure is also increasingly being used in scientific literature as a valid composite outcome measure. While the AGS agrees that the issues of risk adjustment and incorporating social determinants of health (SDOH) are crucial, these challenges are not unique to this specific measure. We encourage efforts to improve measures by improving risk adjustment of SDOH.

Developer Response

N/A

NQF Response

Thank you for your comment. This measure was submitted as outcome measure not a composite outcome measure. The Standing Committee reviewed the measure as it was submitted. Your comment has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

Dr. Clarke Ross, DPA, American Association on Health and Disability

Comment ID#: 7955 (Submitted: 04/22/2022)

Council / Public: HPR
Level of Support: Member Does Support

Comment

The American Association on Health and Disability, Altarum, and the Lakeshore Foundation appreciate the opportunity to provide comments. We write to support the measure recommended by the NQF committee. A core tenet of the disability rights movement, enshrined in the Americans with Disabilities Act (ADA) and L.C. v. Olmstead, is that people with disabilities of all ages have a right to receive services and supports in the most integrated setting, regardless of the source of payment for services or the intensity of their service needs. Most people far prefer to age in their homes, and research has shown that individuals who receive needed services in their communities – including individuals with the most complex intellectual disabilities who require the most substantial supports -- experience improved quality of life. The Consortium for Citizens with Disabilities (CCD) and the Disability and Aging Collaborative (DAC) address the services and supports that enable older adults and individuals with disabilities of all ages to live in their homes and communities. We are CCD and DAC members, and Altarum is also a DAC member. In particular, these coalitions focus on the Medicaid Home and Community-Based Services (HCBS) program, recognizing that HCBS is the key to community integration, full participation, independent living, and economic self-sufficiency for many people with disabilities and older adults. These critical services make it possible for people with disabilities and older adults to fully exercise their civil and human rights. NQF Measure #3667 is an innovative provider group-level measure of days at home or in a community setting. It is stewarded by CMS and is a Yale Center for Outcomes Research and Evaluation (CORE) measure. The proposed measure is focused on Medicare fee-for-service (FFS) beneficiaries with complex chronic conditions, and the level of analysis is the Accountable Care Organization. This measure is coming forward at a key moment, as the U.S. health care system moves further toward provision of multiple services in home and community-based settings (other than for specialty care in hospitals and medical centers). NQF Measure #3667 therefore has outsize public policy significance, given that it is poised to set an important precedent for analyzing provider performance in the context of person-centered care. The disability and aging communities have been promoting HCBS services and programs for decades as desired alternatives to institutional settings and as strategies for “rebalancing” Medicaid and other public program financing away from institutions. To fully realize these approaches requires dissemination and use of a meaningful quality metric that measures how providers fare in keeping their patients and clients out of medical institutions. Measure #3667 now being considered for use through Medicare and ACOs, is a clear recognition that the larger health care system is moving to meaningfully promote the objectives of home and community living. We therefore urge NQF to approve the measure, and to move work forward that will measure what matters to millions of people who need and want their medical care to help them return home as soon as possible, and to remain there for as long as possible, with appropriate support services if required. In closing, the disability and aging advocacy and research communities are committed to supporting quality measurement experts whose work aims to expand funding and programming for care in HCBS settings. We are heartened to see Congressional proposals being considered that would further incentivize HCBS services and supports, and we believe that if approved, NQF Measure #3667 would strengthen and reinforce these trends over time.

Developer Response

N/A

NQF Response

N/A

NQF Committee Response

Thank you for your comment. The Standing Committee concluded that the developer's approach to risk adjustment was not sufficient. Therefore, the Standing Committee did not pass the measure on validity; a must pass criterion.

Dr. Clarke Ross, DPA, American Association on Health and Disability

Comment ID#: 7956 (Submitted: 04/22/2022)
Council / Public: HPR
Level of Support: Member Does Support

Comment

Comments - part 2 - info on 3 submitting organizations: The American Association on Health and Disability, Altarum, and the Lakeshore Foundation appreciate the opportunity to provide comments. We write to support the measure recommended by the NQF committee. The American Association on Health and Disability (AAHD) (www.aahd.us) is a national non-profit organization of public health professionals, both practitioners and academics, with a primary concern for persons with disabilities. The AAHD mission is to advance health promotion and wellness initiatives for persons with disabilities. AAHD is specifically dedicated to integrating public health and disability into the overall public health agenda. The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise. Altarum is a nonprofit health services research organization (www.altarum.org) that helps federal and state health agencies and foundations improve health equity and outcomes through better systems of care, primarily for disenfranchised populations. Altarum strives to produce solutions that go beyond being road maps for improvement; rather they serve to catalyze, accelerate, and implement innovations.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

Kyle Bagshaw, Yale New Haven Health Services Corporation – Center for Outcomes Research and Evaluation (CORE)

Comment ID#: 7972 (Submitted: 04/25/2022)
Council / Public: Public
Level of Support: N/A

Comment

As developer of NQF#3667 "Days at Home for Patients with Complex, Chronic Conditions" (hereafter "Days at Home"), the Yale New Haven Health Services Corporation Center for Outcomes Research & Evaluation (CORE) was disappointed by the Standing Committee's decision not to support endorsement of the measure. We are submitting this comment to bring attention to and provide corrections in response to important instances of mischaracterization of the measures and testing provided both in the "Primary Care and Chronic Illness Standing Committee Measure Evaluation Web Meeting Summary" published for public comment and the information provided to the Standing Committee before their review meeting. First, we were concerned to note mischaracterizations of the measure and the measure testing that were presented in the draft "Primary Care and Chronic Illness Standing Committee Measure Evaluation Web Meeting Summary" document, published for the current Public Comment period. We respectfully request that NQF correct the following items in the final version of the report: 1. The summary states that "the construct validity testing found that NQF #3667 did not correlate well with the other measures. The developer emphasized that the lack of correlation may be due to the other measures having smaller sample sizes and not being risk-adjusted." o This statement is incorrect. CORE tested Days at Home against six conceptually related measures and found modest to high correlation with four of the six as anticipated; the hypotheses for lack of correlation were only applicable to two measures which were narrowly defined and not risk adjusted. Overall, this testing demonstrated that the Days at Home did correlate well with other measures, supporting construct validity. o We also note that these results showing construct validity, together with the face-validity established by unanimous support from our large and diverse Technical Expert Panel, demonstrate that the Days at Home measure meets NQF criteria for validity testing of new measures. 2. The summary states: "The Standing Committee expressed concerns about social determinants of health (SDOH) factors not being included in the risk adjustment model. The developer noted that there is no national, standardized approach to address SDOH factors, and the small sample size hindered the developer's ability to account for SDOH factors. Thus, the developer decided to utilize dual eligibility as an alternative to SDOH in the risk adjustment model." o The measure is adjusted for beneficiaries' dual-eligible status. Dual-eligible status is included not as an alternative to SDOH, it is a conceptually valid indicator of low income and lack of wealth and was the most significant SDOH factor identified in measure testing. o Dual-eligible status is the preferred SDOH factor by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) as detailed in their December 2016 Report to Congress. While imperfect, this indicator represents lack of income and wealth in a way that correlates highly with other issues. o It is also not correct that "small sample size hindered the developer's ability to account for SDOH factors." The approach to SDOH testing was constrained by the lack of relevant and reliable data available at the patient level. Nonetheless, the measure was tested using data that are currently available at a geographic level to consider other factors for inclusion in the measure; these factors proved to have low predictive value in measure testing and

were ultimately excluded for that reason. Thank you for considering these corrections for the final Fall 2021 Cycle report for the PCCI Standing Committee. In addition, we are concerned that some errors in the information packet provided to the Standing Committee prior to their meeting may have contributed to some misunderstanding of the measure. For the accuracy of future information about the measure, we would like to provide the following clarifications in particular: • The measure does not count "days after death occurs" as days in care. • The measure does not exclude long-term nursing home residents; current residents are considered to be "at home" and eligible for subsequent days in care. • The decision not to exclude care in some settings (such as emergency department visits) and count these settings toward "days in care" was made in order to reflect the priorities and preferences of patients. While there may be individual cases in which a "day in care" is preferable to a "day at home," the Technical Expert Panel unanimously supported this broad conception of "days in care," noting that a measure called "days at home" would lack face validity if any care in an inpatient setting was defined to be "at home" and agreed that in aggregate counting these settings would be inappropriate. Finally, CORE is very appreciative of the thoughtful consideration of the Standing Committee. We note, however, that at times the Committee's discussion did not provide clear indications of how their concerns could be addressed. For example, some Committee members noted they would have liked to see comparisons to other measures of care coordination; however, currently no such measures exist, and it is unclear how the measure developer could meet such a request. Similarly, some Committee members would have liked to see testing for different social risk factors, but acknowledged the lack of availability of data elements. Given the substantial time and resources that go into measure development and testing, we request that in the post-comment discussion the Committee clarify more concretely what modifications or feasible future testing would address concerns about the measure's validity so we can plan for future phases of measure testing and evaluation.

Developer Response

N/A

NQF Response

Thank you for your comment. NQF will make the appropriate adjustments to the draft report.

NQF Committee Response

Thank you for your comment. The Standing Committee would like to provide the following recommendations for the measure developer to consider. 1. Introducing a survey instrument or a patient-reported outcome measure that would assess factors, which may affect the quality of care and feasibility of care being provided at home. 2. Focus assessment of the measure on the continuum of care versus location of care (i.e., home). 3. Dual-eligibility risk identifier is not an accurate capture of SDOH factors. Not all patients who are able to receive care at home are duel-eligible and this could penalize the provider. Additionally, there are significant policy variations in Medicaid from state-to-state, which impact entity-level SDOH factors. The Standing Committee maintains it's decision to not recommend the measure for endorsement, based on the measure failing to pass the validity criterion.

Ms. Koryn Y. Rubin, MHA, American Medical Association

Comment ID#: 7953 (Submitted: 04/20/2022)
Council / Public: HPR
Level of Support: Member Does NOT Support

Comment

The American Medical Association agrees with the concerns raised by the Standing Committee on this measure, particularly around the validity of the measure. We support the Committee's recommendation to not endorse the measure at this time.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

Ms. Tilithia McBride

Comment ID#: 8007 (Submitted: 04/25/2022)
Council / Public: PRO
Level of Support: N/A

Comment

The Federation of American Hospitals (FAH) agrees with the concerns raised by the Standing Committee on this measure, particularly around its validity. We support the Committee's recommendation to not endorse the measure at this time.

Developer Response

N/A

NQF Response

Thank you for your comment. It has been shared with the Standing Committee and the measure developer.

NQF Committee Response

N/A

Stephanie Collingwood, UnityPoint Health; Submitted by Stephanie Collingwood

Comment ID#: 7969 (Submitted: 04/25/2022)
Council / Public: PRO
Level of Support: N/A

Comment

UnityPoint Health respectfully offers comments in support of measures 3667. UnityPoint Health is one of the nation's most integrated health care systems. Through more than 32,000 employees and our relationships with more than 480 physician clinics, 40 hospitals in urban and rural communities and 14 home health agencies throughout our 9 regions, UnityPoint Health provides care throughout Iowa, central Illinois, and southern Wisconsin. On an annual basis, UnityPoint Health hospitals, clinics and home health provide a full range of coordinated care to patients and families through more than 8.4 million patient visits. UnityPoint Health is supportive of this measure; however, challenges exist today in operationalizing. Market variations exist regionally with a metric like this. For patient outcomes, it's all about access. If there are no care at home options, then patients may have no choice but to go to the emergency department/hospital. For example, if a patient needs an IV diuresis for heart failure, while optimal to offer within the home, this isn't always an option, particularly with RN staffing shortages. Another concern for providers is that it's frustrating to have metrics where there's a perceived or actual lack of control. For example, we have numerous patients in our hospitals that are there for weeks or even months while they wait for an open bed at a mental health facility or long-term care facility. Lack of bed access is entirely out of a provider's control. Claim base measures bring their own challenges as data is delayed, in some cases up to six months, making reactive action less effective. This is where population health management needs to become stronger and align with a global value base strategy.

Developer Response

• UnityPoint Health Comment: UnityPoint Health is supportive of this measure; however, challenges exist today in operationalizing. Market variations exist regionally with a metric like this. For patient outcomes, it's all about access. If there are no care at home options, then patients may have no choice but to go to the emergency department/hospital. For example, if a patient needs an IV diuresis for heart failure, while optimal to offer within the home, this isn't always an option, particularly with RN staffing shortages. o Developer Response: We appreciate your support of this concept and your thoughtful consideration of the measure. We discussed the issue of regional differences in patient access to services extensively with our Technical Expert Panel and acknowledge this as a concern for some providers. However, we have not found that any providers are systematically disadvantaged in performance on the measure as a result. During testing for potential risk factors, we found that urban residence and local density (per 100,000 population) of hospital beds were not significantly associated with patients' days in care. Greater local density of primary care physicians and specialists was associated with fewer days in care, but the practical magnitude of this effect was quite small compared to that of clinical risk factors and dual-eligibility. Conversely, greater local density of nursing home beds was associated with more days in care, but the practical magnitude of this effect was also quite small. o Furthermore, the population-based focus and broad outcome of this measure is intended in part to allow flexibility and promote innovation to meet the goal of reducing the use of acute inpatient care utilization across their patients, in recognition that there is no one-size-fits-all approach for every provider group's situation. • UnityPoint Health Comment: Another concern for providers is that it's frustrating to have metrics where there's a perceived or actual lack of control. For example, we have numerous patients in our hospitals that are there for weeks or even months while they wait for an open bed

at a mental health facility or long-term care facility. Lack of bed access is entirely out of a provider's control. o Developer Response: We acknowledge that some factors contributing to days at home are outside of providers' ability to control. Accordingly, the goal for the measure is not to eliminate "days in care" entirely but to encourage providers to explore other options when feasible, as one piece of a larger quality strategy. Furthermore, the measure is intended for organizations like ACOs that provide comprehensive services to patients across the continuum of care and so have more opportunities to engage with patients both to mitigate the risk of health deterioration leading to hospitalization and to organize care to provide for needed outpatient services. • UnityPoint Comment: Claim base measures bring their own challenges as data is delayed, in some cases up to six months, making reactive action less effective. o Developer Response: Unfortunately, it is true that claims-based measures will have some delay in providing feedback. The reporting delay associated with Days at Home is comparable to that of many other claims-based measures in current use. • UnityPoint Comment: This is where population health management needs to become stronger and align with a global value base strategy. o Developer Response: We agree that promoting good population health management is a key strategy. We hope that introducing this measure will put a spotlight on this issue and highlight further opportunities to improve care, outcomes and experiences of patients.

NQF Response

N/A

NQF Committee Response

Thank you for your comment. The Standing Committee concluded that the developer's approach to risk adjustment was not sufficient. Therefore, the Standing Committee did not pass the measure on validity; a must pass criterion.

National Quality Forum
1099 14th Street NW, Suite 500
Washington, DC 20005
https://www.qualityforum.org