NATIONAL QUALITY FORUM

Agenda

Measure Applications Partnership
Dual Eligible Beneficiaries Workgroup Web Meeting

April 30, 2013

1:00 pm - 3:00 pm ET

Participant Instructions:

- Please log in 15 minutes prior to the scheduled start to allow time for troubleshooting
- Direct your web browser to: http://nqf.commpartners.com for slides and streaming audio
- Under "Enter a Meeting," type in the meeting number **994737** and click "Enter"
- In the "Display Name" field, type in your first and last name and click "Enter Meeting"
- Public attendees dial **(855) 452-6871**; use conference ID code **34575141** to access the audio platform.

Meeting Objectives:

- Begin work on measures for dual eligible beneficiaries disabling behavioral and cognitive conditions
- Prepare for in-person meeting by introducing the approach for creating a family of measures
- Review public comments received on December 2012 Interim Report and discuss how to address them going forward
- Develop understanding of the quality issues facing beneficiaries with disabling behavioral and cognitive conditions and the opportunities for improvement through measurement

1:00 pm **Welcome**

Alice Lind, MAP Dual Eligible Beneficiaries Workgroup Chair
Cheryl Powell, Centers for Medicare & Medicaid Services (CMS)

- Prior accomplishments and current priorities
- Reflections from CMS

1:10 pm **How Will the Pieces Fit Together?**

Alice Lind

- Review the Evolving Core Set of Measures for Dual Eligible Beneficiaries and measures for high-need subgroups as inputs for a family of measures

- Review public comments received on December 2012 Interim Report
- Discussion and questions

1:35 pm **What Is Known about Quality Issues for Dual Eligible Beneficiaries with Disabling Behavioral and Cognitive Conditions?**

Amaru Sanchez, Project Analyst, NQF
Megan Duevel Anderson, Project Analyst, NQF

- Serious mental illness (SMI)
- Substance use disorders (SUD)
- Intellectual/developmental disabilities
- Dementia and other acquired cognitive impairments

2:00 pm **State of Performance Measures for Behavioral Health**

Alice Lind
Harold Pincus, NQF Behavioral Health Steering Committee Co-Chair and MAP Coordinating Committee Member
Mady Chalk, NQF Behavioral Health Steering Committee Member and MAP Dual Eligible Beneficiaries Workgroup Subject Matter Expert: Substance Use

- SAMHSA quality framework
- NQF's behavioral health measure endorsement project and related measure development efforts
- Additional inputs and information from workgroup members

2:35 pm **Key Issues for Measurement**

Sarah Lash, Senior Program Director, NQF

- Discuss proposed key issues
- Strategy to identify measures for behavioral health sub-populations

2:45 pm **Opportunity for Public Comment**

2:55 pm **Summary and Next Steps**

Alice Lind

- Preview goals for the May 21-22 in-person meeting

3:00 pm **Adjourn**

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Dual Eligible Beneficiaries Workgroup Web Meeting

April 30, 2013

NATIONAL QUALITY FORUM

Welcome

Dual Eligible Beneficiaries Workgroup Membership

Chair: Alice Lind, MPH, BSN

Organizational Members

American Association on Intellectual and Developmental Disabilities	Margaret Nygren, EdD
American Federation of State, County and Municipal Employees	Sally Tyler, MPA
American Geriatrics Society	Jennie Chin Hansen, RN, MS, FAAN
American Medical Directors Association	**Gwendolen Buhr, MD, MHS, MEd, CMD**
Center for Medicare Advocacy	Alfred Chiplin, JD, M.Div.
Consortium for Citizens with Disabilities	E. Clarke Ross, DPA
Humana, Inc.	George Andrews, MD, MBA, CPE, FACP, FACC, FCCP
L.A. Care Health Plan	Laura Linebach, RN, BSN, MBA
National Association of Public Hospitals and Health Systems	Steven Counsell, MD
National Association of Social Workers	Joan Levy Zlotnik, PhD, ACSW
National Health Law Program	Leonardo Cuello, JD
National PACE Association	Adam Burrows, MD
SNP Alliance	Richard Bringewatt

Subject Matter Experts

Substance Abuse	Mady Chalk, MSW, PhD
Disability	Anne Cohen, MPH
Emergency Medical Services	James Dunford, MD
Measure Methodologist	Juliana Preston, MPA
Home & Community Based Services	Susan Reinhard, RN, PhD, FAAN
Mental Health	Rhonda Robinson-Beale, MD
Nursing	Gail Stuart, PhD, RN

Federal Government Members

Agency for Healthcare Research and Quality	D.E.B. Potter, MS
CMS Federal Coordinated Healthcare Office	Cheryl Powell
Health Resources and Services Administration	Samantha Meklir, MPP
Administration for Community Living	**Marisa Scala-Foley**
Substance Abuse and Mental Health Services Administration	**Lisa Patton, PhD**
Veterans Health Administration	Daniel Kivlahan, PhD

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Dual Eligible Beneficiaries Workgroup Vision for High-Quality Care

In order to promote a system that is both sustainable and person- and family-centered, individuals eligible for both Medicare and Medicaid should have timely access to appropriate, coordinated healthcare services and community resources that enable them to attain or maintain personal health goals.

Workgroup's Timeline

Reflections from CMS

How Will the Pieces Fit Together?

Why and how is a family of measures constructed?

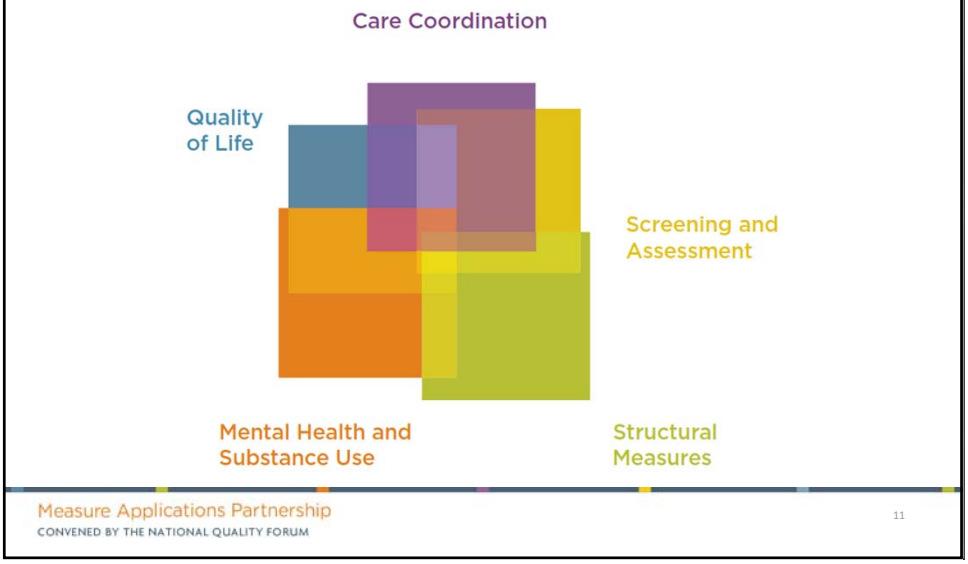
Purpose

- A family of measures provides end-users with a pre-screened group of measures carefully selected to work together for a given topic
- Families of measures transcend any specific healthcare service location to evaluate an individual's experience across health care settings over time

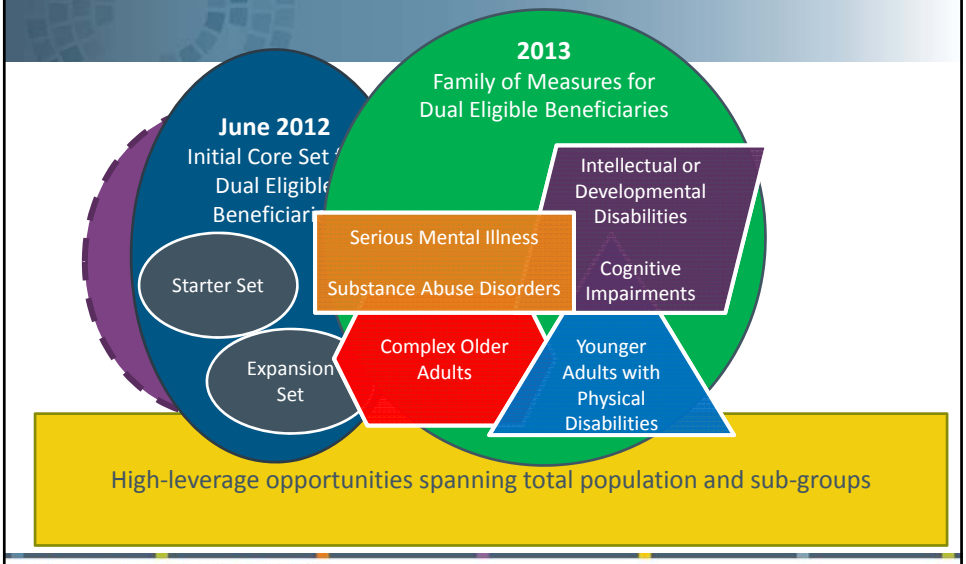
Methodology

- ✓ Establish framework
- ✓ Inventory measures
- Review measures and select best available
- Define the family of measures
- Identify gaps

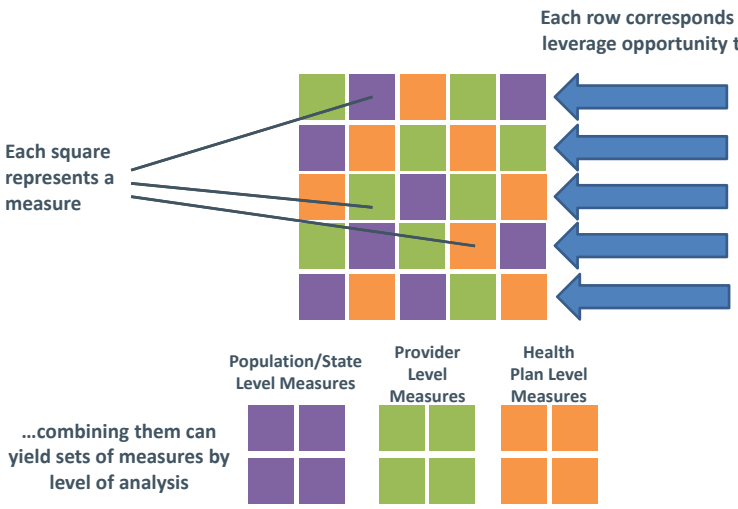
High-Leverage Opportunities for Improvement Through Measurement



Inputs to a Family of Measures



Family of Measures for Dual Eligible Beneficiaries



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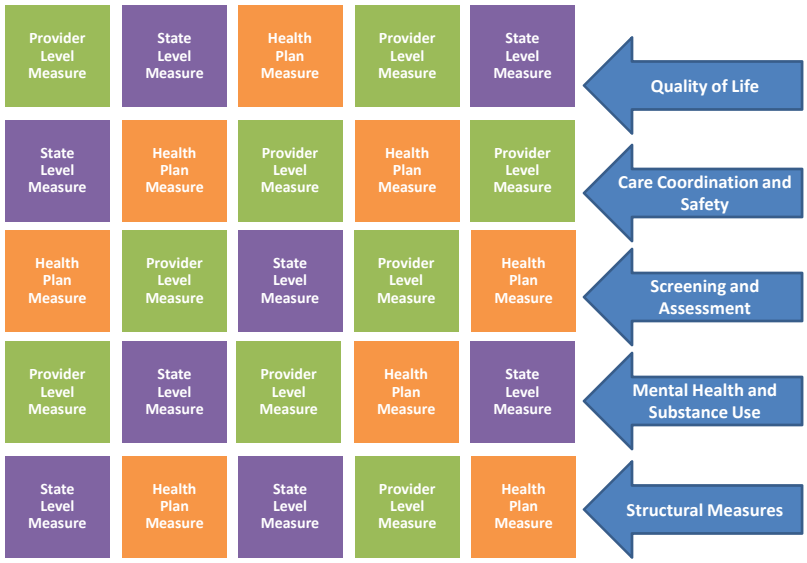
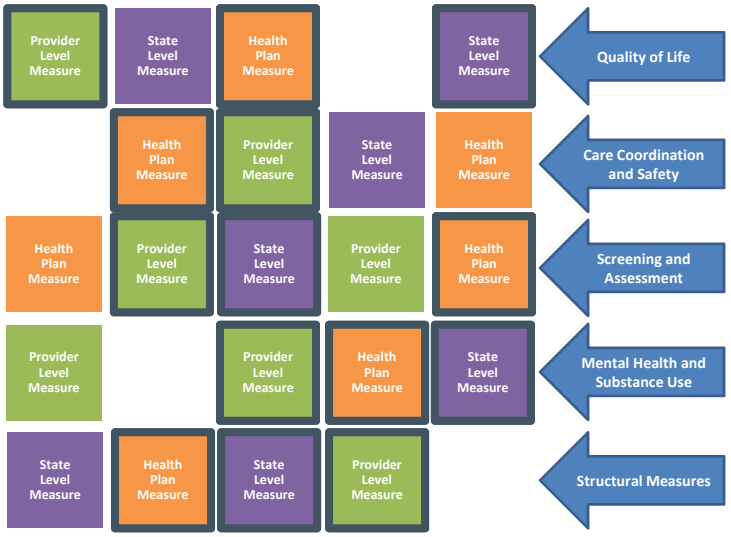
Family of Measures for Dual Eligible Beneficiaries



Family of Measures for Dual Eligible Beneficiaries
Measures for High-Need Sub-Groups

Dark outline indicates the subset of measures that apply to complex older adults



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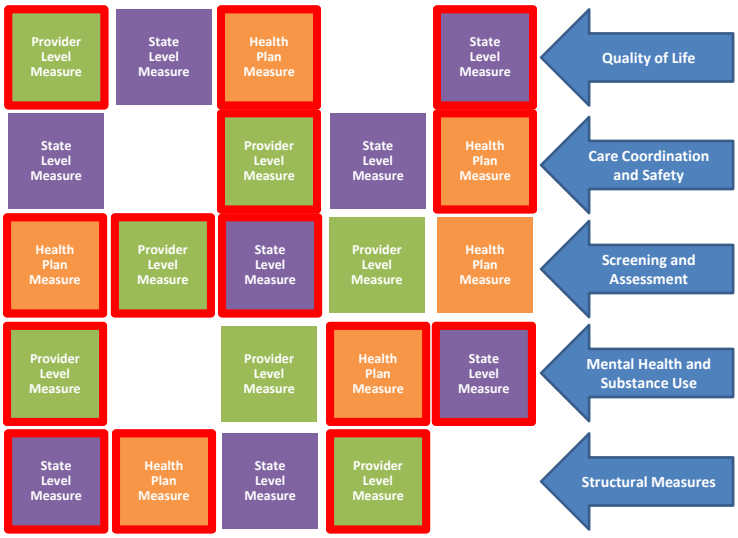
Family of Measures for Dual Eligible Beneficiaries
Measures for High-Need Sub-Groups

Dark outline indicates the subset of measures that apply to younger adults with physical disabilities



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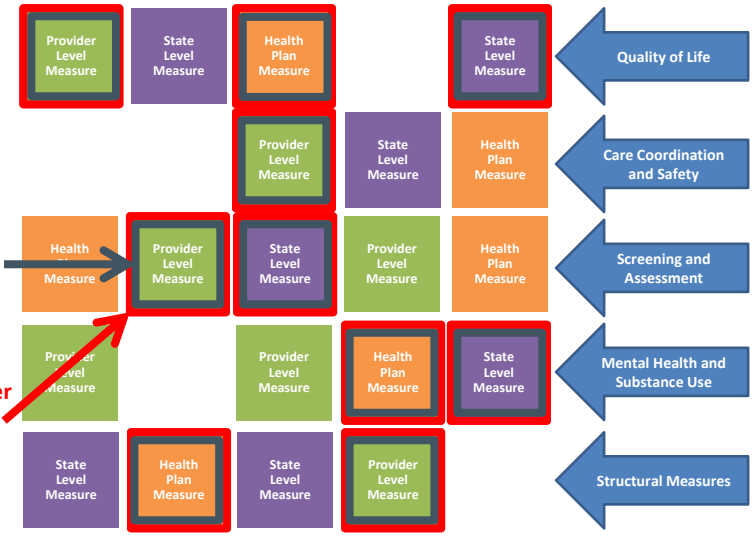
Family of Measures for Dual Eligible Beneficiaries

Measures for High-Need Sub-Groups

Dark outline indicates the subset of measures that apply to **complex older adults** and the red outline indicates the subset that applies to **younger adults with physical disabilities**



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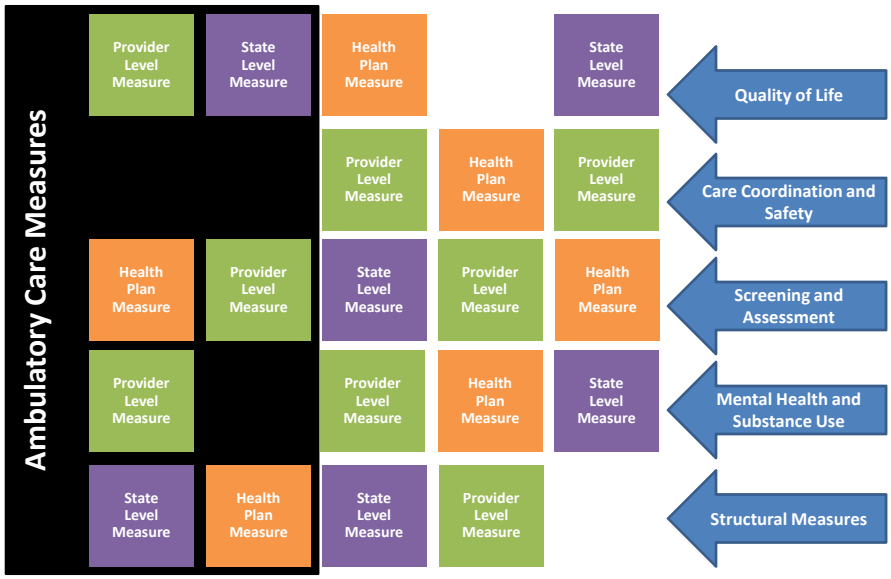
Family of Measures for Dual Eligible Beneficiaries



Public Comment Themes on Workgroup's 2012 Phase 2 Interim Report

- Received 42 comments from across stakeholder groups, including:
  - Patient advocates and representatives, provider organizations and specialty societies, purchasers and payers, and device and pharmaceutical companies.
- Commenters supported:
  - Selecting the most salient measures for high-risk beneficiaries across the continuum of care;
  - Minimizing the burden of measurement on stakeholders
  - A phased approach to address the most prominent opportunities;
  - Gathering feedback from the field.
- Commenters communicated:
  - Further measure gaps related to nutrition, accessibility for people with disabilities, re-hospitalization of individuals with behavioral health needs, and other topics;
  - Concerns for methodological issues that complicate the application of measures, such as alignment, risk adjustment, and attribution;
  - A desire to better understand the relationship between MAP's dual eligible beneficiaries work and specific Medicare and Medicaid quality reporting programs;
  - The need for further consideration of high-need subgroups.

Discussion

- *How should the workgroup address the public's comments in our ongoing work?*
- *A family of measures is a tool to promote alignment across programs. What are the most important Medicare and/or Medicaid alignment opportunities for us to address?*

What Is Known about Quality Issues for Dual Eligible Beneficiaries with Disabling Behavioral /Cognitive Conditions?

Mental Illness and Disability

- The World Health Organization has reported that in the US and other developed countries, four of the ten leading causes of disability are mental disorders.
- Mental Illness is defined as:
  - "Health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning."
- Evidence has shown that mental disorders, especially depressive disorders, are strongly related to:
  - The occurrence, successful treatment, and course of many chronic diseases including diabetes, cancer, cardiovascular disease, asthma, and obesity; and
  - Many risk behaviors for chronic disease, such as, physical inactivity, smoking, excessive drinking, and insufficient sleep.

CDC Mental Health Basics: http://www.cdc.gov/mentalhealth/basics.htm, Kaiser Slides on People Who are Dually Eligible for Medicare and Medicaid: http://facts.kff.org/results.aspx?view=slides&detail=49

Burden of Mental / Cognitive Impairment on Dual Eligible Beneficiaries

- In 2008, 58% of dual eligible beneficiaries had cognitive or mental impairments, compared to 25% of other Medicare beneficiaries.
- 38% of dual eligible beneficiaries have both physical and mental/cognitive conditions.
- 20% of dual beneficiaries have more than one mental/cognitive condition: 23% of duals age 18-64, 13% duals age 65-79, and 27% age 80 and older.
  - Annually, half of dual beneficiaries with more than one mental/cognitive condition use inpatient hospital care, 38% use nursing home care, and 20% use community-based long term supports and services (LTSS).
  - Annual spending for this group was $38,500, of which $15,300 was paid by Medicare and $23,200 was paid by Medicaid.

Kaiser Family Foundation, Medicaid and the Uninsured, Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for patterns of Medicaid and Medicare Service Use and Spending, http://www.kff.org/medicaid/upload/8081.pdf

Serious Mental Illness

- Serious Mental Illness (SMI) is a long-lasting disorder of thought, mood, perception, orientation, or memory that impairs judgment, behavior, capacity to recognize reality, and/or the ability to meet the ordinary demands of life.
  - SMI generally includes schizophrenia/paranoid disorders, bipolar disorders, major depression, and dysthymic disorders.
  - Milder mood, anxiety, or personality disorders are not typically SMIs.
- Individuals living with SMI face an increased risk of chronic medical conditions.
  - On average, adults with SMI die 25 years earlier than other Americans, largely due to treatable medical conditions.
- SMI affected approximately 51% of dual eligible beneficiaries in 2008.
  - 56% of Medicare beneficiaries with at least one inpatient psychiatric facility (IPF) discharge were dually eligible for at least one month of 2010.

(MEDPAC Databook, http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf), NAMI, Mental Illness: Facts and Numbers, http://www.nami.org/Template.cfm?Section=About_Mental_Illness&Template=/ContentManagement/ContentDisplay.cfm&ContentID=53155), (Lin et al., Am J Geriatr Psychiatry, 2011)

Burden of SMI on Dual Eligible Beneficiaries

- 27% of dual eligible beneficiaries had depression in 2010 (vs. 11% of Medicare-only)
  - Depression has an estimated workplace cost of over $34 billion in the US annually.
- 6% of dual beneficiaries had schizophrenia in 2003, (vs. 0.4% of Medicare-only)
  - Schizophrenia affects a greater share of working-age adults (11.8%)
  - Schizophrenia poses a high risk of suicide: 1/3 of individuals with schizophrenia will attempt suicide and eventually, 1/10 take their own lives.
  - Schizophrenia's direct and indirect costs to the U.S. were estimated at $62.7 billion in 2002.
- Bipolar disorder has been deemed the most expensive behavioral health diagnosis
  - Bipolar disorders affect nearly 4% of Americans, with a median onset age of 25.
  - Reported inpatient hospitalization rate is 39.1% for bipolar patients, significantly greater than 4.5% for all other behavioral health diagnoses.
  - $1.80 is spent on inpatient mental health care for every $1 spent on outpatient care.
  - Of people with bipolar disorders, about 56% used drugs and 44 % also abuse alcohol.

CDC Mental Health Basics: http://www.cdc.gov/mentalhealth/basics.htm, (National Alliance on Mental Illness, The Impact and Cost of Mental Illness: The Case of Depression, http://www.nami.org/Template.cfm?Section=Policymakers_Toolkit&Template=/ContentManagement/ContentDisplay.cfm&ContentID=19043) 2010 MEDPAC Databook, http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf, (SAHMSA 2010 Chronic Conditions Chartbook).

Burden of Substance Use Disorders

- About 20% of working-age disabled dual beneficiaries have substance use problems.
- Substance Use Disorders (SUD) include abuse or dependence on alcohol or many types of drugs
- Substance use in the United States for persons age 12+:
  - 26.5% of people reported using tobacco products in the past month
  - In 2011, 22.6% participated in binge drinking and 6.2% reported heavy drinking .
  - In 2009, 8.9% of people had alcohol or illicit drug dependence or abuse, which is similar to the rate of illicit drug use of 8.7% in 2011.

SAMHSA, 2012, Results from the 2011 National Survey on Drug Use and Health, Coordinating Care for Washington State Dual Eligibles, 2011, http://www.aasa.dshs.wa.gov/duals/documents/Dual%20Eligible%20Population%20Profile.pdf)

Interactions Between SMI and Substance Use

- In 2011, adults with any type of mental illness were more likely than adults who did not have mental illness to use illicit drugs (25.2% vs. 11.8%), smoke cigarettes (34.7% vs. 20.9%), and binge drink (27.6% vs. 23.5%).
  - Adults with SMI used substances to an even greater extent (illicit drug use 31.3%, heavy alcohol use 8.7%, and cigarette use 44.4%).
- Among the 18.9 million adults with SUD, 42.3% had co-occurring mental illness.
  - Of adults with SMI, 17.5% had alcohol dependence or abuse, 22.6% also had substance dependence or abuse and 9.9% also met the criteria for illicit drug dependence or abuse.
  - Co-occurring mental illness and substance abuse was more common in: adults ages 18-25, adult males, the unemployed, and adults living in poverty.
  - 31% of adults using homeless services reported having a combination of mental health and addition disorders.
  - Among adults who had a past year with both SMI and SUD, only **65.6% received mental health care or specialty substance use treatment**.

SAMHSA, Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings, http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf, NAMI, Mental Illness: Facts and Numbers

Profile:
Beneficiary with SMI Diagnosis and Substance Use Disorder

- Richard, a 42 year old dual eligible beneficiary diagnosed with bipolar disorder and who experiences paranoid episodes
- Poor medication adherence
- Divorced and estranged from his adult children and other family
- Regular smoker with untreated illicit drug use
- Emergency room visit resulted in diagnosis of diabetic neuropathy and surgery for foot amputation
- Currently resides in subsidized housing and will need additional assistance

Burden of Acquired Cognitive Impairments on Dual Eligible Beneficiaries

- Dementia is the loss of cognitive functioning – thinking, remembering, and reasoning – and behavioral abilities to such an extent that it interferes with a person's daily life and activities.
  - Most commonly caused by Alzheimer's disease and vascular dementia
  - **28.1% of dual beneficiaries 65+ had dementia**, compared to 8.2% of Medicare only and 4% of Medicaid only beneficiaries.
  - In 2010, **20% of dual eligible beneficiaries had Alzheimer's** (vs. 9% of Medicare FFS beneficiaries)
  - Approximately 50% of dual beneficiaries 65+ with SMI also had a diagnosis of dementia.
  - The **risk of developing Dementia is 2 to 6 times greater for people with Parkinson's disease**, a condition more common among dual beneficiaries.
- Alzheimer's and Parkinson's diseases are among the most costly conditions for dual eligible beneficiaries.

CDC Mental Health Basics: http://www.cdc.gov/mentalhealth/basics.htm, 2010 MEDPAC Databook, http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf, KFF, Health Reform Opportunities, 2009, http://www.kff.org/medicaid/upload/7957.pdf , NIH, Alzheimer's Disease Education and Referral Center, 2012 CCW and KFF Chronic Disease and Co-Morbidity Among Dual Eligibles, 2010, PubMed Health, Parkinson's disease, http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001762/; Liu et al. Am J Geriatr Psychiatry. 2011

Burden of Developmental and Intellectual Disabilities on Dual Eligible Beneficiaries

- Developmental disabilities (DD) **cause lifelong problems with how a body part or system works**.
  - Includes nervous system disabilities, sensory-related disabilities, metabolic disorders, and degenerative disorders
- Intellectual disabilities (ID) are a type of developmental disability characterized by impaired intellectual functioning and adaptive behaviors
  - Most common IDs are **Autism Spectrum Disorders, Down syndrome, Fragile X syndrome, and Fetal Alcohol Spectrum Disorder**.
  - Impact of the disability varies for each individual and by the disease.
  - Early diagnosis and treatment may decrease severity and improve outcomes.
  - Persons with IDs commonly **need services** such as case management, family caregiver supports, vocational programs, day programs, residential options, early intervention, special education, and transition services.
- Approximately 3.1% of all dual eligible beneficiaries have an ID, while **6.7% of dual beneficiaries age 18-64** have an ID.

National Institute of Child Health and Human Development

Profile: Beneficiary with ID/DD and Acquired Cognitive Impairment

- Samuel, 56 y/o male with Down Syndrome
- Lives with his elderly mother
- Increasing short-term memory loss
- Difficulty doing complex tasks requiring multiple steps
- Reduced interest in being sociable and enthusiasm for usual activities
- Diagnosis of early stages of dementia

State of Performance Measures for Behavioral Health

SAMHSA's National Behavioral Health Quality Framework

Purpose of the SAMHSA Framework

- Inform policy, measure program impact, and lead to improved quality of services and outcomes
- Provide leadership and coordination to the numerous efforts aimed at improving the quality of services for people with, or at risk of, behavioral health disorders
- SAMHSA's framework will assist MAP in selecting measures that align with national priorities

Priorities, Goals, and Opportunities for Success

Priority: Promote the most effective prevention, treatment, and recovery practices for behavioral health disorders

Goal: Prevent and reduce the harm caused by mental illness and addictions

Opportunities for Success:

- Reduce suicides
- Reduce underage drinking and problem drinking
- Reduce binge drinking
- Reduce illicit drug use
- Improve functioning
- Increase the number of individuals who achieve recovery goal of health, home, purpose, and community

Priorities, Goals, and Opportunities for Success

Priority: Assure behavioral health care is patient- and family-centered

Goal:

Structuring services in ways that meet individual and family needs and making patients centrally involved in decision-making about their care. Includes enhancing capacity to capture and act on patient-reported info, including:

- Preferences
- Desired outcomes
- Experiences with behavioral health care

Opportunities for Success:

- Integrate behavioral health consumer feedback on preferences and experiences of care into all care settings
- Increase use of electronic health records (EHRs) that capture the voice of the behavioral health consumer

Priorities, Goals, and Opportunities for Success

Priority: Encourage effective coordination within behavioral health care, and between behavioral health care and other health care and social support services

Goal: Create a less fragmented and more coordinated behavioral health care system, and improve coordination of this system with other health care and social support systems

Opportunities for Success:

- Reduce preventable behavioral health hospital admissions and readmissions
- Prevent and manage chronic illness and disability among behavioral health consumers
- Ensure secure information exchange to promote efficient behavioral health care delivery

Priorities, Goals, and Opportunities for Success

Priority: Assist communities to utilize best practices to enable healthy living

Goal: Support every U.S. community as it pursues local behavioral health priorities and support individuals in achieving recovery

Opportunities for Success:

- Increase the provision of preventive behavioral health services for children and adults
- Increase the adoption of evidence-based behavioral health interventions to improve public health

Priorities, Goals, and Opportunities for Success

Priority: Make behavioral health care safer by reducing harm caused in the delivery of care

Goal: Eliminate preventable and/or adverse behavioral health care induced consequences

Opportunities for Success:

- Reduce adverse medication events
- Eliminate abuse and neglect in psychiatric facilities

Priorities, Goals, and Opportunities for Success

Priorities: Foster affordable, high-quality behavioral health care for individuals, families, employers, and governments by developing and advancing new delivery models

Goal: Reduce behavioral health costs while improving service quality and efficiency for individuals, families, employers, and government

Opportunities for Success:

- Increase health insurance coverage
- Improve access to behavioral health care
- Reduce financial barriers to care

NQF's Behavioral Health Measure Endorsement Process

Behavioral Health Project Overview

- **About the Project**
  - Seeks to endorse measures of accountability for improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population, especially those with mental illness and substance abuse
  - Phase 1 began in November 2011; 10 measures were recommended for NQF endorsement
  - Phase 2 began in September 2012; 25 measures will be reviewed
  - A third phase is expected
- **NQF Process**
  - NQF's formal endorsement process is used by a Steering Committee; the Steering Committee represents a broad spectrum of healthcare stakeholders
  - Both new and maintenance measures are reviewed
  - Work is funded by HHS

Behavioral Health Project, Phase 1: Recommended Measures (10)

0004 - Initiation, Engagement of Alcohol and Other Drug Dependence Treatment*

0027 - Medical Assistance With Smoking and Tobacco Use Cessation

0028 - Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention*

1879 - Adherence to Antipsychotics for Individuals with Schizophrenia (combined w/1936 Continuity of Antipsychotic Medications for Treatment of Schizophrenia)

1932 - Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications

1927 - Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications

1933 - Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia

1934 - Diabetes monitoring for people with diabetes and schizophrenia

1937 - Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

0576 - Follow-Up After Hospitalization for Mental Illness*

(*) denotes MAP Duals Core Measure

Behavioral Health Project, Phase 2: Submitted Measures

- **Phase 2 measures will address the following topic areas:**
  - Alcohol Use (screening and brief intervention)
  - Drug Use (screening, offering treatment, follow-up)
  - Tobacco Use (screening, offering treatment, follow-up)
  - Medication Adherence
  - Depression and Major Depression (screening, plan for follow-up, suicide risk assessment, medication adherence and management, progress toward remission at 6 and 12 months)
  - Hospital-based Inpatient Psychiatric Services (HBIPS) (screening, inpatient, seclusion/restraint, discharge planning, post-discharge follow-up)
  - Change in behavioral health symptoms and functioning

Behavioral Health Project, Phase 1
Recommendations for Future Measure Development

The Steering Committee recognized gaps in measurement in the areas of:

- Screening for alcohol and drugs, specifically using tools such as Screening Brief Intervention and Referral to Treatment (SBIRT)
- Screening for post-traumatic stress disorder (PTSD) and bi-polar disorder in all patients diagnosed with depression, with an eye toward differentiating between the disorders

Issues in Developing Behavioral Health Measures

- Lack or inconclusiveness of evidence on appropriate care
- Clinical assessment and treatment practices not yet standardized and classified for use in administrative datasets (e.g., evidence-based psychotherapies)
- Outcome measurement not widely applied or standardized in spite of reliable and valid instruments ("measurement-based care")
- Risk adjustment less well developed and more complex
- Far behind in implementation of HIT (exclusion from HITECH)
- Insufficient resources and lack of stewardship for development of behavioral health measures

Themes Going Forward in Developing Behavioral Health Measures

- Measurement-Based Care
- Integration of Behavioral and General Health Care
- Shared Accountability
- Recovery- Based Care
- Linkage with Social Services and Education
- Quality of Care in Correctional Institutions
- Structural Measures for "Evidence-Based Behavioral Health Care Homes"

Issues In Developing Substance Use Measures

- Treatment practices not yet classified for use in administrative data sets, (e.g., CBT, MET despite solid evidence of effectiveness)
- Standardized assessment and brief interventions available but rarely applied
- Outcome measurement confused with system performance measurement and not well developed
- Assessment without measurement of follow-up
- Need for structural measures (e.g., medication management, information transfer)

Issues Going Forward for Measurement of Substance Use Disorders

- Application of substance use measures for high need subgroups such as frail elderly needs attention
- Implementation of HIT in treatment programs and among addiction specialty physicians is very low
- Identifying stewards for measures and resources to support the work
- Measures for screening, managing, and treating substance use in the context of treatment and management of other chronic conditions in primary care settings (e.g., asthma, hypertension, diabetes, sleep disorders)

Discussion

Are members aware of additional behavioral health frameworks to consult?

How can MAP's deliberations best inform the Steering Committee and vice versa?

Key Issues for Measurement

Proposed Key Issues: Quality of Life

Common Issues Across High-Need Subgroups	SMI	SUD	Dementia/Acquired Impairments	ID/DD
Preventing abuse and neglect (specifically in institutional settings) Maintaining or improving functional status Shared decision-making Respect for personal preferences	Improving personal independence and self-direction	Withdrawal management Maintaining or improving functional status Decision support/shared-decision making	Rehabilitation and redevelopment of functional skills Improving or maintaining personal independence and self-direction Social engagement and involvement in meaningful activities	Habilitation and development of key functional and personal skills Engagement and participation in healthy activities Improving or maintaining personal independence and self-direction Physical accessibility and mobility Maintaining or improving functional status

Proposed Key Issues: Care Coordination and Safety

Common Issues Across High-Need Subgroups	SMI	SUD	Dementia/Acquired Impairments	ID/DD
Avoidable admissions, readmissions, complications Person-centered care planning Care transitions, discharge planning Communication between providers Communication between providers and beneficiaries Cultural competence Medication management: access, appropriateness, reconciliation, adherence Adverse drug events	Use of physical restraints Suicide prevention	Suicide prevention	Use of physical restraints Advance care planning	Use of physical restraints

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Proposed Key Issues: Screening and Assessment

Common Issues Across High-Need Subgroups	SMI	SUD	Dementia/Acquired Impairments	ID/DD
Oral Health Nutrition and weight management New or worsening chronic conditions, especially cardiometabolic diseases	Broad screening for SMIs Screening for substance use and/or risky behaviors Preventative and cancer screenings Sexual and gynecologic health	Broad screening for substance use/abuse Screening individuals with SU for mental illness (e.g., schizophrenia) Sexual and gynecologic health	Broad screening for dementia Screening individuals with impairments for mental illness (e.g., depression) Cognitive functioning assessment Pain management Fall risk assessment	Functional status assessment Screening for SMIs Preventive cancer screening Sexual and gynecologic health

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Proposed Key Issues: Mental Health and Substance Use

Common Issues Across High-Need Subgroups	SMI	SUD	Dementia/Acquired Impairments	ID/DD
	Engagement and counseling Affective disorders (e.g., major depression, bipolar disorders) Schizophrenia Paranoid disorders Illicit drug use Tobacco and alcohol use	Engagement and counseling Tobacco and alcohol use Illicit drug use	Dementia Alzheimer's disease Tobacco and alcohol use	Screening for SMIs

Proposed Key Issues: Structural Measures

Common Issues Across High-Need Subgroups	SMI	SUD	Dementia/Acquired Impairments	ID/DD

- Access to needed services (e.g., health home, primary care, specialty care, dental care, vision care, durable medical equipment, habilitation, rehabilitation, occupational therapy, community mental health providers)
- Workforce adequacy, stability, and training
- Providers' linkages to community resources (e.g., special education, human services, transportation)
- Formal caregiver support
- Informal caregiver support
- Cultural competency
- Monitoring referrals

Strategy to Identify Measures for Behavioral Health Subgroups

- Scan NQF portfolio for relevant measures
- Consult external sources for relevant measures
- Match measures to high-leverage opportunity areas and key issues
- Consider alignment opportunities
- If a large volume of measures emerges, staff may perform initial prioritization to help target in-person discussion

Discussion

What edits should be made to the list of proposed key quality issues?

Are members aware of additional behavioral health sources of measures to consult?

Opportunity for Public Comment

Summary and Next Steps

May In-Person Meeting Objectives

- Dialogue with experts in quality measurement related to behavioral health issues
- Identify potential measures for use with high-need behavioral health subgroups
- Consolidate measures identified for high-need beneficiaries with Evolving Core Set to form a Family of Measures for dual eligible beneficiaries
- Finalize meeting themes and action items for HHS

Important Dates

- **May 21-22:** In-Person Meeting of Dual Eligible Beneficiaries Workgroup
- **June:** Workgroup review of preliminary findings on behavioral health subpopulations and the family of measures for dual eligible beneficiaries
- **July 13:** Findings due to HHS

Thank You!

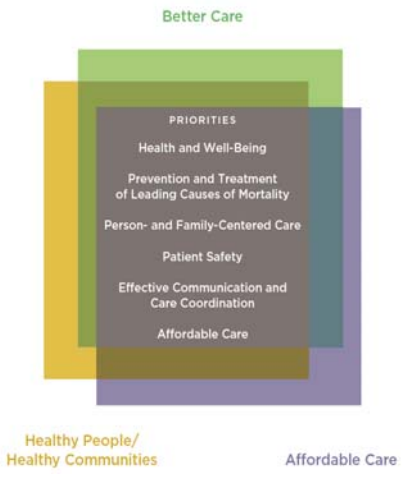
Reference Material

Workgroup Charge for 2012/2013

- Identify opportunities to improve measurement for dual eligible beneficiaries.
- Determine the most suitable performance measures currently available, concentrating on high-need subgroups to include:
  - Older adults with functional limitations and chronic conditions
  - Adults younger than 65 with physical disabilities
  - Individuals with serious mental illness
  - Individuals with cognitive impairment
- Document potential strategies to address measurement limitations.
- Delineate specific gaps in measures and available evidence to inform future measure development.
- Advise the Coordinating Committee on cross-cutting measurement issues and ensure alignment. These include MAP's strategic plan, families of measures, and pre-rulemaking input.

MAP Framework for Aligned Performance Measurement: National Quality Strategy

- Working with communities to promote wide use of best practices to **enable healthy living**
- Promoting the most effective **prevention and treatment practices** for the leading causes of mortality, starting with cardiovascular disease
- Ensuring that each **person and family are engaged** as partners in their care
- **Making care safer** by reducing harm caused in the delivery of care
- Promoting effective **communication and coordination** of care
- **Making quality care more affordable** for individuals, families, employers, and governments by developing and spreading new health care delivery models



Evolving Core Measure Set for Dual Eligible Beneficiaries

NQF Measure Number/Status	Measure Name
NQF 0004 Endorsed	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
NQF 0022 Endorsed	Use of High-Risk Medications in the Elderly
NQF 0028 Endorsed	Tobacco Use Assessment and Tobacco Cessation Intervention
NQF 0097 Endorsed	Medication Reconciliation
NQF 0101 Time-Limited Endorsement	Screening for Fall Risk
NQF 0209 Endorsed	Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment
NQF 0228 Endorsed	3-Item Care Transition Measure
NQF 0260 Endorsed	Assessment of Health-related Quality of Life [Physical and Mental Functioning]
NQF 0326 Endorsed	Advance Care Plan
NQF 0418 Endorsed	Screening for Clinical Depression
NQF 0420 Endorsed	Pain Assessment Prior to Initiation of Patient Therapy
NQF 0421 Endorsed	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
NQF 0430 Endorsed	Change in Daily Activity Function as Measured by the AM-PAC
NQF 0557 Endorsed	HBIPS-6 Post Discharge Continuing Care Plan Created
NQF 0558 Endorsed	HBIPS-7 Post Discharge Continuing Care Plan Transmitted to Next level of Care Provider Upon Discharge

Evolving Core Measure Set for Dual Eligible Beneficiaries

NQF Measure Number/Status	Measure Name
NQF 0576 Endorsed	Follow-up after Hospitalization for Mental Illness
NQF 0647 Endorsed	Transition Record with Specified Elements Received by Discharged Patients
NQF 0648 Endorsed	Timely Transmission of Transition Record
NQF 0729 Endorsed	Optimal Diabetes Care
NQF 1632 Endorsed	CARE – Consumer Assessments and Reports of End of Life
NQF 1626 Endorsed	Patients Admitted to ICU who Have Care Preferences Documented
NQF 1641 Endorsed	Hospice and Palliative Care – Treatment Preferences
NQF 1768 Endorsed	Plan All-Cause Readmissions
NQF 1789 Endorsed	Hospital-Wide All-Cause Unplanned Readmissions
NQF 1825 Endorsed	COPD – Management of Poorly Controlled COPD
NQF 1909 Endorsed	Medical Home System Survey
NQF 1919 Endorsed	Cultural Competency Implementation Measure
Multiple Surveys Endorsed	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys
Not Endorsed; to be added pending endorsement	Unhealthy Alcohol Use: Screening and Brief Counseling
Not Endorsed	SNP 6: Coordination of Medicare and Medicaid Coverage

High-Priority Measure Gaps

Goal-directed person-centered care planning/implementation
System structures to connect health system and long-term supports and services
Appropriate prescribing and comprehensive medication management
Screening for cognitive impairment, poor psychosocial health, and health literacy
Appropriateness of hospitalization (e.g., avoidable admission/readmission)
Optimal functioning (e.g., improving when possible, maintaining, managing decline)
Sense of control/autonomy/self-determination
Independent living skills
Appropriateness of care and care setting
Level of beneficiary assistance navigating Medicare/Medicaid
Utilization benchmarking (e.g., outpatient/ED/nursing facility)

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ENDORSEMENT SUMMARY:
Behavioral Health Measures

NOVEMBER 2012

Purpose of the Project

Behavioral health refers to a state of mental or emotional being and choices and actions that affect wellness, as defined by the Substance Abuse Mental Health Services Administration (SAMHSA). Behavioral health problems include substance abuse and misuse, alcohol and drug addiction, serious psychological distress, suicide, and mental and substance abuse disorders.

The World Health Organization estimates that more than 26 percent of the U.S. population suffers from mental illness and substance abuse. Within this group, six percent suffer from a serious mental illness. Many of these individuals – whose mental health status can dramatically impact how they engage with and respond to medical treatment – die 25 years earlier than the general population.[1]

Given these troubling statistics, SAMHSA is now working to advance the National Behavioral Health Quality Framework, aimed at establishing national priorities, goals, and opportunities for improving the delivery of behavioral health services, achieving better behavioral health outcomes, and improving the behavioral health of the U.S. population, especially for those with mental illnesses and substance abuse. It is an example of how the broader National Quality Strategy has been tailored within a topic area of healthcare. Quality measurement is an essential component of this effort.

NQF has previously endorsed performance measures related to behavioral health, specifically focused on mental health and substance abuse. In November 2011, NQF – at the request of the Department of Health and Human Services – began a two-phase project aimed at endorsing new behavioral health measures applicable to all care delivery settings – including primary and specialty care – and capable of advancing the tenets of SAMHSA's quality framework.

The resulting endorsed measures are an important step forward in improving behavioral health services and care throughout the country.

What Was Endorsed

Summary of Behavioral Endorsement Maintenance Measures Project

	Maintenance	New	Total
Measure submitted for consideration	4	18	22
Measures deferred	0	8	8
Measures withdrawn from consideration	0	3	3
Measures recommended for endorsement	4	6	10
Measures not recommended for endorsement	0	1	1

Under the behavioral health endorsement project, NQF endorsed 10 measures suitable for accountability and quality improvement. Of the 10 measures, four were previously endorsed and granted continued endorsement status, and six were newly submitted measures.

Measure stewards included a range of healthcare stakeholders, including the National Committee for Quality Assurance; the Physician Consortium for Performance Improvement, convened by the American Medical Association; and the Centers for Medicare & Medicaid Services. A full list of measures is available at the end of this report.

The Need these Measures Fill

This project sought to identify and endorse measures that specifically address behavioral health services for accountability and quality improvement. The resulting measures focus on a wide range of care processes and services, including medical treatment for individuals experiencing new episodes of alcohol or other drug dependence; oral antipsychotic medication adherence for individuals diagnosed with schizophrenia; diabetes and cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications; and post care follow-up rates for hospitalized individuals with mental illness.

NQF has previously endorsed a small number of behavioral health measures, yet many measurement gaps remained. These new measures will help fill some of those gaps and give the healthcare community a significant opportunity to learn how to improve care for those suffering from mental illness and substance abuse.

Potential Use

These measures are applicable for use in a range of clinical settings and providers, which will help improve behavioral health quality across the healthcare spectrum. Settings include acute care hospitals, outpatient facilities, and physician offices.

Project Perspectives

With more than a quarter of the U.S. population suffering from some form of mental illness or substance abuse, efforts to measure and report on behavioral health treatment are critically important, and have the potential to dramatically improve the health and well-being of millions of individuals in this country. These measures will be key to helping the healthcare community achieve this aim.

NQF volunteer expert steering committee members identified several measurement gaps – as well as measures that could be harmonized – during their deliberations. Gaps in measurement include screening for alcohol and drugs, as well as screening for post-traumatic stress disorder and bipolar disorder in all patients diagnosed with depression. The steering committee hopes to address these measures gaps in phase 2 of the project, slated to kick off soon.

The Centers for Medicare & Medicaid Services and the National Committee for Quality Assurance also worked together and successfully harmonized measures #1879 and #1936, focused on medication adherence for schizophrenic individuals and antipsychotic medication continuity for schizophrenia treatment, respectively. The committee also recommended that measure #1932 be harmonized with existing measure #0003 within the next 12 months, given their shared focus on diabetes screening for individuals with schizophrenia and bipolar disorder. These harmonized measures will help ease reporting burdens on providers.

Endorsed Measures

0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA)

Description: The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who received the following:

- Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.
- Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

0027: Medical Assistance With Smoking and Tobacco Use Cessation (NCQA)

Description: Assesses different facets of providing medical assistance with smoking and tobacco use cessation:

- Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who received advice to quit during the measurement year.
- Discussing Cessation Medications: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year.

- Discussing Cessation Strategies: A rolling average represents the percentage of members 18 years of age and older who were current smokers or tobacco users and who discussed or were provided smoking cessation methods or strategies during the measurement year.

0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (AMA-PCPI)

Description: Percentage of patients aged 18 years and older who were screened for tobacco use at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user.

1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS)

Description: The measure calculates the percentage of individuals 18 years of age or greater with schizophrenia who are prescribed an oral antipsychotic medication, with adherence to the antipsychotic medication [defined as a Proportion of Days Covered (PDC) of at least 0.8 during the measurement period (12 consecutive months).

1932: Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA)

Description: The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder, who were prescribed any antipsychotic medication, and who received a diabetes screening during the measurement year.

1927: Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (NCQA)

Description: The percentage of individuals 25 – 64 years of age with schizophrenia or bipolar disorder who were prescribed any antipsychotic medication who received a cardiovascular health screening during the measurement year.

1933: Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia (SMC) (NCQA)

Description: The percentage of individuals 25 – 64 years of age with a schizophrenia diagnosis and a diagnosis of cardiovascular disease who received a cardiovascular health monitoring test (LDL-C) during the measurement year.

1934: Diabetes monitoring for people with diabetes and schizophrenia (NCQA)

Description: The percentage of individuals 25 – 64 years of age with schizophrenia and diabetes who received diabetes monitoring as specified by an HbA1c test and LDL-C test during the measurement year.

1937: Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)

Description: The percentage of discharges for individuals 25 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

- The percentage of individuals who received follow-up within 30 days of discharge
- The percentage of individuals who received follow-up within 7 days of discharge

0576: Follow-Up After Hospitalization for Mental Illness (NCQA)

Description: This measure assesses the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported:

Rate 1: The percentage of members who received follow-up within 30 days of discharge.

Rate 2: The percentage of members who received follow-up within 7 days of discharge.

Endnotes

1. Parks J, Radke A, Mazade NA, Measurement of Health Status for People with Serious Mental Illness. Alexandria, VA :National Association of State Mental Health Program Directors; 2008. Available at www.nasmhpd.org/general_files/publications/med_directors_pubs/NASMHPD%20Medical%20Directors%20Health%20Indicators%20Report%2011-19-08.pdf. Last accessed October 2011.

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
0103	Major Depressive Disorder (MDD): Diagnostic Evaluation	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period	AMA-PCPI
0104	Major Depressive Disorder (MDD): Suicide Risk Assessment	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period	AMA-PCPI
0105	Antidepressant Medication Management	The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported. a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks). b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).	NCQA
0418	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for clinical depression on the date of encounter using an age appropriate standardized depression screening tool AND, if positive, a follow-up plan is documented on the date of the positive screen.	CMS / Quality Insights of PA
0518	Depression Assessment Conducted	Percent of patients who were screened for depression (using a standardized depression screening tool) at start or resumption of home health care	CMS/Acumen

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
0552	HBIPS-4 Patients discharged on multiple antipsychotic medications	Patients discharged on multiple antipsychotic medications overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-5: Patients discharged on multiple antipsychotic medications with appropriate justification.	The Joint Commision
0557	HBIPS-6 Post discharge continuing care plan created	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan created overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-7: Post discharge continuing care plan transmitted to next level of care provider upon discharge.	The Joint Commision
0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Patients discharged from a hospital-based inpatient psychiatric setting with a continuing care plan provided to the next level of care clinician or entity overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-6: Post discharge continuing care plan created.	The Joint Commision
0560	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	Patients discharged from a hospital-based inpatient psychiatric setting on two or more antipsychotic medications with appropriate justification overall and stratified by age groups: Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years). Note: this is a paired measure with HBIPS-4: Patients discharged on multiple antipsychotic medications.	The Joint Commision

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
0640	HBIPS-2 Hours of physical restraint use	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint per 1000 psychiatric inpatient hours, overall and stratified by age groups: : Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	The Joint Commision
0641	HBIPS-3 Hours of seclusion use	The number of hours that all patients admitted to a hospital-based inpatient psychiatric setting were held in seclusion per 1000 psychiatric inpatient hours, overall and stratified by age groups:Children (Age 1 through 12 years), Adolescents (Age 13 through 17 years), Adults (Age 18 through 64 years), Older Adults (Age greater than and equal to 65 years).	The Joint Commision
1651	TOB-1 Tobacco Use Screening	Hospitalized patients age 18 years and older who are screened during the hospital stay for tobacco use (cigarettes, smokeless tobacco, pipe and cigars) within the past 30 days. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-2 Tobacco Use Treatment Provided or Offered (during the hospital stay); TOB-3 Tobacco Use Treatment Provided or offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)	The Joint Commision
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom tobacco use treatment was provided during the hospital stay, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment during the hospital stay. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-3 Tobacco Use Treatment Provided or Offered at Discharge; TOB-4 Tobacco Use: Assessing Status After Discharge.)	The Joint Commision

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age an older to whom tobacco use treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received tobacco use treatment at discharge. Treatment at discharge includes a referral to outpatient counseling and a prescription for one of the FDA-approved tobacco cessation medications. Refer to section 2a1.10 Stratification Details/Variables for the rationale for the addition of the subset measure. These measures are intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB 2 Tobacco Use Treatment Provided or Offered During the Hospital Stay; TOB-4 Tobacco Use: Assessing Status After Discharge).	The Joint Commision
1657	TOB-4 Tobacco Use: Assessing Status after Discharge	Hospitalized patients 18 years of age and older who are identified through the screening process as having used tobacco products (cigarettes, smokeless tobacco, pipe, and cigars) within the past 30 days who are contacted between 15 and 30 days after hospital discharge and follow-up information regarding tobacco use status is collected. This measure is intended to be used as part of a set of 4 linked measures addressing Tobacco Use (TOB-1 Tobacco Use Screening; TOB-2 Tobacco Use Treatment Provided or Offered (during hospital stay); TOB-3 Tobacco Use Treatment Provided or Offered at Discharge.	The Joint Commision
1661	SUB-1 Alcohol Use Screening	Hospitalized patients 18 years of age and older who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).	The Joint Commision

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom a brief intervention was provided, or offered and refused, and a second rate, a subset of the first, which includes only those patients who received a brief intervention. The Provided or Offered rate (SUB-2), describes patients who screened positive for unhealthy alcohol use who received or refused a brief intervention during the hospital stay. The Alcohol Use Brief Intervention (SUB-2a) rate describes only those who received the brief intervention during the hospital stay. Those who refused are not included. These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).	The Joint Commision

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
1664	SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge	The measure is reported as an overall rate which includes all hospitalized patients 18 years of age and older to whom alcohol or drug use disorder treatment was provided, or offered and refused, at the time of hospital discharge, and a second rate, a subset of the first, which includes only those patients who received alcohol or drug use disorder treatment at discharge. The Provided or Offered rate (SUB-3) describes patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. The Alcohol and Other Drug Disorder Treatment at Discharge (SUB-3a) rate describes only those who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment. Those who refused are not included. These measures are intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1 Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).	The Joint Commision
1665	SUB-4 Alcohol & Drug Use: Assessing Status After Discharge	Hospitalized patients age 18 years and older who screened positive for unhealthy alcohol use or who received a diagnosis of alcohol or drug disorder during their inpatient stay, who are contacted between 7 and 30 days after hospital discharge and follow-up information regarding their alcohol or drug use status post discharge is collected. This measure is intended to be used as part of a set of 4 linked measures addressing Substance Use (SUB-1) Alcohol Use Screening ; SUB-2 Alcohol Use Brief Intervention Provided or Offered; SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; SUB-4 Alcohol and Drug Use: Assessing Status after Discharge).	The Joint Commision

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder	The measure calculates the percentage of individuals 18 years of age or greater as of the beginning of the measurement period with bipolar I disorder who are prescribed a mood stabilizer medication, with adherence to the mood stabilizer medication [defined as a Proportion of Days Covered (PDC)] of at least 0.8 during the measurement period (12 consecutive months).	CMS/ FMQAI
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 > 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.	MN Community Measurement
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 > 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.	MN Community Measurement
1922	HBIPS-1 Admission Screening	The proportion of patients admitted to a hospital-based inpatient psychiatric setting who are screened within the first three days of hospitalization for all of the following: risk of violence to self or others, substance use, psychological trauma history and patient strengths. This measure is a part of a set of seven nationally implemented measures that address hospital-based inpatient psychiatric services (HBIPS-2: Physical Restraint, HBIPS-3: Seclusion, HBIPS-4: Multiple Antipsychotic Medications at Discharge, HBIPS-5: Multiple Antipsychotic Medications at Discharge with Appropriate Justification, HBIPS-6: Post Discharge Continuing Care Plan and HBIPS-7: Post Discharge Continuing Care Plan Transmitted) that are used in The Joint Commission's accreditation process.	The Joint Commision

NQF Behavioral Health Project
Phase II Submitted Measures

Measure #	Title	Description	Developer
1923	Severity-adjusted Effect Size Measure for Adult Behavioral Health Symptoms and Functioning	This measure estimates a Severity-Adjusted Effect Size (SAES) of change in behavioral health symptoms and functioning among adult patients (18 years and older) receiving outpatient behavioral health services. The SAES is estimated for behavioral health providers ('provider' refers to individual behavioral health clinicians or group practices). The SAES is derived through four steps: 1. Change in behavioral health symptoms and functioning is measured using the Global Distress Scale (GDS) of the Wellness Assessment (WA) during an episode of outpatient behavioral health treatment. The WA is administered to adult patients at the onset of behavioral health treatment episode ("baseline") and at least once more within six months ("follow-up"). A treatment episode change score is calculated by subtracting the baseline GDS score from the follow-up GDS score. 2. The treatment episode change score is then severity-adjusted using general linear modeling to account for the patients' clinical characteristics. To derive the residualized change score, the actual change score is subtracted from severity-adjusted change score. 3. A population effect size is calculated and then added to each episode's residualized effect size. This represents the episode-level severity-adjusted effect size. 4. Hierarchical linear modeling (HLM) is used to create a provider-level Severity Adjusted Effect Size (SAES) and associated confidence interval.	Optum Health
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method AND who received brief counseling if identified as an unhealthy alcohol user	AMA-PCPI

Proposed Key Issues for Measurement in High-Need Subgroups of Dual Eligible Beneficiaries: Serious Mental Illness (SMI), Substance Use Disorder (SUD), Dementia and Other Acquired Impairments, and Intellectual/Developmental Disabilities (ID/DD)

High-Leverage Opportunities	Common Issues Across High-Need Subgroups	Serious Mental Illness	Substance Use Disorders	Dementia/Acquired Impairments	Intellectual and Developmental Disabilities
Quality of Life	**Preventing abuse and neglect (specifically in institutional settings)** **Maintaining or improving functional status** **Shared decision- making** **Respect for personal preferences**	Improving personal independence and self-direction	Withdrawal management Maintaining or improving functional status Decision support/shared-decision making	Rehabilitation and redevelopment of functional skills Improving or maintaining personal independence and self-direction Social engagement and involvement in meaningful activities	Habilitation and development of key functional and personal skills Engagement and participation in healthy activities Improving or maintaining personal independence and self-direction Physical accessibility and mobility Maintaining or improving functional status
Care Coordination and Safety	**Avoidable admissions, readmissions, complications** **Person-centered care planning** **Care transitions, discharge planning** **Communication between providers** **Communication between providers and beneficiaries** **Cultural competence** **Medication management: access, appropriateness, reconciliation, adherence** **Adverse drug events**	Use of physical restraints Suicide prevention	Suicide prevention	Use of physical restraints Advance care planning	Use of physical restraints

Proposed Key Issues for Measurement in High-Need Subgroups of Dual Eligible Beneficiaries: Serious Mental Illness (SMI), Substance Use Disorder (SUD), Dementia and Other Acquired Impairments, and Intellectual/Developmental Disabilities (ID/DD)

High-Leverage Opportunities	Common Issues Across High-Need Subgroups	Serious Mental Illness	Substance Use Disorders	Dementia/Acquired Impairments	Intellectual and Developmental Disabilities
Screening and Assessment	**Oral Health** **Nutrition and weight management** **New or worsening chronic conditions, especially cardio-metabolic diseases**	Broad screening for SMIs Screening for substance use and/or risky behaviors Preventative and cancer screenings Sexual and gynecologic health	Broad screening for substance use/abuse Screening individuals with SU for mental illness (e.g., schizophrenia) Sexual and gynecologic health	Broad screening for dementia Screening individuals with impairments for mental illness (e.g., depression) Cognitive functioning assessment Pain management Fall risk assessment	Functional status assessment Screening for SMIs Preventive cancer screening Sexual and gynecologic health
Mental Health and Substance Use		Engagement and counseling Affective disorders (e.g., major depression, bipolar disorders) Schizophrenia Paranoid disorders Illicit drug use Tobacco and alcohol use	Engagement and counseling Tobacco and alcohol use Illicit drug use	Dementia Alzheimer's disease Tobacco and alcohol use	Screening for SMIs
Structural Measures	**Access to needed services (e.g., health home, primary care, specialty care, dental care, vision care, durable medical equipment, habilitation, rehabilitation, occupational therapy, community mental health providers)** **Workforce adequacy, stability, and training** **Providers' linkages to community resources (e.g., special education, human services, transportation)** **Formal caregiver support** **Informal caregiver support** **Cultural competency** **Monitoring referrals**				