NATIONAL QUALITY FORUM

Memo

TO: Behavioral Health Standing Committee

FR: NQF Staff

RE: Post-Comment Call to Discuss Public and Member Comments

DA: January 2, 2015

Background

In the United States, it is estimated that approximately 26.4 percent of the population suffers from a diagnosable mental disorder.[1] These disorders – which can include serious mental illnesses, substance use disorders, and depression – are associated with poor health outcomes, increased costs, and premature death.[2] Although general behavioral health disorders are widespread, the burden of serious mental illness is concentrated in about six percent of the population.[3] In addition, many people suffer from more than one mental disorder at any given time; nearly half of those suffering from one mental illness meet the criteria for at least two more.[4] By 2020, behavioral health disorders are expected to surpass all physical diseases as the leading cause of disability worldwide.[5]

In 2012, NQF endorsed 10 behavioral health measures in the areas of tobacco and alcohol use, medication adherence, diabetes health screening and assessment, and hospitalization follow-up. A subsequent phase of work recommended 20 measures for endorsement in the areas of: tobacco and alcohol use, depression screening, medication adherence, and hospital-based inpatient psychiatric services. These recommendations were put forth for public comment in September, 2013; the project was completed by March of 2014. In the third phase of the behavioral health work, the 24 Standing Committee members recommended 16 out of 18 measures for endorsement, deferred 1 measure and approved for trial use 1 measure. These measures were open for comment from November 10, 2014 to December 12, 2014.

Purpose of the Call

The Behavioral Health Standing Committee will meet via conference call on January 8, 2015 from 2:00pm to 4:00pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.

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[1] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

[2] Kilbourne, A., Keyser, D., & Pincus, H. (2010). Challenges and opportunities in measuring the quality of mental health care. *Canadian Journal of Psychiatry*, *55*(9), 549-557.

[3] Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, 2005 Jun;62(6):617-27.

[4] Ibid.

[5] Department of Health and Human Services, Department of Mental Health and Substance Abuse. (2011). Leading change: a plan for SAMPHSA'S roles and actions 2011-2014 (1104692). Washington, D.C.

- Determine whether reconsideration of any measures or other courses of action is warranted.
- Discuss Related and Competing Measures.

Due to time constraints, during this call we will review comments by exception, in the case the Committee disagrees with the proposed responses.

Standing Committee Actions

1. Review this briefing memo and Draft Report
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments.
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.

Conference Call Information

Please use the following information to access the conference call line and webinar:

Speaker dial-in #: 1 (877) 829-9898
Web Link: http://nqf.commpartners.com/se/Rd/Mt.aspx?841967
Registration Link: http://nqf.commpartners.com/se/Rd/Rg.aspx?841967

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from August 21-September 10, 2014 for 14 of the 19 measures under review. A total of nine pre-evaluation comments were received, the majority of which pertained to creating a composite of the Diabetes Care for People with Serious Mental Illness measures. All of these pre-evaluation comments were provided to the Committee prior to their initial deliberations held during the workgroups calls and in-person meeting.

Post-evaluation comments

After the workgroup calls and in-person meeting, NQF staff prepared a report of the proceedings which captured the discussions of the Standing Committee during evaluations, the comments received to date and where the developers have provided any additional information. The Draft Report went out for Public and Member comment November 10, 2014 to December 12, 2014. During this commenting period, NQF received 58 comments from 12 organizations (two of which were members):

Consumers – 0	Professional – 0
Purchasers – 0	Health Plans – 1
Providers – 1	QMRI – 0

Supplier and Industry – 0 Public & Community Health - 0

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

Two major themes were identified in the post-evaluation comments, as follows:

1. Stratifying Subpopulations in Current Diabetes Measures
2. Reconsider 0722: Pediatric Symptom Checklist (PSC)

Theme 1 - Stratifying Subpopulations in Current Diabetes Measures

Two commenters expressed concerns the SMI subpopulation is being captured in existing measures already, and adding a subset will increase the burden of data collection and lessen room for quality improvement activities. They urged the committee to recommend that the subpopulation measures be stratified into the current measures before endorsement

Developer Response:

Thank you. We agree that some measures are amenable to stratification by different factors including chronic conditions, such as serious mental illness. However, these conditions often do not have sufficient sample size in most measures to draw attention to known disparities in care and identify successful efforts to improve quality and accountability. Our panels recommended that a stand-alone measure of eye screening for diabetic retinal eye disease adapted from a related measure was the best approach for this population. We differ in the viewpoint that adding a separate measure focused on the vulnerable SMI population lessens room for quality improvement activities, and suggest that this approach actually opens the door for these QI activities and related accountability.

Proposed Committee Response:

During their deliberations, the committee discussed the possible data collection burden of endorsing these measures. The committee agreed that the measures focus on a high risk subpopulation of people with serious mental illness who have a higher risk of diabetes and for whom there is evidence of disparity in treatment compared to the general population. Additionally, the measures were adapted from existing measures

and use a "hybrid" data collection (administrative data combined with chart review) method. The committee recommended the developers take action to reduce burden as much as possible.

Theme 2 – Reconsider 0722: Pediatric Symptom Checklist (PSC)

One commenter encouraged the committee to allow the measure developer to refine and resubmit this measure. If the measure is not recommended, the measure will lose endorsement and will not be able to resubmit until another Behavioral Health or related project is slated to begin. If the measure is deferred, the developer will be able to retain endorsement until a new project is slated to start. The measure previously received endorsement in 2013.

Committee Action:

Does the Committee wish to re-vote on the measure (and therefore potentially change the overall recommendation from "Do Not Recommend" to deferred)?

Measure Specific Comments

0108: Follow-Up Care for Children Prescribed ADHD Medication (ADD)

One commenter felt the 30-day follow-up timeframe was too prescriptive and would not allow for the clinical judgment of the physician when determining the frequency of follow-up care.

Developer Response:

Thank you. The AACAP clinical guidelines recommend early and ongoing monitoring for potential side effects and response to treatment when a child is on ADHD medication. NCQA's Behavioral Health Measurement Advisory Panel considered the timeframe for the measure to be reasonable and consistent with the principles of the guidelines. We agree that treating clinicians should determine the frequency of follow-up care for each patient. However, the measure establishes minimum necessary expectations for monitoring and follow-up care.

Proposed Committee Response:

During their deliberations, the Committee acknowledged that the evidence supporting the 30-day timeframe and its linkage to improved outcomes was indirect, however, agreed with the developer that the 30-day follow up period worked best in balancing when it was most possible to get children seen, and allowing the claims system to process the claim.

1365: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

One commenter expressed concerns regarding the validity of the measure specifying one screening tool for treatment and encouraged that the developer allow more flexibility by allowing multiple approved screens. The Committee did not reach consensus on the validity of the measure during their deliberations.

Developer Response:

The PCPI appreciates the concerns raised regarding validity for this measure. To address this concern, we will revise the numerator definition to provide clarity around the

intent of the measure. The revised definition (pending review of clinical content expert) is as follows: "The specific type and magnitude of the suicide risk assessment is intended to be at the discretion of the individual clinician and should be specific to the needs of the patient. At a minimum, suicide risk assessment should evaluate:
1. Risk (eg, age, sex, stressors, comorbid conditions, hopelessness, impulsivity) and protective factors (eg, religious belief, concern not to hurt family) that may influence the desire to attempt suicide.
2. Current severity of suicidality.
3. Most severe point of suicidality in episode and lifetime.

Low burden tools to track suicidal ideation and behavior such as the Columbia-Suicidal Severity Rating Scale can also be used."

We hope that the by delineating minimum criteria to be included in a risk assessment and providing an example of a tool that would meet the measure, there will be less variability in how these assessments are performed and captured.

Proposed Committee Response:

Response pending discussion during post-comment call.

Harmonization Discussion

Related and Competing: Depression Remission

Measure Number	Title	Steward
0710	Depression Remission at 12 Months	MN Community Measurement
0711	Depression Remission at 6 Months	MN Community Measurement

Measures #0710 Depression Remission at 12 Months and #0711 Depression Remission at 6 months are completely harmonized in that they have the same denominator and exclusion definitions, same methodology for rate calculation and the same risk adjustment model. These measures are identical with the exception that they are measuring the outcome of remission at two different points, first at six months and then at twelve months, following the index event (combination of diagnosis and elevated PHQ-9 > 9). These measures, developed in concert with the ICSI DIAMOND collaborative care model, complement each other in demonstrating effective treatment strategies and then sustaining that improvement at one year.

Related and Competing: Screening for Alcohol, Tobacco and Substance Use

Measure Number	Title	Steward
2597	Substance Use Screening and Intervention Composite	American Society of Addiction Medicine

2599	Alcohol Screening and Follow-up for People with Serious Mental Illness	National Committee for Quality Assurance
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence	National Committee for Quality Assurance

NCQA Response:

NQF has requested that NCQA report on opportunities for harmonizing two measures, NCQA's Alcohol Screening for People with Serious Mental Illness (NQF #2599) and Tobacco Use Screening for People with Serious Mental Illness or Alcohol or Other Drug Dependence with ASAM's Substance Use Screening & Intervention Composite (NQF #2597) and M3's Multidimensional Mental Health Screening Assessment measure (NQF #2620) *(This measure has been deferred and will not be discussed now).* NCQA's measures were intentionally designed to harmonize to the extent possible with existing NQF-endorsed measures for alcohol and tobacco screening (NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling and NQF #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention).

NCQA first learned of these new ASAM and M3 measures in late summer 2014. Key differences exist in the denominator (population focus), numerator (measure focus), level of accountability (reporting level), data source, measurement period and exclusions. At this late stage of development, NCQA is open to recommendations for future alignment and harmonization, where possible, with these related measures.

Denominator and population focus: NCQA's measures focus on people with serious mental illness and alcohol or other drug dependence while the M3 and the ASAM measure focus on the general population.

Numerator and measure focus: NCQA's measures focus on screening for tobacco and alcohol use for a subpopulation with serious mental illness or alcohol or other drug dependence. The alcohol screening and follow-up measure captures alcohol use screening during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and receiving two events of counseling within 3 months if identified as an unhealthy alcohol user. The tobacco screening and follow-up measure captures screening any time during the year prior to the measurement year or during the first 9 months of the measurement year and two events of services within 3 months of screening if identified as a tobacco user. The Multidimensional Mental Health Screening Assessment measure screens for the presence or risk of psychiatric and substance abuse disorders. The ASAM Substance Use Screening & Intervention Composite measure screens for tobacco, alcohol, and drug use and one intervention event.

Reporting level: NCQA's measures are reported by health plans while the ASAM and M3 measures are reported at the provider level. At the health plan level, there is the opportunity and the responsibility not only to capture screening, but also follow-up care beyond the visit.

Data source: NCQA's measures use claims data for the denominator and medical records and claims for the numerator. The M3 and ASAM measures use patient-reported/survey and EHR data, respectively.

Measurement period: NCQA's alcohol measure captures alcohol use screening during the last 3 months of the year prior to the measurement year through the first 9 months of the measurement year and receiving two events of counseling within three months of screening if identified as an unhealthy alcohol user. These time windows are considered critical by our stakeholders for this population in order for them to get care in a timely fashion once screened positive. NCQA's tobacco measure captures screening during the year prior to the measurement year to the first 9 months of the measurement year and two events of services within 3 months of screening if identified as a tobacco user. M3's measure captures the assessment at least once during the calendar year. The ASAM's measure requires screening at least once during the past 24 months and receiving an intervention for all positive screening results.

Exclusions: NCQA's alcohol screening and follow-up measure focus on a new event and therefore excludes an active diagnosis of alcohol abuse or dependence during the first nine months of the year prior to the measurement year. There are no exclusions for NCQA's tobacco screening and follow-up measure. ASAM's measure has exception for patients with documented medical reasons for not doing screening. The M3 measure excludes patients who have not turned 18 years of age during the measurement year.