Behavioral Health 2016-2017

TECHNICAL REPORT

August 28, 2017

This report is funded by the Department of Health and Human Services under contract HHSM-500-2012-00009I Task Order HHSM-500-T0008.

NATIONAL QUALITY FORUM

Contents

Behavioral Health 2016-2017

TECHNICAL REPORT

Executive Summary

Mental illness and substance use disorders are leading causes of disability and premature mortality in the United States. Access to quality behavioral healthcare is thus essential to leading a healthy, productive life. Given that one in five American adults experience a mental illness in a given year, performance measurement in this area needs to remain operational and current.

This report is the fourth in a series of reports describing the National Quality Forum's (NQF) measure evaluation projects for behavioral health measures. The background and description of the project and overview of NQF's behavioral health portfolio are available on NQF's project webpage. The multiphase project aims to endorse measures of accountability for improving the delivery of behavioral health services and achieving better behavioral health outcomes for the U.S. population. Project phase 4, detailed in this report, examines measures of tobacco use, alcohol and substance use, attention deficit hyperactivity disorder (ADHD), depression, medication continuation and reconciliation, and follow-up after hospitalization for mental illness.

For this project, the Standing Committee evaluated seven newly submitted measures and six measures undergoing maintenance review against NQF's standard evaluation criteria. Nine measures were recommended for endorsement, three were not recommended, and one was deferred. The Standing Committee endorsed the following nine measures:

- 0027 Medical Assistance with Smoking and Tobacco Use Cessation (NCQA)
- 0576 Follow-Up After Hospitalization for Mental Illness (NCQA)
- 3132 Preventive Care & Screening: Screening for Clinical Depression and Follow-Up Plan (eMeasure) (CMS)
- 3148 Preventive Care & Screening: Screening for Clinical Depression and Follow-Up Plan (CMS)
- 3175 Continuity of Pharmacotherapy for Opioid Use Disorder (RAND Corporation)
- 3205 Medication Continuation Following Inpatient Psychiatric Discharge (Health Services Advisory Group, Inc.)
- 3185 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (eMeasure) (PCPI Foundation)
- 3225 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (PCPI Foundation)
- 0108 Follow-Up Care for Children Prescribed ADHD Medication (NCQA)

The Committee did not recommend the following measures:

- 3172 Continuity of Pharmacotherapy for Alcohol Use Disorder (RAND Corporation)
- 3207 Medication Reconciliation on Admission (Health Services Advisory Group, Inc.)

- 3229 Patient Panel Adult Smoking Prevalence (CMS)

The Committee deferred an endorsement decision on the following measure:

- 0008 Experience of Care and Health Outcomes (ECHO) Survey (AHRQ)

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

Introduction

Behavioral healthcare refers to a continuum of services for individuals at risk of—or suffering from—mental, behavioral, or addictive disorders ranging from mood and anxiety disorders to substance use disorders to post-traumatic stress disorder. In the United States, approximately 43.8 million (18.5 percent) of the population experiences a mental illness in a given year.[1] In addition, 20.2 million U.S. adults had a substance use disorder of which 50.5 percent had both a mental and substance use disorder, also known as a co-occurring disorder.[2]

Behavioral health continues to be a leading cause of disabilities that contribute to rising healthcare expenditure, and this costs employers billions of dollars each year. The U.S. national expenditure for mental healthcare in 2013 was $201 billion, and that number is expected to continue rising.[3] Combining that number with updated projections of lost earnings and public disability insurance payments associated with mental illness, an estimate for the full financial cost of mental disorders in the United States in 2012 was at least $467 billion.[4]

While many of the illnesses and disorders that fall under the behavioral health umbrella are often chronic, people can and do recover when provided with timely, high-quality, coordinated, and evidence-based care. For example, the treatment success rate for bipolar disorder and major depression is 80 percent, and 60 percent for schizophrenia.[5] Proper screening and assessment of populations at risk, consistent evaluation and management of illnesses, and ongoing care has the potential to change recovery trajectories over time. Improving quality measures and shifting towards a culture of measurement-based care enhance the quality and, ultimately, the outcomes of behavioral health services.

NQF Portfolio of Performance Measures for Behavioral Health

The Behavioral Health Standing Committee (see Appendix D) oversees NQF's portfolio of behavioral health measures. Measures in this portfolio address tobacco, alcohol, and substance use; depression, major depressive disorders (MDD), schizophrenia, and bipolar disorders; health screening and assessment for those with serious mental illness; attention deficit hyperactivity disorder (ADHD); safe and appropriate inpatient psychiatric care; and follow-up after hospitalization (see Appendix B). As shown in Table 1, these measures fit into the care trajectory and address populations at risk (phase 1), evaluation and initial diagnosis (phase 2), and follow-up care (phase 3). This portfolio contains 54 measures: 42 process measures, 11 outcome and resource use measures, and one structure measure.

Table 1. NQF Behavioral Health Portfolio of Measures

	Process	Outcome/Resource Use	Structure
Phase 1: Population at risk	10	0	1
Spans between phase 1 & 2	8	0	0
Phase 2: Evaluation & initial management	10	0	0
Spans between phase 2 & 3	2	0	0
Phase 3: Follow-up care	12	11	0
Total	**42**	**11**	**1**

Additional measures related to behavioral health are assigned to other projects including Person and Family Centered Care, Pediatrics, Cardiovascular, and Neurology.

National Quality Strategy

NQF-endorsed measures for behavioral health support the National Quality Strategy (NQS). The NQS serves as the overarching framework for guiding and aligning public and private efforts across all levels (local, state, and national) to improve the quality of healthcare in the United States. The NQS establishes the "triple aim" of better care, affordable care, and healthy people/communities and focuses on six priorities to achieve those aims: *Safety, Person and Family Centered Care, Communication and Care Coordination, Effective Prevention and Treatment of Illness, Best Practices for Healthy Living, and Affordable Care.*

Quality measures for behavioral health align with several of the NQS priorities, including:

- **Making care safer by reducing harm caused in the delivery of care.** Poor medication adherence, which is common among patients with severe mental illness, leads to poor health outcomes and increased healthcare costs. Many barriers to adherence exist, including patient and family attitudes, treatment-related issues, health-system factors, cultural influences, and stigma. Ensuring that patients are adhering to their medications is an important role that providers must play in order to promote better health outcomes. Several measures in the behavioral health portfolio focus on medication adherence, continuation, and follow-up to treatment.
- **Promoting effective communication and coordination of care.** Effective communication among patients, families, and providers ensures that the needs and care preferences of the patient and family are recognized. Communication and coordination among providers is also important, as behavioral health spans across multiple providers and settings. Effective communication and coordination among these providers increases the likelihood of alignment between care preferences and care delivery.
- **Working with communities to promote wide use of best practices to enable healthy living.** Promoting healthy habits through better access to healthcare or by employing preventive healthcare measures is imperative to creating healthy communities. Early screening and detection can not only prevent illnesses, but can also identify them at earlier and more treatable

stages. Several measures in the behavioral health portfolio focus on tobacco use screening and cessation, screening for clinical depression, and screening for alcohol use.

Use of Measures in the Portfolio

Endorsement of measures by NQF is valued not only because of the rigorous and transparent evaluation process, but also because evaluations are conducted by multistakeholder committees, which comprise clinicians and other experts from the full range of healthcare providers, employers, health plans, public agencies, community coalitions, and patients—many of whom use measures on a daily basis. Moreover, NQF-endorsed measures undergo routine "maintenance" (i.e., re-evaluation) to ensure that they are still the best-available measures and reflect the current science. Importantly, federal law requires that preference be given to NQF-endorsed measures for use in federal public reporting and performance-based payment programs. NQF measures also are used by a variety of stakeholders in the private sector, including hospitals, health plans, and communities.

Many of the measures in the behavioral health portfolio are used in at least one federal program, such as the Medicare Shared Savings Program, Home Health Quality Reporting, Inpatient Psychiatric Hospital Quality Reporting, and the Physician Quality Reporting System. In addition, some of these measures are used as part of state, regional, and community measurement initiatives. See Appendix C for details of federal program use for the measures in the portfolio.

Improving NQF's Behavioral Health Portfolio

Committee Input on Gaps in the Portfolio

Although the number of new measures submitted for endorsement has continued to grow, measure gaps remain in specific focus areas that individuals, families, and the broader healthcare community may value. During its discussions, the Committee identified numerous areas where additional measure development is needed, including:

- Outcome measures for psychotic disorders, including schizophrenia
- Overprescription of opiates
- Setting-specific measures (e.g., jails)
- Proximal outcome measures
- Measures specific to child and adolescent behavioral health needs
- Measures that encompass multiple settings to better assist in the push towards integrated behavioral health and physical health
- Measures that focus on substance use disorders in the primary care setting
- Composite measures that incorporate myriad mental illnesses (e.g., bipolar disorder, depression, and schizophrenia) rather than separate screening measures for each illness
- Patient-reported outcome measures
- Measures that examine the period of time between screening and remission. For example, after screening patients on tobacco use, what percentage actually stopped smoking, and what was the duration?
- Measures that address access to behavioral health facilities, or lack thereof.
- Measures that focus not only on treatment and prevention but also on recovery

Previous NQF reports highlighted several of these gaps. For example, one of NQF's MAP 2017 final reports[6] emphasized the importance of "high-value measures," including general outcome measures and patient-reported outcomes. Further, the June 2012 NQF report[7] on dual eligible beneficiaries identified mental health and substance use conditions as having high-leverage opportunities for improvement through measurement; in particular, the workgroup noted the need to develop measures that evaluate coordination with primary care. In December 2012,[8] the same workgroup specifically identified beneficiaries with serious mental illness and/or substance use disorders as a high-need subgroup.

Behavioral Health Measure Evaluation

On February 28 to March 1, 2017, the Behavioral Health Standing Committee evaluated seven newly submitted measures and six measures undergoing maintenance review against NQF's standard evaluation criteria. Additionally, the Committee agreed to defer an endorsement decision for one measure, *Experience of Care and Health Outcomes (ECHO)*, and provided feedback to the developer to assist in future adjustments to the measure. NQF expects to review this measure for consideration of endorsement after the measure is updated as part of its annual review in 2018.

Table 2. Behavioral Health Measure Evaluation Summary

	Maintenance	New	Total
Measures under consideration	6	7	13
Endorsed measures	5	4	9
Measures not recommended for endorsement	0	3	3
Measure recommendation deferred	1	0	1
Reasons for not recommending	Importance – 0 Scientific Acceptability – 0 Overall – 0 Competing Measure - 0	Importance – 2 Scientific Acceptability – 1 Overall – 0 Competing Measure – 0	

Comments Received Prior to Committee Evaluation

NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). In addition, NQF solicits comments prior to the evaluation of the measures via an online tool located on the project webpage. For this evaluation cycle, the pre-evaluation comment period was open from February 2 to February 16, 2017, for the 13 measures under review. NQF received one pre-evaluation comment (Appendix F).

All submitted comments were provided to the Committee prior to its initial deliberations during the in-person meeting.

Overarching Issues

During the discussion of the measures, the Standing Committee considered overarching issues that emerged. These issues are discussed below and are not repeated in detail with each individual measure.

Potential Unintended Consequences of Measurement

For maintenance measures, the Committee noted that they would like to know more about the potential harms of the measures before voting for continued endorsement. The Committee agreed that a number of measures in the behavioral health portfolio expect the healthcare system to do more, assuming these actions will not have any unintended consequences for the patient.

The Committee suggested that measure developers be required to include data on the measures' potential harms and burdens prior to coming back for maintenance review to ensure that the measures do not place a large, unnecessary burden on providers.

eMeasure Numbering

When the developer of a previously endorsed, claims-based measure introduces an electronic-based version (eMeasure), the original measure is paired with the eMeasure, and NQF renumbers both measures. For example, NQF #0028 *Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention* was a maintenance, claims-based measure; a new, eMeasure version was reviewed during this phase of work. When the eMeasure was submitted, the eMeasure was assigned a new NQF measure number, NQF #3185, and the claims-based version was renumbered as NQF #3225. The Committee noted that this renumbering is not intuitive and creates unnecessary confusion for measure implementers. For example, when a claims-based measure is assigned a new number, users must retool their EHR, which leads to unexpected costs. The Committee recommended that rather than renumbering each time an eMeasure version is introduced, NQF should consider adding an 'e' to the end of the original number to denote the eMeasure.

Measure Burden

The Institute for Healthcare Improvement (IHI) has talked about the need to simplify and reduce the total number of measures. The Committee noted that there is a lot of discussion at NQF about measure harmonization, but that equal effort is needed to synthesize measures—i.e., to combine similar measures into a single measure. The Committee further expressed a desire to narrow the field to measures of proximal outcomes and potentially new types of measures such as those that address access to behavioral health facilities (or lack thereof) and measures that focus on recovery as well as treatment and prevention.

Developer Feedback

In part, the role of the Committee is to identify current gaps and priority measurement areas in order to signal to measure developers where they should focus their efforts. The Committee discussed the cost of measure development and noted that by the time developers submit a measure for endorsement, there has been significant investment in developing that measure. The Committee expressed a desire to provide input to developers earlier in the measure development process. Committee members also noted that developers are not submitting measures for endorsement because they do not believe they

can pass NQF's rigorous evaluation criteria. NQF staff also noted the availability of technical assistance for measure developers as well as the NQF Measure Incubator™—an NQF effort to convene the appropriate stakeholders to develop needed measures. The NQF Measure Incubator™ has already identified behavioral health as an area with significant gaps in measurement.

Refining the NQF Measure Evaluation Process

New Endorsement and Appeals Process

In August 2016, NQF implemented changes to its ratification and appeals process that were initiated and approved by its Board of Directors. Following public comment and voting by the NQF membership, the Consensus Standards Approval Committee (CSAC) makes the final measure endorsement decision, without ratification by another body. Additionally, the Board requested that NQF establish a five-member Appeals Board that is responsible for adjudicating all submitted appeals regarding measure endorsement decisions. These changes apply to NQF measure endorsement projects with in-person meetings scheduled after August 2016.

The newly constituted Appeals Board, composed of NQF Board members and former CSAC and/or committee members, adjudicates appeals to measure endorsement decisions without a review by the CSAC. The decision of the Appeals Board is final.

All submitted appeals are published on the NQF website. Staff compile the appeals for review by the Appeals Board, which will evaluate the concerns raised and determine if the appeal warrants overturning the endorsement decision. Decisions on an appeal of endorsement will be publicly available on NQF's website.

Throughout the process, project staff will serve as liaisons between the CSAC, the Appeals Board, the committee, developers/stewards, and the appellants to ensure the communication, cooperation, and appropriate coordination to complete the project efficiently.

Summary of Measure Evaluation

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

Endorsed Measures

0027 Medical Assistance with Smoking and Tobacco Use Cessation (National Committee for Quality Assurance): Endorsed

Description: The three components of this measure assess different facets of providing medical assistance with smoking and tobacco use cessation: (1) Advising Smokers and Tobacco Users to Quit: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who received advice to quit during the measurement year. (2) Discussing Cessation Medications: A rolling average represents the percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were recommended cessation medications during the measurement year. (3) Discussing Cessation Strategies: A rolling average represents the

percentage of patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Clinician office/Clinic setting; **Data Source**: Patient-reported data (CAHPS Health Plan Survey 5.0H, Adult Version; Medicare CAHPS)

Tobacco smoking is the leading cause of preventable disease and death in the United States, resulting in approximately 480,000 premature deaths and more than $300 billion in direct healthcare expenditures and productivity losses each year.[9] Studies show that advice from a physician or nurse increases smoking cessation compared to no advice or usual care. This health plan level process measure, initially endorsed in 2009 and most recently endorsed in 2012, is a long-standing measure that uses patient-reported data from the CAHPS survey to assess if patients have received assistance from a doctor or other healthcare provider to stop smoking and tobacco use. The Committee agreed that based on the performance data provided by the developer, gaps in care remain for advising patients to quit smoking, discussing cessation medications, and discussing cessation strategies. Because the CAHPS survey is based on patient-reported data, the Committee expressed concern about recall bias and debated the extent to which the survey questions are clearly defined. This measure is currently used in several programs including the Medicaid Adult Core Set and in NCQA's accreditation of healthcare plans. The Committee recommended this measure for continued endorsement.

0576 Follow-Up After Hospitalization for Mental Illness (National Committee for Quality Assurance): Endorsed

Description: The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:
(1) The percentage of discharges for which the patient received follow-up within 30 days of discharge, and
(2) The percentage of discharges for which the patient received follow-up within 7 days of discharge; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Behavioral Health: Inpatient, Behavioral Health: Outpatient, Clinician Office/Clinic; **Data Source**: Claims (Only)

Evidence suggests that brief, low-intensity case management interventions are effective in bridging the gap between inpatient and outpatient treatment for mental illnesses.[10] Low-intensity interventions are typically implemented at periods of high risk for treatment dropout, such as following an emergency room or hospital discharge or the time of entry into outpatient treatment.[11] This health plan level process measure, originally endorsed in 2009 and most recently endorsed in 2012, assesses whether health plan members who were hospitalized for a mental illness received a timely follow-up visit. The developer provided several updated clinical guidelines supporting follow-up after hospitalization and cited evidence that follow-up reduces suicide attempts and readmissions and improves functioning. Variability in performance exists among health plans, and there are statistically significant differences in the rates among various racial and ethnic groups. The Committee had several suggestions for revising the measure in the future, specifically, including telehealth as follow-up visits, removing the same-day

visit, considering expanding the definition of 'mental health practitioner,' and adding hospitalizations for drug and alcohol disorders. This measure is used in several programs including the Medicaid Child Core Set and in NCQA's accreditation of healthcare plans. The Committee recommended this measure for continued endorsement.

3132 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (eMeasure) (Quality Insights of Pennsylvania): Endorsed

Description: Percentage of patients aged 12 years and older screened for depression on the date of the 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; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Clinician Office/Clinic; **Data Source**: Electronic Health Record (Only)

The World Health Organization describes major depression as the leading cause of disability worldwide. In 2014, 11.7 percent of adolescents aged 12 to 17 and 6.6 percent of adults 18 years and older in the United States received a diagnosis of major depressive disorder.[12] The U.S. Preventive Services Task Force (USPSTF) guidelines recommend routine screening for depression as a part of primary care for both children and adults, in an effort to increase detection and treatment of depression and reduce the associated economic burden. This newly proposed process measure is the eMeasure version of NQF #3148 (formerly #0418) and assesses whether clinicians are screening patients for depression and are developing a follow-up plan if the screen is positive. The USPSTF and ICSI guidelines from the claims-based version of this measure (#3148) have been updated, but are relatively similar as they were in the last review. As the evidence presented was the same as for NQF #3148, the rating for evidence was automatically assigned to this eMeasure without discussion. Data elements of the eMeasure were found to comply with industry standards. The measure score was assessed for reliability using EHR data from two practices; for validity, the developer used BONNIE testing on 22 test cases as well as a technical expert panel of 12 clinicians. The Committee noted concerns about particular exclusions (e.g., patient refusal) and the challenges in documenting follow-up plans, but the developer noted that these exclusions do not occur frequently. The Committee recommended this measure for endorsement.

3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (Quality Insights of Pennsylvania): Endorsed

Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the 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; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Clinician Office/Clinic; **Data Source**: Claims (Only), Registry

The World Health Organization describes major depression as the leading cause of disability worldwide. In 2014, 11.7 percent of adolescents aged 12 to 17 and 6.6 percent of adults 18 years and older in the United States received a diagnosis of major depressive disorder. The USPSTF guidelines recommend routine screening for depression as a part of primary care for both children and adults, in an effort to increase detection and treatment of depression and reduce the associated economic burden. This claims/registry-based process measure (formerly NQF #0418), originally endorsed in 2008 and most

recently endorsed in 2014, assesses whether clinicians are screening patients for depression and are developing a follow-up plan if the screen is positive. USPSTF and ICSI guidelines have been updated, but are relatively similar as they were in the last review. Performance rates continue to show a significant gap among providers, and the literature indicates lower rates of screening and treatment in minority adults. The Committee attributed a decline in performance rates over the last few years to the increase in the number of providers reporting on the measure. The Committee agreed that this is a typical phenomenon as early reporters are usually higher performers, and the lower rates may show the true opportunity for improvement. Several individual Committee members expressed concerns about particular exclusions (e.g., patient refusal), but the developer noted that these exclusions do not occur frequently. The data elements are routinely collected in electronic sources, and there have been no reported implementation challenges, although one Committee member expressed concern regarding the difficulty of documenting the follow-up plan. The measure is used in various CMS programs, including the Medicaid Adult Core Set. The Committee recommended this measure for continued endorsement.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder (RAND Corporation): Endorsed

Description: Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment; **Measure Type**: Process; **Level of Analysis**: Health Plan, Population: Regional and State; **Setting of Care**: Behavioral Health: Outpatient, Clinician Office/Clinic; **Data Source**: Claims (Other), Pharmacy

According to the 2014 National Survey on Drug Use and Health (NSDUH), 1.7 million adults 18 years of age and older were classified as having a pain reliever use disorder, and 886,000 adults had used heroin in the past year. In 2014, there were 489,532 episodes of treatment for opioid use disorder (OUD), including outpatient treatment, detoxification, and residential treatment. Medication-assisted treatment (i.e., pharmacotherapy combined with counseling) is an evidence-based effective treatment option for patients with OUD. This newly proposed process measure focuses on continuity of pharmacotherapy, defined as treatment duration of at least 180 days and absence of treatment gaps of greater than 7 days. In particular, the measure is based on the evidence showing the increased mortality associated with interruption of medication, with highest risks being in the first few weeks after stopping the medication. The mean performance rate in 2014-2015 was 27.7 percent. The Committee had extensive discussions about the measure specifications. They expressed concern about the measure capturing individuals who are appropriately discontinuing medication, as the measure cannot tell which patients have been on medication for years. Given concerns for capturing individuals who are appropriately stopping medications, the Committee strongly recommended that this measure not be used in pay-for-performance programs initially. The Committee also recommended expansion of the patient pool, stratification of data for patients who have just initiated treatment versus those who have been on the medication for a long time, and the addition of a counseling component. The Committee recommended this measure for endorsement.

3205 Medication Continuation Following Inpatient Psychiatric Discharge (Health Services Advisory Group, Inc.): Endorsed

Description: This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years; **Measure Type**: Process; **Level of Analysis**: Facility; **Setting of Care**: Behavioral Health: Inpatient; **Data Source**: Claims (Only)

Medication continuation is particularly important in the psychiatric patient population because discontinuing psychotropic medication can have a range of adverse effects, from mild withdrawal to life-threatening autonomic instability and psychiatric decompensation.[13] The aim of this process measure is to assess whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within two days prior to discharge and 30 days post-discharge. Evidence demonstrates that interruption of medication leads to relapse and negative outcomes. The Committee noted that the overall distribution of performance on the measure was somewhat high (66.7 percent in the 10th percentile), but agreed that the specifications likely limited the patient pool to those without access challenges. The Committee raised concerns for hospitals being held responsible for patients filling their prescriptions, but they noted that this may drive hospitals to use outpatient pharmacies and also ensure proper education on the importance of taking the medication. In the future, the Committee recommended that the developer expand the measure denominator to include Medicare Advantage and/or other patients. The Committee recommended this measure for endorsement.

3185 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (eMeasure) (PCPI Foundation): Endorsed

Description: Percentage of patients aged 18 years and older who were screened for tobacco use, one or more times within 24 months, AND who received cessation intervention, if identified as a tobacco user; **Measure Type**: Process; **Level of Analysis**: Clinician: Group/Practice, Clinician: Individual; **Setting of Care**: Behavioral Health: Outpatient, Clinician Office/Clinic, Home Health, Other; **Data Source**: Electronic Health Record (Only)

Tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. This newly proposed process measure is the eMeasure version of NQF #3225 (formerly #0028), and it intends to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. As the evidence presented was the same as for NQF #3225, the rating for evidence was automatically assigned to this eMeasure without discussion. Data elements of the eMeasure were found to comply with industry standards. The measure score was assessed for reliability using 2015 data reported via the EHR option to the PQRS program; for validity, the developer used BONNIE testing on 40 test cases as well as a technical expert panel of 10 clinicians. Although the Committee noted concerns about particular exclusions (e.g., medical reasons for not screening), it recommended this measure for endorsement.

3225 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (PCPI Foundation): Endorsed

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user; **Measure Type**: Process; **Level of Analysis**: Claims (Only), Claims (Other), Registry; **Setting of Care**: Behavioral Health: Outpatient, Clinician Office/Clinic, Home Health, Other; **Data Source**: Claims (Only), Claims (Other), Registry

Tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. This process measure, first endorsed in 2009 and most recently in 2012, is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. USPSTF and U.S. Public Health Service guidelines have been updated, but are relatively similar as they were in the last review. The Committee agreed that the high rates of performance are likely due to high performers choosing this measure to report on, noting literature that suggests performance is likely lower in the broader provider population. The literature also demonstrates that rates of tobacco screening and intervention vary by race, age, and insurance status, so the Committee agreed this was still important to measure. The Committee discussed expanding the measure to include the adolescent population as well as other forms of nicotine delivery (e.g., electronic cigarettes). The Committee also expressed concern for allowing exclusions for "medical reasons" and a desire to see the measure stratified for patients with mental health and substance use disorders. This measure is used in several programs including PQRS and Physician Compare. The Committee recommended the measure for continued endorsement.

0108 Follow-Up Care for Children Prescribed ADHD Medication (National Committee for Quality Assurance): Endorsed

Description: 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; **Measure Type**: Process; **Level of Analysis**: Health Plan, Integrated Delivery System; **Setting of Care**: Clinician Office/Clinic; **Data Source**: Claims (Only), Pharmacy

Attention-deficit/hyperactivity disorder (ADHD) is a brain disorder marked by an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development. Medications can improve function, but proper monitoring is recommended. The intent of this measure is to ensure timely and continuous follow-up visits for children who are newly prescribed ADHD medication. This process measure, originally endorsed in 2009 and most recently in 2015, encourages the monitoring of children for medication effectiveness, occurrence of side effects, and adherence. The Committee did not reach consensus on the subcriterion of evidence, mainly due to the lack of evidence for a follow-up visit within 30 days (initiation rate). While agreeing that a performance gap persists for this measure, the Committee also recognized that the performance rate continues to show little change over the years. The Committee found the measure to be reliable based on score-level testing. However,

during the in-person meeting, the Committee did not pass the measure on the subcriterion of validity, largely based on the lack of evidence for the specification of the initiation rate as well as the inability for providers to engage with patients in ways other than an in-person, face-to-face visit for the initial visit. The Committee stated that in this way, the measure has not kept pace with the changing practice patterns. Therefore, the measure did not pass the validity subcriterion, and the Committee did not recommend this measure for endorsement.

During the comment period, the developer submitted additional information, including a second-round evidence review and cited additional randomized control studies showing that children on ADHD medications who received follow-up visits (including medication management and monitoring services) within a few weeks to a year had improved clinical outcomes. The Committee discussed its continued concerns with the specification for a 30-day follow-up visit, including whether another similar timeframe might be just as reasonable. NCQA noted that the American Academy of Pediatrics (AAP) has maintained its support of this timeframe based on the consensus of an expert panel. NCQA stated that AAP supports keeping the first follow-up visit as an in-person visit in order to check vital signs; however, some Committee members noted the ability of patients to provide vital signs remotely. NCQA also noted that it is currently evaluating the reliability of telehealth for NCQA's HEDIS nonbehavioral health measures (e.g., blood pressure control); if recommendations are made about devices that could monitor vital signs remotely, NCQA would update this measure accordingly. NCQA also indicated its intention to allow videoconferencing and telephone visits for one of the continuation phase visits, once approved by NCQA's Board of Directors. Following the post-comment call, the Committee voted to recommend the measure for continued endorsement.

Measures Not Endorsed

3172 Continuity of Pharmacotherapy for Alcohol Use Disorder (RAND Corporation): Not Endorsed

Description: Percentage of adults 18-64 years of age with pharmacotherapy for alcohol use disorder (AUD) who have at least 180 days of treatment and a Proportion of Days Covered (PDC) of at least 0.8; **Measure Type**: Process; **Level of Analysis**: Health Plan, Population: Regional and State; **Setting of Care**: Clinician Office/Clinic, Behavioral Health: Outpatient; **Data Source**: Claims (Other), Pharmacy

According to the 2014 National Survey on Drug Use and Health (NSDUH), 16.3 million Americans ages 18 years and older suffered from alcohol use disorder (AUD), representing almost 7 percent of the adult population. However, only 15.2 percent of patients, who reported that they needed alcohol treatment, actually received it. Medication-assisted treatment (i.e., pharmacotherapy combined with counseling) is an evidence-based and effective treatment option for patients with AUD. This newly proposed process measure focuses on continuity of pharmacotherapy, defined as treatment duration of at least 180 days and sufficient adherence for the duration of treatment. The definition of adherence follows the established convention of having access to medication for at least 80 percent of treatment days. The Committee regarded the evidence on the individual medications to be of varied strength and quality, stating that some of the individual medications had little evidence to support the timeframe of the measure or even the efficacy of the medication itself. The Committee was particularly concerned that the medications are used to reduce the number of days of alcohol use and that relapses are not specifically associated with discontinuation of AUD medications. The Committee expressed further

concern that the Food and Drug Administration did not approve some of the included medications for AUD; in addition, some of the medications have other uses (e.g., gabapentin for neuropathy), so the measure would capture appropriate discontinuation of these medications for those uses. The Committee noted that cognitive-behavioral therapies could be equally effective in treating AUD. The Committee concluded that the evidence for using medication alone for AUD is not strong, and therefore questioned the importance of measuring medication use in isolation of cognitive-behavioral therapies. The measure did not pass the evidence subcriterion, and the Committee did not recommend this measure for endorsement.

3207 Medication Reconciliation on Admission (Health Services Advisory Group, Inc.): Not Recommended

Description: The average completeness of the medication reconciliation process within 48 hours of admission to an inpatient facility; **Measure Type**: Composite; **Level of Analysis**: Facility; **Setting of Care**: Behavioral Health: Inpatient; **Data Source**: Other, Paper Records

According to a 2015 study by the Agency for Healthcare Research and Quality (AHRQ), more than half of admitted patients' medication lists contain at least one discrepancy, and 40 percent of these identified discrepancies have the potential to cause harm. These errors in prescription medication history most commonly occur during the admission process. This newly proposed composite measure has three components for the process of medication reconciliation on admission, each of which has between one and five scoring elements. The Committee expressed concern that the evidence was weak for the measure focus, noting that in the systematic review cited, only six of the 26 studies were rated as good quality, and the review did not distinguish when the reconciliation occurred. The Committee also noted that while national organizations may acknowledge that medication reconciliation is important, they do not see clear evidence that specifically links each of the components of the measure with enhanced outcomes. The developer stated the measure is consistent with best practices of the Joint Commission, but the Committee noted these are not evidenced-based recommendations. The measure did not pass the evidence subcriterion, and the Committee did not recommend this measure for endorsement.

3229 Patient Panel Adult Smoking Prevalence (Centers for Medicare & Medicaid Services): Not Recommended

Description: Percentage of adults (age 18 years or older) who are tobacco smokers at time of most recent encounter during the measurement period; **Measure Type**: Outcome; **Level of Analysis**: Clinician: Individual; **Setting of Care**: Clinician Office/Clinic, Other, Behavioral Health: Outpatient; **Data Source**: Electronic Health Record (Only)

Despite declines in use, tobacco consumption, and cigarette smoking in particular, remains the single most preventable cause of disease and death in the United States. As of 2015, an estimated 36.5 million (15.1 percent) of adults currently smoke cigarettes. This newly proposed intermediate outcome measure looks at the percentage of adults who are tobacco smokers to emphasize the outcome rather than the process. The evidence demonstrates that there are interventions that can result in the desired outcome (decreased smoking rates). The developer showed variation in provider-level prevalence rates of smoking that range from 0.0 percent to 69.2 percent, with a mean rate of 13.2 percent. The Committee noted high reliability in testing, but expressed concern about a provider's ability to report

the measure appropriately. The measure excludes all patients who do not have a recorded smoking status; this resulted in 26.5 percent of patients being excluded during testing, which the Committee noted could affect the validity of the results. The Committee had other concerns including attributing failure of a patient to quit smoking to a provider who is actively working with a patient who has relapsed, as well as attributing failure to a provider who is seeing a patient for the first time. The Committee noted that the measure is an important first step in moving towards outcomes; however, it suggested several considerations for the developer to consider, including, revising the measure to assess the percent change in smoking, combining the measure with a screening measure, and ensuring patients are attributed to providers who have seen them continuously. The measure did not pass the validity subcriterion, and the Committee did not recommend this measure for endorsement.

Measures with Endorsement Decision Deferred

0008 Experience of Care and Health Outcomes (ECHO) Survey: Endorsement Decision Deferred

Description: The ECHO is a survey that includes 5 multiple item measures and 12 single item measures:

Multiple Item Measures:

Getting treatment quickly
- Get treatment as soon as wanted when it was needed right away
- Get appointments as soon as wanted
- Get professional help by telephone

How well clinicians communicate
- Clinicians listen carefully
- Clinicians explain things in an understandable way
- Clinicians show respect
- Clinicians spend enough time
- Feel safe with clinicians
- Patient involved as much as wanted in treatment

Perceived improvement
- Compare ability to deal with daily problems to 1 year ago
- Compare ability to deal with social situations to 1 year ago
- Compare ability to accomplish things to 1 year ago
- Compare ability to deal with symptoms or problems to 1 year ago

Getting treatment and information from the plan
- Getting new clinician
- Delays in treatment while wait for plan approval
- Getting necessary treatment
- Understanding information about treatment in booklets or on the web
- Getting help when calling customer service
- Filling out paperwork

Informed about treatment options
- Told about self-help or consumer run programs
- Told about different treatments that are available for condition

Single Item Measures:

- Overall rating of counseling and treatment (MCO and MBHO)
- Overall rating of the health plan (MCO only)
- Wait more than 15 minutes past appointment time to see clinician
- Told about medication side effects
- Talk about including family & friends in treatment
- Given as much information as wanted about how to manage condition
- Given information about rights as a patient
- Patient feels that he or she could refuse a specific type of treatment
- Was information revealed that should have been kept private
- Cultural competence -Care responsive to language, race, religious, ethnic
- Amount helped by treatment
- Plan provides information about how to get treatment after benefits used up

The measures are based on reports of care experiences over the previous six months from adult (18 years of age or older) patients receiving behavioral healthcare (mental health and substance abuse treatment) and the organization that provides or manages their treatment and health outcomes. Each measure score is the mean of the responses to the survey questions from patients receiving care at a particular health plan or managed behavioral health organization. More detail can be found at: http://www.ahrq.gov/cahps/surveys-guidance/echo/about/survey-measures.html; **Measure Type**: Outcome; **Level of Analysis**: Health Plan; **Setting of Care**: Behavioral Health: Outpatient; **Data Source**: Patient Reported Data

This patient-reported outcome measure, originally endorsed in 2007, assesses patient experiences with behavioral health services in areas such as timely treatment, communication with clinicians, and information about treatment options. Shortly before the in-person meeting, NQF, in agreement with the Committee co-chairs, decided to defer consideration of endorsement for this measure because there was insufficient data for the Committee to consider. The developer explained that it does not currently have data on performance scores and use, but asserts that there has been a resurgence of interest in the instrument. The developer noted several large studies underway and indicated that it is in the process of performing new field testing. The Committee agreed that measures that capture patient experience are very important, and this is one of a few patient experience measures for behavioral health. The Committee preferred to give feedback to the developer to inform revisions to the measure for future, continued endorsement consideration. The Committee recommended several potential partners who might be able to provide the developer with needed data on current use and performance. The Committee also suggested the development of a clear logic model that helps explain the various patient-reported outcomes included within the measure. Furthermore, the Committee recommended that the developer reconsider the current exclusion of patients treated in primary care settings. NQF expects to review this measure for continued endorsement consideration as part of its annual review in 2018.

Comments Received After Committee Evaluation

After the Committee's in-person evaluation of the measures, NQF solicited comments on the draft report via an online tool from April 5, 2017, through May 4, 2017. During this period, NQF received 52 comments from 13 commenters, including nine member organizations. Comments included support for

the Committee's decisions to either recommend or not recommend the measures under review, comments noting concerns with the Committee's decision to recommend measure #3205 *Medication Continuation Following Inpatient Psychiatric Discharge*, and comments sharing the Committee's concerns about measure #0576, specifically removing the same-day visit as a qualifying event. Measure-specific comments are included in the Appendix A measure discussions.

References

[1] National Institute of Mental Health (NIMH). Any Mental Illness (AMI) Among U.S. Adults website. https://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-us-adults.shtml. Last accessed March 2017.

[2] Substance Abuse and Mental Health Services Administration (SAMHSA). *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health.* Rockville, Maryland: SAMHSA; 2015. Available at https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf. Last accessed March 2017.

[3] Roehrig C. Mental Disorders Top the List of The Most Costly Conditions in the United States: $201 Billion. *Health Aff (Millwood)*. 2016;35(6):1130-5. Available at http://content.healthaffairs.org/content/early/2016/05/13/hlthaff.2015.1659. Last accessed March 2017.

[4] Insel TR. Assessing the economic costs of serious mental illness. *Am J Psychiatry*. 2008;165(6):663-5.

[5] Depression and Bipolar Support Alliance (DBSA). http://www.dbsalliance.org/site/PageServer?pagename=home. Last accessed March 2017.

[6]National Quality Forum (NQF). *MAP 2017 Considerations for Implementing Measures in Federal Programs: MIPS and MSSP*. Washington, DC: NQF; 2017. Available at http://www.qualityforum.org/Publications/2017/03/MAP_2017_Considerations_for_Implementing_Measures_in_Federal_Programs__Clinicians.aspx. Last accessed May 2017.

[7] NQF. *Measuring Healthcare Quality for the Dual Eligible Beneficiary Population.* Washington, DC: NQF; 2012. Available at http://www.qualityforum.org/Publications/2012/06/Measuring_Healthcare_Quality_for_the_Dual_Eligible_Beneficiary_Population.aspx. Last accessed May 2017.

[8] NQF. *Further Exploration of Healthcare Quality Measurement for the Dual Eligible Beneficiary Population*. Washington, DC: NQF; 2012. Available at http://www.qualityforum.org/Publications/2012/12/Dual_Eligible_Beneficiary_Population_Interim_Report_2012.aspx. Last accessed May 2017.

[9] Centers for Disease Control and Prevention (CDC) Smoking and Tobacco Use Fast Facts. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/fast_facts/. Last accessed March 2017.

[10] Dixon L, Goldberg R, Iannone V, et al. Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization. *Psychiatr Serv*. 2009;60(4):451-458.

[11] Kreyenbuhl J, Nossel I, Dixon L. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophr Bull*. 2009;35(4):696-703.

[12] SAMHSA. *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings.* Rockville, Maryland: SAMHSA; 2014. Available at https://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.htm. Last accessed March 2017.

[13] Ward M, Schwartz A. Challenges in pharmacologic management of the hospitalized patient with psychiatric comorbidity. *J Hosp Med*. 2013;8(9):523-9.

Appendix A: Details of Measure Evaluation

Rating Scale: H=High; **M**=Moderate; **L**=Low; **I**=Insufficient; **NA**=Not Applicable; **Y**=Yes; **N**=No

Endorsed Measures

0027 Medical Assistance With Smoking and Tobacco Use Cessation

Submission | Specifications

Description: The three components of this measure assess 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 patients 18 years of age and older who are 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 patients 18 years of age and older who are 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 patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

Numerator Statement: Advising Smokers and Tobacco Users to Quit:

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider

Discussing Cessation Medications:

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications

Discussing Cessation Strategies:

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication

Denominator Statement: Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.

Exclusions: None

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Clinician Office/Clinic, Other

Type of Measure: Process

Data Source: Patient Reported Data

Measure Steward: National Committee for Quality Assurance

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

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

1a. Evidence Exception: **Y-22; N-0**; 1b. Performance Gap: **H-11**; **M-11**; **L-0**; **I-0**

<u>Rationale</u>:

- In the previous submission, the developer provided evidence in the form of guidelines and recommendations from the USPSTF, ICSI, VA/DoD, and the U.S. Public Health Service related to the importance of tobacco-related prevention and treatment. For this submission, the developer provided an updated guideline from the USPSTF (2015) on behavioral and pharmacotherapy interventions for tobacco smoking cessation in adults (including pregnant women). The Committee agreed these updates were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and vote on evidence.
- The developer provided performance data at the health plan level (commercial, Medicare, Medicaid) for 2014-2016 for each of the three rates reported within this measure.
    - For 'advising smokers to quit,' mean scores in 2016 were 86 percent (Medicare), 75 percent (commercial), and 76 percent (Medicaid).
    - For 'discussing cessation medications,' the mean scores in 2016 were 48 percent (commercial) and 48 percent (Medicaid).
    - For 'discussing cessation strategies,' the mean scores in 2016 were 44 percent (commercial) and 43 percent (Medicaid).
- The developer provided literature about significant disparities in tobacco use among certain populations, but provided limited evidence on the disparities among smoking cessation efforts in these populations.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-5**; **M-15**; **L-2**; **I-0** 2b. Validity: **H-9**; **M-12**; **L-1**; **I-0**

<u>Rationale</u>:

- The Committee noted concerns raised in the last round of endorsement for this measure regarding recall bias. The developer expressed interest in a future measure that triangulates data from prescriptions or claims for counseling, or quit lines in order to determine what services have actually been provided to patients who still smoke.
- The developer provided an updated assessment of measure score reliability using data from all the health plans that submitted HEDIS data to NCQA for this measure and had a valid rate in 2015-2016. Beta-binomial statistics for each rate in the measure were provided by type of health plan. The 2016 statistics for Medicaid and commercial plans ranged from 0.69 to 0.83 (which were similar to improve from the scores provided in the last submission). The beta-binomial statistic for the rate of 'advising smokers to quit' for Medicare was 0.95 in 2010; the testing in Medicare was not updated. These scores indicate sufficient signal strength to discriminate performance between accountable entities.
- In 2011, the developer reported systematic assessment of face validity and basic information about cognitive testing (of data elements) of the CAHPS survey instrument done in 2008. The face validity testing showed that NCQA's Committee on Performance Measurement recommended the measure for public reporting (10 supported, 1 opposed, 1 abstained).

- The Committee discussed concerns around the clarity of the questions in the measure and ensured that patients are able to differentiate between each of the three questions. The developer explained that all questions undergo testing to help determine whether individuals are accurately interpreting the questions.
- For this submission, the developer provided new construct validity testing. This testing provided Pearson correlations ranging from 0.68 to 0.85. Scores of 0.37 or larger are considered to have a "large" correlation effect, indicating that the measure rates are significantly correlated with each other in the direction that was hypothesized.
- The Committee raised concerns related to behavioral health being a "carve out" for many states, and so behavioral health providers may be left out of this measure, since they would not be required to complete the CAHPS survey. The Committee also suggested having a stratification for behavioral health patients; the developer noted that the data captured in CAHPS could not be stratified in this way, but there could be a requirement for sampling in specific populations.

---

3. Feasibility: H-13; M-9; 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 required data elements for this measure are collected from a patient-reported survey (CAHPS).
- The patient/family reported information may be obtained via electronic or paper sources.

---

4. Usability and Use: H-10; M-11; L-1; I-0

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

Rationale:

- This measure is currently used in several programs including the Medicaid Adult Core Set and the CMS Quality Rating System (QRS).
- The measure is also used for NCQA's accreditation of commercial, Medicaid, and Medicare Advantage plans. One Committee member noted that 49 states recognize NCQA health plan accreditation.

---

5. Related and Competing Measures

- This measure is related to several other measures:
    - 0028/3225/3185: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
    - 1654 (TOB-2): Tobacco Use Treatment Provided or Offered
    - 1656 (TOB-3): Tobacco Use Treatment Provided or Offered at Discharge
    - 2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
    - 2803: Tobacco Use and Help with Quitting Among Adolescents

- The Committee had a brief discussion about the portfolio of tobacco-related measures, and found that none of the measures were competing. They noted minor differences in definitions that may be considered for harmonization, but the Committee decided to table the discussion.

Standing Committee Recommendation for Endorsement: Y-22; N-0

6. Public and Member Comment:

- This measure received three comments. Two comments were in support of its continued endorsement and one provided feedback on expanding this measure for the adolescent population and users of e-cigarettes.
    - Developer response: Thank you very much for this feedback. NCQA's measure is based on the USPSTF recommendations for tobacco use screening and interventions. The USPSTF does not currently have a recommendation for screening or providing interventions to adolescents for tobacco cessation. In addition, the USPSTF found insufficient evidence to recommend electronic nicotine delivery systems for tobacco cessation in adults. NCQA will continue to monitor the guidelines and will consider updates to the measure as the evidence changes.

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for continued endorsement

8. Appeals

No appeals received.

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

Submission | Specifications

Description: The percentage of discharges for patients 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had a follow-up visit with a mental health practitioner. Two rates are reported:

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

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

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

Denominator Statement: Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

Exclusions: Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Clinician Office/Clinic, Behavioral Health : Inpatient, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Claims (Only)

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

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

1a. Evidence: **M-15**; **L-4**; **I-1**; 1b. Performance Gap: **H-8**; **M-12**; **L-0**; **I-0**

<u>Rationale</u>:

- For the previous submission, the developer provided National Institute for Health and Care Excellence (NICE) guidelines on the treatment and management of schizophrenia.
- For this submission, the developer provided several updated clinical guidelines for the care and management of schizophrenia (NICE and American Psychological Association [APA]), bipolar disorder (APA), and major depressive disorder (APA). The developer stated that these clinical practice guidelines support follow-up after hospitalization. They also stated that evidence shows follow-up care reduces suicide attempts and readmissions and improves functioning.
- The Committee noted the variability in performance among plans, with mean scores for 2016 ranging from 33.8 percent (Medicaid) to 50.3 percent (Commercial) for the 7-day rate and from 52.4 percent (Medicare) to 69.7 percent (Commercial) for the 30-day rate.
- The Committee noted data cited by the developer that show statistically significant differences in the rates for follow-up after hospitalization for a mental disorder among various racial and ethnic groups.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-6**; **M-11**; **L-3**; **I-0**; 2b. Validity: **M-12**; **L-7**; **I-0**

<u>Rationale</u>:

- The Committee questioned the evidence for the 7-day and 30-day follow-up timeframes. The developer responded that these are consensus-based timeframes from their advisory panel. The developer also noted that studies are emerging that show that follow-up within these

timeframes are contributing to reduced readmissions. One Committee member said that the 7-day and 30-day follow-up visits have become standard for managed behavioral health organizations.
- One Committee member suggested allowing telehealth visits to count toward follow-up. The developer noted that they are testing this and if approved, they will update the measure.
- One Committee member expressed concern about hospitals setting up same-day visits in their outpatient clinics in order to perform well on the measure. The developer stated they are looking at this issue, and may update the measure at a later date.
- Several Committee members expressed concern about limiting follow-up to a mental health practitioner only and suggested broadening the definition. The developer noted that their advisory panel advised this based on the seriousness of the illness (requiring hospitalization), and that they will keep pace with developments in how states define mental health providers (e.g., pediatricians getting more specialized training).
- One Committee member encouraged broadening the measure to include hospitalizations for drug and alcohol disorders.
- Several Committee members talked about potentially testing the measure at the facility (hospital) level in the future. The developer agreed this might help with care coordination.
- For reliability testing, the developer provided a signal-to-noise analysis for the measure score, which resulted in beta-binomial statistics all at 0.95 or above. These results were similar to the results calculated for the 2012 submission.
- For the 2012 submission, the developer stated face validity was assessed via NCQA's standardized process (the "HEDIS measure life cycle").
- The developer provided data on the ability to identify statistically meaningful differences by using 2016 HEDIS data to compare the differences between the 25th and 75th percentiles of performance on a measure.

---

3. Feasibility: H-6; M-12; L-2; 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 Committee noted that data are in electronic sources and no implementation challenges have been reported.
- One Committee member stated a concern for areas in which the behavioral health system is not integrated with the physical health system, noting that it can be a challenge to have those data systems interact in order to sufficiently gather the necessary data.

---

4. Usability and Use: H-6; M-10; L-3; I-0

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

Rationale:

- This measure is currently used in several CMS programs, including: Medicaid Child Core Set, Hospital Compare, the Physician Quality Reporting System (PQRS), the Physician Value-Based Payment Modifier (VBM), the Physician Feedback/Quality and Resource Use Reports (QRUR), and the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR).

- The measure is also used for NCQA's accreditation of commercial, Medicaid, and Medicare plans.

---

5. Related and Competing Measures

- This measure relates to NQF #1937: Follow-Up After Hospitalization for Schizophrenia (7-day and 30-day). In 2012, the Committee recommended the developer incorporate NQF # 1937 as a subset or target population within NQF # 0576. At this current meeting, the Committee decided to table discussion of any updates.

Standing Committee Recommendation for Endorsement: **Y-16**; **N-4**

Rationale

- The Committee clarified that they were voting on the measure as it stands, and not considering potential updates as previously suggested (e.g., inclusion of telehealth, removal of same-day visit).

---

6. Public and Member Comment:

- This measure received five comments, most of which were in support of the Committee's decision to recommend this measure as well as to emphasize the Committee's concerns for this measure. Three of the comments focused on the Committee's recommendation to revise the measure to allow for telehealth to count as a visit towards the seven and 30-day follow-up criteria. Two of the comments supported the recent decision by NQF's Measures Application Partnership to remove this measure from the Inpatient Psychiatric Facility Quality Reporting Program pending re-specification for the acute care setting. Comments also raised concerns around the developer's decision to no longer credit organizations for provider visits conducted on the same day of discharge.
    - Developer response: We appreciate the challenge related to shortage of mental health providers. NCQA reviewed the same day visit topic with our Behavioral Health Measurement Advisory Panel, which supported removing the same day visit. Our panel agreed that an encounter on the date of discharge after hospitalization can be viewed as a quality improvement intervention designed to improve a patient's likelihood of receiving timely clinical follow-up care within 7 and 30-days, it should not be the only visit that patients have within a week of discharge, and does not reflect good quality of clinical care on its own; therefore it does not meet the intent of the measure .In addition, HEDIS auditors have also noticed that some organizations count case management or check list services on the same day toward the measure. Some of these services were being performed in locations such as the hospital cafeteria and thus were billed as an outpatient service. It is challenging to discern whether some services were provided before or after discharge. Because of these practical challenges, NCQA decided to remove the same-day visit to ensure the validity and comparability of the measure and to align with the measure intent.
    - Regarding telehealth, we are proposing to add video conferencing to the measure for HEDIS 2018 and if approved by our governing Committee and Board of Directors in June 2017, will update the NQF endorsed version accordingly.
    - Committee response: The Committee expressed concern that the measure under consideration for endorsement allows for a same-day visit (post discharge) to count as a

qualifying follow-up encounter, but that in the field, NCQA recently removed the same-day visit as a qualifying event. The Committee noted that this is a timing issue – the developer would be expected to update the specifications as part of its annual update. NCQA noted that they submitted the measure for endorsement at the end of 2016, but after that, their advisory panel recommended removing the same-day visit from the HEDIS version of the measure. Ultimately, the Committee decided to maintain its recommendation for endorsement of the measure as it stood in its submission. That is, the Committee recommended endorsement for the measure that allows a same-day visit to count as a follow-up visit in the initial phase. The Committee will review the removal of the same-day visit as part of the annual update to determine if this change affects the Committee's recommendation for endorsement. The Committee emphasized that the measure as currently implemented in the field does not align exactly with the specifications of the measure as recommended for endorsement.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for continued endorsement

---

8. Appeals

No appeals received.

3132 Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Submission | Specifications

Description: Percentage of patients aged 12 years and older screened for depression on the date of the 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

Numerator Statement: Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

Denominator Statement: All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period

Exclusions: Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder are excluded.

Patients with any of the following are excepted: patient reason(s), patient refuses to participate, or medical reason(s); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (for example: certain court appointed cases or cases of delirium).

Adjustment/Stratification: N/A

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

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Electronic Health Record (Only)

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

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

1a. Evidence Exception: **Y-23; N-0**; 1b. Performance Gap: **H-13**; **M-10**; **L-0**; **I-0**

<u>Rationale</u>:

- This measure is the new eMeasure version of measure #3148. The information provided for evidence is identical to that submitted for #3148. Measure #3148 was discussed first and the rating for evidence was automatically assigned to this eMeasure without further discussion.
- The developer provided data on performance rates for EHR data showing a mean performance rate in CY2015 of 68.8 percent.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-9**; **M-13**; **L-1**; **I-0;** 2b. Validity: **M-18**; **L-4**; **I-1**

<u>Rationale</u>:

- The data elements are clearly defined and compliant with industry standards.
- The Committee noted that the measure score was assessed using EHR data from two different practices (one primary care and one pediatrics), and a beta binomial method was used to perform a signal-to-noise analysis. This analysis showed a mean reliability score of 0.984.
- One Committee member expressed a concern about the small sample. The developer cited a short timeframe to prepare for the Committee meeting, and given that participation was voluntary, they could not include more sites in this round of testing.
- The Committee noted that BONNIE testing on 22 test cases confirmed there was a test case for each pathway of logic, and that all the test cases performed as expected.
- The Committee noted that face validity testing with an expert panel showed that nine of 12 clinicians surveyed (75 percent) agreed or strongly agreed that the measure accurately reflects quality of care.

---

3. Feasibility: H-8; M-14; L-1; 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)

<u>Rationale</u>:

- The Committee noted that data elements are routinely collected in electronic sources, and the developer reported that the data elements required are in structured data fields.
- One Committee member expressed concern about eMeasures in general, and asked if there was an ability to test whether the events actually occurred. The developer noted they did workflow analysis in their testing and looked for how the follow-up plan is documented in the EHR, which they said works better in some EHR systems than others.

- The developer noted concern about identifying follow-up interventions or those in the denominator exceptions, but they concluded that these elements are unlikely to be used frequently enough to compromise feasibility.

---

4. Usability and Use: H-7; M-16; L-0; I-0

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

Rationale:

- The Committee noted the measure is widely used in various CMS programs and that the measure is similar to NQF #3148 and so did not require additional discussion.

---

5. Related and Competing Measures

- This measure relates to NQF #3148: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. NQF #3132 is the eMeasure version of NQF #3148 and has been harmonized to the extent possible, thus the Committee did not discuss harmonization.

Standing Committee Recommendation for Endorsement: Y-23; N-0

---

6. Public and Member Comment:

- This measure received two comments; both supported the Committee's decision to recommend this measure but one noted that it should only be applied at the clinician level, not at the health plan level.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for endorsement

---

8. Appeals

No appeals received.

3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Submission | Specifications

Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the 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.

Numerator Statement: Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

Denominator Statement: All patients aged 12 years and older

Exclusions: Not Eligible – A patient is not eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

Adjustment/Stratification: N/A

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

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), Registry

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

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

1a. Evidence Exception: **Y-23; N-0**; 1b. Performance Gap: **H-17**; **M-6**; **L-0**; **I-0**

Rationale:

- In the last review, the developer cited several studies and reviews related to screening for depression in both children and adults (USPSTF 2009, ICSI 2011, ICSI 2012).
- The developer provided USPSTF and ICSI guidelines (2016). The Committee agreed these updated guidelines were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and vote on evidence.
- The Committee noted data showing a mean performance rate in CY2015 of 36.5 percent for claims and 28.9 percent for registry (provider). The developer also provided literature indicating lower rates of screening and treatment in minority adults.
- The Committee noted that PQRS data show performance rates have been going down (from 82.6 percent in 2011 to 52.4 percent in 2014). However, the developer noted more providers are reporting on this measure, as it is required for ACOs. Committee members acknowledged that this is typical when measures are often reported initially by high performers, and then performance rates go down as the pool of reporting providers broadens.

---

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-8**; **M-14**; **L-1**; **I-0** 2b. Validity: **M-18**; **L-3**; **I-2**

Rationale:

- In the previous review, the developer provided data on the inter-rater reliability testing of the data elements on a random sample of 275 Medicare claims, resulting in 89.7 percent agreement

for the numerator, 100 percent agreement for the denominator, and 66.5 percent agreement for exclusions.

- The Committee noted good results in updated reliability testing – using a signal-to-noise analysis at the score level, the developer reported a mean reliability statistic of 0.99 for both claims and registry.
- Committee members expressed concerns about particular exclusions. One expressed concern about excluding people who refuse screening, noting that people who are depressed might be more inclined to refuse to engage in such activity. Committee members expressed concern about other exclusions including the emergent nature of a visit, noting that the emergent visit might be the result of a risk-taking behavior related to depression and about excluding individuals with bipolar disorder, because the assumption that they're in treatment may not be true. One Committee member expressed concern about emergency room physicians evaluated on this measure, but the developer clarified that the evaluation and management codes for emergency medicine are excluded from this measure.
- The developer noted that exclusions do not occur frequently. (For Medicare claims, 3.6 percent of eligible encounters were excluded and for registry data, 4.9 percent of eligible encounters were excluded.) The developer further noted that "active diagnosis of depression" was the most common exclusion.
- One Committee member suggested adding an exclusion for "adjustment disorder with depressed mood" in order to avoid overly aggressive treatment. The developer clarified that the "follow-up plan" does not require being seen by a psychiatrist or psychologist or starting medication, but rather could include referral to pastoral counselor or even just to have a return visit in 2 weeks, as long as it is documented.
- The Committee expressed concern about the frequency of screening, asking if the screening should occur at each visit. The developer noted that the clinician could screen more frequently if there were indications that it was needed.
- The Committee noted that face validity testing showed that nine of 12 clinicians surveyed (75 percent) agreed or strongly agreed that the measure accurately reflects quality of care.

---

3. Feasibility: H-12; M-9; L-1; 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 Committee noted that data elements are routinely collected in electronic sources and there have been no implementation challenges noted. The developer emphasized that for this claims/registry measure, they use HCPCS codes for reporting.
- One Committee member expressed concern with the difficulty of documenting the follow-up plan.

---

4. Usability and Use: H-3; M-17; L-2; I-0

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

Rationale:

- This measure is currently used in several CMS programs, including: Medicaid Adult Core Set, the Medicare Shared Savings Program (MSSP), the Electronic Health Record Incentive Program, the

Physician Value-Based Payment Modifier (VBM), the Physician Feedback/Quality and Resource Use Reports (QRUR), and Physician Compare.

- As noted earlier, the Committee restated the decreasing performance that is likely due to the increased number of individuals reporting on the measure. The developer agreed, noting the declining numbers as more people are reporting show the true gap and opportunity for improvement.
- The Committee expressed a desire to learn more about impact on outcomes and comparison across plans. The developer noted that they only have access to CMS Medicare claims. The developer further noted that they are using the measure to identify the under-diagnosis of depression and encourage more screening.
- One Committee member asked about harmonizing this measure with the PHQ-9 depression measure. The developer noted they have discussed this with their expert work group, but this measure is not prescriptive about which screening tool should be used.

---

5. Related and Competing Measures

- This measure relates to NQF #3132: Preventive Care and Screening: Screening for Depression and Follow-Up Plan. NQF #3132 is the eMeasure version of NQF #3148 and has been harmonized to the extent possible, thus the Committee did not discuss harmonization.

Standing Committee Recommendation for Endorsement: **Y-23**; **N-0**

6. Public and Member Comment:

- This measure received three comments. One comment notes that it was considered for inclusion in the Core Measure Set, but ultimately rejected, primarily because consumer members desired a more robust, outcome-focused measure. A lack of trends in performance data indicates there may be issues with data collection in actual practice, and we share the concerns regarding exclusions as noted by the committee. In addition, the measure does not clearly define frequency, nor does it indicate if a screen is required at all encounters. For example, screening for depression may not be appropriate in cases where a patient is being seen by a primary care physician for the sole purpose of an acute condition, such as an URI.
    - Developer response: We thank you for your feedback and comment. Although this is a process measure, evidence shows that screening patients for depression and providing appropriate follow up care to patients who screen positive leads to better patient outcomes. In relation to your comment, we offer the following information:
      1.Trends in performance data
      •Analysis of claims and registry data did reveal a decrease in the average performance rate (from 82.6% in 2011 to 52.4% in 2014). However, the pool of total eligible professionals or clinicians reporting this measure to the Physician Quality Reporting System (PQRS) increased substantially from 1,700 to 61,000. Given the sharp increase in the pool of reporting eligible professionals or clinicians, we anticipated instability in performance. These data demonstrate that providers are beginning to report this measure and that there is still significant room for improvement. Therefore, it is difficult to assess trends over time as the eligible professionals or clinicians who recently began voluntarily reporting the measure may have lower performance rates than those who have been reporting it for a longer period of time.
      2.Exclusion criteria

•Expert work groups review exclusion criteria annually and have accounted for certain situations in which it is appropriate not to screen and follow up with patients for depression, such as when patients are already diagnosed with depression or when patients are in emergent situations. We will review the Committee's comments with the expert work group when it re-convenes.

3.Frequency of Screening

•We agree that specifications could provide more specific guidance to define the frequency of screening. Because this measure is patient-based rather than encounter-based, the measure requires depression screening once per measurement period but not at all encounters. We will consider clarifying the frequency of screening in the specification in a future update.

- The second comment noted that it should only be applied at the clinician level, not at the health plan level.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for continued endorsement

---

8. Appeals

No appeals received.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

Submission | Specifications

Description: Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

Numerator Statement: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

Denominator Statement: Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

Exclusions: There are no denominator exclusions.

Adjustment/Stratification: N/A

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

Setting of Care: Clinician Office/Clinic, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Claims (Other), Pharmacy

Measure Steward: RAND Corporation

STANDING COMMITTEE MEETING 03/01/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H: 3; M-10**; **L-0; I-5;** 1b. Performance Gap: **H-5**; **M-11**; **L-1**; **I-1**

Rationale:

- The developer provided guidelines on the management of substance use disorders (VA/DoD 2015). In addition, they cited evidence showing the increased mortality associated with interruption of medication, with highest risks being in the first few weeks after stopping the medication.
- One Committee member noted an article not included in this submission from the *New England Journal of Medicine* in March 2016 on Vivitrol that looked at the efficacy of Vivitrol.
- The developer also provided evidence on reasoning for choice of 6-month continuation (based on FDA trial lengths) and 7-day gap (drug effectiveness and mortality risk following interruption of medication). The developer noted there is no empirical evidence on the best length of time overall for patients to stay on these medications, and suggests this as a needed area of research.
- The Committee noted the gaps in performance, with mean performance in 2014-2015 of 27.7 percent, (10^{th} percentile at 16.2 percent and 90^{th} percentile at 40.9 percent).

---

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-0**; **M-15**; **L-2**; **I-2;** 2b. Validity: **M-14**; **L-2**; **I-3**

Rationale:

- The Committee had extensive discussions about how the measure was specified – in particular, they expressed concern about the measure capturing individuals who are appropriately discontinuing their medication, as the measure cannot tell which patients have been on medication for years. The Committee asked why the measure was not specified to only look at those who had just initiated treatment. The developer acknowledged this could lead to some measurement error, but they expected this to only be a small number. The developer said they made the choice to err on the side of sensitivity over specificity in order to be more generalizable and look at a cross-section of patients, given that the performance gap is so large. The developer also noted that the measure has a rolling 2-year timeframe. Furthermore, the developer noted that it can be difficult to identify those who have been on medications long term in commercial insurance because individuals can change plans over time.
- One Committee member expressed concern that the measure could encourage providers to keep patients on their medications unnecessarily.
- The Committee also questioned why the measure does not include counseling in conjunction with medication. The developer cited issues with defining counseling, and the ability to capture all types of counseling (e.g., community-based support groups). The Committee suggested in the future the measure might be expanded to set a minimum standard for the occurrence of any type of counseling.
- The Committee asked why the measure had only been tested in the commercial insurance pool. The developer noted timeline constraints to submit the measure for consideration, but stated they intend to conduct testing in both the Medicare and Medicaid populations.
- The developer provided a signal-to-noise analysis showing reliability rates of 0.977 at the state level and 0.891 at the health plan level.

- The Committee noted the face validity testing of the measure score resulted in eight of 10 experts in agreement that the measure can be used to distinguish good quality from poor quality.
- The Committee had several suggestions for improvements to the measure's specifications in the future including:
    - Expansion of the patient pool (e.g., Medicare, Medicaid).
    - Stratification of the data for patients who have just initiated medication and those who have been on medication for a longer time.
    - Addition of a counseling component.

---

3. Feasibility: H-8; M-10; L-1; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

Rationale:

- The Committee noted that the data are readily available in electronic form and no issues have been reported in testing.

---

4. Use and Usability: H-1; M-11; L-5; I-2

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

Rationale:

- The Committee strongly recommended that the measure not be used in pay-for-performance programs initially.

---

5. Related and Competing Measures

- This measure relates to NQF #0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET). NQF #0004 was discussed with the Committee in October 2016, and discussions around harmonization have been deferred until after an update is available.
- This measure relates to NQF #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, a facility-level measure for the hospital setting. There are minor differences that may be considered for harmonization, but the Committee decided to table discussion.

Standing Committee Recommendation for Endorsement: **Y-12**; **N-7**

- The Committee clarified that they were voting on the measure as it stands, and not considering potential updates as previously suggested (e.g., stratification of new users, addition of counseling).

---

6. Public and Member Comment:

- This measure received three comments. One comment supported the endorsement of the measure and two comments raised concerns around the endorsement of the measure at the health plan level and failure to distinguish between dangerous non-therapeutic MAT-

discontinuation and appropriate, planned Opioid Substitution Treatment (OST) tapers (e.g., discontinuation of Vivitrol, naltrexone for extended-release injectable suspension).

- The developer of this measure also provided additional information and testing data based on Medicaid claims from national databases in response to the Committee's request for this information during the in-person meeting.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for endorsement

---

8. Appeals

No appeals received.

3205 Medication Continuation Following Inpatient Psychiatric Discharge

Submission | Specifications

Description: This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years.

Numerator Statement: The numerator for this measure includes:

1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

Denominator Statement: The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

Exclusions: The denominator for this measure excludes discharged patients who:

1. Received Electroconvulsive Therapy (ECT) during the inpatient stay or follow-up period.

2. Received Transcranial Magnetic Stimulation (TMS) during the inpatient stay or follow-up period.

3. Were pregnant during the inpatient stay.

4. Had a secondary diagnosis of delirium.

5. Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia.

Adjustment/Stratification: N/A

Level of Analysis: Facility

Setting of Care: Behavioral Health : Inpatient

Type of Measure: Process

Data Source: Claims (Only)

Measure Steward: Centers for Medicare & Medicaid Services, Contracting Officer's Representative (COR)

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **M-21**; **L-2; I-0;** 1b. Performance Gap: **H-7**; **M-16**; **L-0**; **I-0**

<u>Rationale</u>:

- The developer provided evidence for medication continuation based on treatment guidelines for major depressive disorder (APA 2010, VA/DoD 2016), schizophrenia (APA 2010), and bipolar disorder (APA 2002, VA/DoD 2010).
- The Committee agreed there is evidence that lack of adherence to medication leads to relapse and negative outcomes. They also noted that claims data related to medication adherence are directly correlated to outcomes.
- The Committee noted that the overall distribution of performance score seemed somewhat high with a performance rate of 66.7 percent in the tenth percentile, and a rate of 88.3 percent in the 90th percentile. The developer agreed with a hypothesis that the patient population likely did not have access issues (e.g., all have full prescription drug coverage). The Committee also notes that this measure may not correlate with the lower performance rates of a measure of post-discharge follow-up because that measure only looks at follow-up with a behavioral health provider, while geriatric patients may more typically follow up with a primary care physician.
- The Committee also noted the developer's findings that black patients have significantly worse rates of mediation continuation than the reference group; specific data were not provided.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-6**; **M-17**; **L-0**; **I-0;** 2b. Validity: **H-2**; **M-18**; **L-3**; **I-0**

<u>Rationale</u>:

- The developer performed a signal-to-noise analysis and found that a provider needs to have at least 75 discharges in order to obtain an overall reliability score of at least 0.7 (the minimum acceptable reliability value). The developer noted that 1,200 of about 1,700 of the facilities had at least 75 discharges. They further noted that they use a 2-year measurement period to increase the number of facilities eligible to report.
- One Committee member expressed concern about the number of patients who do not show their prescription cards due to the extremely low cost of generic drugs, and so may not be captured.
- Committee members raised questions about the measure only assessing filled prescriptions, and not if the medication is being taken correctly (or at all). The developer noted that most studies use a proxy for adherence (filling of the prescription), so most of the outcomes data related to

adverse events are related to filling of the prescription and not a patient-reported measure of attestation about actually taking the medication.
- The Committee also questioned how the measure would work for individuals who already had a supply of medication at home. The developer said they did an analysis of patients in the cohort and found that for the overwhelming majority of patients, their last prescription fill prior to an inpatient hospitalization was for a 30-day supply, so those individuals would still likely be captured.
- For validity testing, the developer performed a Spearman's rank correlation showing that the proposed measure correlates as expected with existing endorsed measures. In particular, the developer noted a large correlation effect (0.43) with a measure of follow-up after hospitalization (30-day).

---

3. Feasibility: H-14; M-9; L-0; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

Rationale:

- The Committee noted that the required data elements are routinely collected, and there have been no reports of implementation challenges.

---

4. Use and Usability: H-5; M-15; L-3; I-0

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

Rationale:

- Several Committee members raised concerns about the hospital being held responsible for patients' filling prescriptions, particularly for hospitals such as public hospitals with transient populations. The developer stated that they see this measure as the first step in continuity of care, and they are not considering the facility responsible for long-term follow up. Other Committee members noted that it may drive hospitals to use outpatient pharmacies and to ensure they are educating the patients on the importance of taking the medication.
- The Committee also recommended the developer to try to expand the measure denominator to include Medicare Advantage and/or other patients.

---

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: **Y-20**; **N-3**

6. Public and Member Comment:

- This measure received seven comments. Three comments expressed concerns with the Committee's decision to recommend the measure. All three commenters agreed that adherence to medication is important, particularly in the psychiatric population where psychotropic medication discontinuation can have a range of adverse effects. However, one commenter agreed that while hospitals should take steps to encourage and help patients obtain and take

their medications as directed, assessing whether patients have their prescriptions filled within a certain time period does not necessarily constitute a hospital level measure. Another commenter stated that measuring a patient's access to a medication does nothing to measure whether a patient actually took the medication.

- Developer response: We thank you for your comments on the measure. The measure does not require the inpatient treatment team to monitor patients' medication adherence following discharge. There is evidence that improvements to the quality of care for patients in the IPF setting, including the discharge processes, can help to increase medication continuation rates.
  In response to the question about the Committee summary, inpatient pharmacies do not generally dispense prescriptions for ambulatory use. We envision the measure may promote innovative approaches to coordinating care post discharge.
  The goal of this measure is to improve medication continuation and reduce the variation in performance across IPFs. Interventions to improve medication continuation should be tailored to meet each patient's needs and circumstances. This measure gives facilities the flexibility to determine which interventions are most appropriate for their patient populations.
  For more information on the measure specifications, supporting literature, and measure results, refer to the measure methodology report at the following link by opening the "Inpatient Psychiatric Facility Medication Continuation Measure" zip file: https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/hospitalqualityinits/measure-methodology.html
- Committee response: The Committee did consider these issues during our in-person meeting, but concluded that hospitals have a role in properly educating patients on the importance of filling prescriptions. Additionally, hospital may be encouraged to increase the use of outpatient hospital pharmacies. The Committee agrees that the issues raised in these comments do not preclude our recommendation for endorsement. Further, NQF's recent work on attribution models noted, "As teams increasingly deliver care and facilities become more integrated, attribution models should reflect what the accountable entities are able to influence rather than directly control."

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for endorsement

---

8. Appeals

No appeals received.

3185 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Submission | Specifications

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user

Numerator Statement: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Denominator Statement: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy, other medical reason)

Adjustment/Stratification: N/A

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

Setting of Care: Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Electronic Health Record (Only)

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

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

1a. Evidence Exception: **Y-24; N-0**; 1b. Performance Gap: **H-8**; **M-16**; **L-0**; **I-0**

Rationale:

- This measure is the new eMeasure version of NQF #3225. The information provided for evidence is identical to that submitted for #3225. Measure 3225 was discussed first and the rating for evidence was automatically assigned to this eMeasure without further discussion.
- The developer provided data showing the average PQRS EHR performance rate for 2015 as 76.38 percent, with a range of 27.84 percent (1st decile) to 100 percent (10th decile)
- As for Measure 3225, the developer cited literature showing that rates of tobacco screening and intervention varied by patients' race, age, and insurance status.

---

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria

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

2a. Reliability: **H-5**; **M-19**; **L-0**; **I-0** 2b. Validity: **M-19**; **L-5**; **I-0**

Rationale:

- The data elements are clearly defined and compliant with industry standards.
- One Committee member suggested that dental offices be included as a setting of care.
- One Committee member suggested making the denominator less restrictive by removing the requirement for "at least two visits," noting that the patients who are seen less frequently may be in more need of assistance.

- A Committee member also suggested changing the measure so that the provider must report separate rates for screening and treatment, with the stipulation that the provider is required to report on both rates. The developer noted they have modeled this and CMS is reviewing this possibility.
- The Committee again discussed the exclusion for "medical reasons" (as was discussed in an earlier discussion of Measure #3225), with the developer again noting this is a rare occurrence (0.4 percent). The Committee discussed the need for caution in creating a situation in which the measure can be "gamed," especially as more individuals report on the measure.
- The developer reported that the reliability of the measure score was assessed using 2015 data reported via the EHR option to the PQRS program. A beta binomial method was used to perform a signal-to-noise analysis. This analysis showed a reliability statistic of 0.81 at the minimum number of events and a statistic of 0.99 at the average number of events.
- The developer reported that BONNIE testing on 40 test cases confirmed there was a test case for each pathway of logic, and that all the test cases performed as expected.
- The developer reported that face validity testing with an expert panel showed that six of 10 clinicians surveyed (60 percent) agreed or strongly agreed that the measure can accurately distinguish good and poor quality.

---

3. Feasibility: H-7; M-17; 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 data can be obtained through EHRs.
- The Committee noted that the feasibility assessment showed that only 17 of the 26 elements were currently feasible. The developer explained that some providers cannot use certain codes (e.g., an internal medicine provider may not be able to use behavioral health codes). In addition, some EHRs cannot capture some of the exclusions in structured fields, and the developer noted that most providers will use free text for documentation.

---

4. Usability and Use: H-10; M-14; L-0; I-0

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

Rationale:

- This measure is currently used in several CMS programs, including: Medicare Shared Savings Program (MSSP); Physician Value-Based Payment Modifier (VBM) and Physician Feedback/Quality and Resource Use Reports (QRUR).
- The Committee stressed the importance and need for screening and intervention in mental health and substance use disorder populations.

---

5. Related and Competing Measures

- No competing measures noted.
- Related Measures include:
    - 0027: Medical Assistance With Smoking and Tobacco Use Cessation

- 1651: TOB-1 - Tobacco Use Screening
- 1654: TOB-2 - Tobacco Use Treatment Provided or Offered
- 1656: TOB-3- Tobacco Use Treatment Provided or Offered at Discharge
- 2600 : Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- 2803 : Tobacco Use and Help with Quitting Among Adolescents
- 3225: Tobacco Use: Screening and Cessation Intervention

- The Committee had a brief discussion about the portfolio of tobacco-related measures, and found that none of the measures were competing. They noted minor differences in definitions that may be considered for harmonization, but the Committee decided to table the discussion.

Standing Committee Recommendation for Endorsement: **Y-24**; **N-0**

6. Public and Member Comment:

- This measure received three comments supporting endorsement of the measure.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for endorsement

---

8. Appeals

No appeals received.

3225 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Submission | Specifications

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user

Numerator Statement: Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

Denominator Statement: All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

Exclusions: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

Adjustment/Stratification: N/A

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

Setting of Care: Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Claims (Only), Claims (Other), Registry

Measure Steward: PCPI Foundation

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: <u>The measure meets the Importance criteria</u>

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

1a. Evidence Exception: **Y-24; N-0**; 1b. Performance Gap: **H-6**; **M-14**; **L-2**; **I-1**

<u>Rationale</u>:

- In 2012, the developer provided guidelines from the U.S. Public Health Service and the USPSTF that recommend clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
- For this submission, the developer provided updated statements from the USPSTF (2015), noting high quality, quantity, and consistency of the evidence base.
- The Committee agreed the updates in the evidence were directionally the same as the evidence presented in the last review and so there was no need to repeat the discussion and vote on evidence.
- The developer reported an average performance rate in 2014 of 88.9 percent, with 21.7 percent of eligible professionals reporting on the measure. For claims, the fourth through tenth percentiles were all performing at 100 percent. For the registry, the eighth through tenth percentiles were performing at 100 percent.
- The Committee discussed the high rates of performance. Some Committee members noted that high performers may be choosing this measure to report on and the developer stated that the literature suggests the performance is likely lower in the broader provider population.
- The developer cited literature showing that rates of tobacco screening and intervention varied by patients' race, age, and insurance status.
- Committee members noted a desire to see gaps specifically for patients with mental health and substance use disorders.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-11**; **M-12**; **L-0**; **I-0** 2b. Validity: **M-20**; **L-2**; **I-1**

<u>Rationale</u>:

- One Committee member questioned the 24-month period for screening and intervention. The developer explained that the interval was based on feedback from expert workgroups; they noted that screening and intervention can certainly be done more often than this interval – the measure only works to ensure it is done at least once in this time period.
- Other Committee members raised issues about how the offer for cessation interventions is documented, and the developer confirmed that this often relies on attestation from the provider. Committee members noted that there may be challenges in documenting interventions that are captured in other places (e.g., workplace wellness programs).
- One Committee member questioned exclusions for "medical reasons" (e.g., limited life). The developer said this was suggested as appropriate by expert workgroups and also deemed appropriate by palliative care groups. They noted that these types of exclusions occur infrequently.

- Several Committee members discussed the need to expand this measure (and other tobacco measures) to include other forms of nicotine delivery (e.g., electronic cigarettes). They also recognized that this would add to the burden of documentation and data collection.
- The Committee also suggested expanding this measure to cover adolescents, and also discussed the possibility of linking this measure to actual decreases in rates of tobacco use. Another suggestion was to develop a stratification for the rates for patients with mental health and substance use disorders.
- The developer reported that the reliability of the measure score was re-assessed for this submission using a beta-binomial method to perform a signal-to-noise analysis. The developer used two testing samples – one using 2015 data reported via the registry option to the PQRS program and one using the claims option. For the registry option, this analysis showed a reliability statistic of 0.78 at the minimum number of events and a statistic of 0.99 at the average number of events. For the claims option, this analysis showed a reliability statistic of 0.71 at the minimum number of events and a statistic of 0.97 at the average number of events.
- The developer provided updated face validity testing which showed that six of ten clinicians (60 percent) surveyed agreed or strongly agreed that the measure can accurately distinguish good and poor quality. During the meeting, the developer noted that since the submission, they had received more feedback from their experts (for a total of 29 responses), resulting in an increase of the validity testing score to 76 percent.

---

3. Feasibility: H-12; M-11; 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 Committee agreed that the measure is feasible to implement, as the data can be obtained through claims registry and/or patient records.

---

4. Usability and Use: H-12; M-10; L-2; I-0

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

Rationale:

- The measure is currently used in several CMS programs including Physician Quality Reporting System (PQRS), Physician Compare, and the Medicare Shared Savings Program (MSSP).

---

5. Related and Competing Measures

- This measure is related to several other measures:
    - 0027: Medical Assistance With Smoking and Tobacco Use Cessation
    - 1651: TOB-1 - Tobacco Use Screening
    - 1654: TOB-2 - Tobacco Use Treatment Provided or Offered
    - 1656: TOB-3- Tobacco Use Treatment Provided or Offered at Discharge
    - 2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
    - 2803: Tobacco Use and Help with Quitting Among Adolescents
    - 3185: Tobacco Use: Screening and Cessation Intervention (eMeasure)

- The Committee had a brief discussion about the portfolio of tobacco-related measures, and found that none of the measures were competing. They noted minor differences in definitions that may be considered for harmonization, but the Committee decided to table further discussions.

Standing Committee Recommendation for Endorsement: **Y-24**; **N-0**

6. Public and Member Comment:

- This measure received four comments mostly in support of the Committee's decision to endorse the measure. Two comments provided feedback on expanding this measure for the adolescent population and users of e-cigarettes.
    - Developer response: Thank you for your comment. The PCPI's measure development is a rigorous, evidence-based and multi-disciplinary process that has been refined and standardized over the past seventeen years of activity. Ensuring that performance measures are evidence-based and relevant to clinical practice remains integral to the process, with an emphasis on measures that reflect the most rigorous clinical evidence, particularly as included in clinical practice guidelines, and address areas most in need of improvement. In 2015, the USPSTF published an update to its 2009 recommendation on counseling and interventions to prevent tobacco use and tobacco-related disease in adults, including pregnant women. The USPSTF reviewed the current evidence for electronic nicotine delivery systems (ENDS) and concluded that it is insufficient to recommend ENDS for tobacco cessation in adults, including pregnant women. Additionally, ENDS are not currently classified as tobacco in the recent evidence review to support the update of the USPSTF recommendation given that the devices do not burn or use tobacco leaves. In light of the current lack of recommendations included in clinical practice guidelines, most notably the USPSTF, regarding ENDS, the measure does not currently capture e-cigarette usage as either tobacco use or a cessation aid and we feel that further evidence is required before we can include ENDS in the measure. The PCPI conducts an annual maintenance review of this and all measures that we steward during which clinical evidence and implementation feedback are reviewed with a Technical Expert Panel. Any new or emerging guideline recommendations regarding ENDS will most certainly be a focal point for upcoming and future reviews and subsequent modifications considered with the input of the TEP. Additionally, as it relates to expanding the measure to include adolescents, the PCPI recognizes that a current NQF endorsed measure, NQF #2803, is focused on assessing clinical level performance on tobacco cessation counseling among adolescents. We have traditionally included the identification of existing performance measures as an essential element in our measure development and maintenance process. These measures are reviewed to determine topic relevance, avoid duplicative efforts and achieve harmonization. With that said, we do see value in parsimony and recognize the seeming arbitrary limitation of the measure by excluding the adolescent population. We plan to review the issue with the aforementioned TEP and will determine if expanding the measure's patient population is appropriate.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for continued endorsement

8. Appeals

No appeals received.

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

Submission | Specifications

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

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

Exclusions: Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan, Integrated Delivery System

Setting of Care: Clinician Office/Clinic

Type of Measure: Process

Data Source: Claims (Only), Pharmacy

Measure Steward: National Committee for Quality Assurance

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

1a. Evidence: **H-1**; **M-8**; **L-7; I-4;** 1b. Performance Gap: **H-6**; **M-9**; **L-2**; **I-1**

UPDATED Votes 1a. Evidence: H-3; M-11; L-4; I-3; 1b. Performance Gap: H-6; M-11; L-3; I-1

Rationale:

- In 2014, the developer cited AAP clinical practice guidelines and AACAP practice parameters for the treatment of ADHD in children and adolescents. For this current submission, the developer stated “Numerous (>100) studies related to the care for patients with ADHD have been published since the publication of this guideline, none of which contradict the need for appropriate follow-up once treatment with medication begins.”
- One Committee member noted that while the initial 30-day timeframe is supported by AAP guidelines, there is no literature to support that timeframe and that the AAP acknowledges it is based on an agreement among individuals that the timeframe is appropriate. The Committee

member further noted a 2017 study of this measure which showed that the poor performers (for the 30-day rate) actually had lower use of EDs and lower hospitalizations, because compliant parents (who came in for follow-up) were willing to bring them in to the ED more often. Additionally, the Committee member stated the study showed that expanding the timeframe resulted in a 20 percent increase in compliance.

- One Committee member emphasized that the focus of the measure is largely supported by clinical practice guidelines and not strong evidence. They also noted that the AACAP guidelines do not suggest a specific timeframe for follow-up.
- One Committee member asked about studies on how consumers felt about having to come back in (related to burden).
- One Committee member asked about the extensiveness of the literature review since the field has been changing. The developer said their review did not rise to the level of a systematic review, but instead was a review for any evidence saying the measure was outdated, no longer effective, or causing harm.
- One Committee member raised concern about an overestimation of adherence, because many children do not get to the maintenance phase.
- Committee members also noted that the use of ADHD medications has gone up exponentially, so follow-up is very important conceptually.
- The Committee did not reach consensus on the evidence subcriterion.
- The Committee noted that the 10th percentile of performers has a performance rate of 29 percent for both Medicaid and Commercial plans, and the 90th percentile has a 50 percent performance rate for Commercial plans and 56 percent for Medicaid, representing a big gap in performance.
- Committee members also noted very little change in performance over the years.
- The developer conducted a second-round evidence review and cited additional studies showing that children on ADHD medications who received follow-up visits within a few weeks to a year had improved clinical outcomes as compared to children who did not have follow-up visits.
- The Committee discussed their continued concerns for the specification for a 30-day follow-up visit, including whether another similar timeframe might be just as reasonable. NCQA noted that they went back to the American Academy of Pediatrics (AAP), and AAP has maintained their support of this timeframe as it is based on the consensus of a panel.
- During the post-comment call, the Committee discussed the new information submitted. Voting was conducted on a post-call voting survey, and the Committee voted to recommend the measure.

---

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria</u>

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

2a. Reliability: **H-7**; **M-8**; **L-5**; **I-0;** 2b. Validity: **H-2**; **M-5**; **L-11**; **I-2**

UPDATED Votes 2a. Reliability: H-5; M-11; L-4; I-1; 2b. Validity: H-0; M-13; L-4; I-4

<u>Rationale</u>:

- The developer provided an update of reliability testing of the measure score using a signal-to-noise analysis. The initiation phase demonstrated beta-binomial statistics of 0.90 (Commercial) and 0.98 (Medicaid) for the initiation phase, and statistics of 0.75 (Commercial) and 0.95 (Medicaid) for the continuation phase.

- Validity testing included face validity testing with panels of experts. One Committee member raised concern about the low number of providers on the panel who were physicians or prescribers of medication, as well as the lack of a pediatrician on the initial panel.
- One Committee member raised concern about the construct validity testing, stating that they did not agree that contact with a primary care provider was a comparable measure.
- In a continuation of earlier discussions about the timeframe for follow-up, the Committee expressed significant concern about the requirement for a face-to-face encounter for the first visit. The Committee noted that providers are being encouraged to use alternative ways to engage with patients (e.g., telehealth, including video conferencing, apps, and other modalities), especially as a way to save costs for patients with high-deductible plans. The developer responded that they are evaluating the use of telehealth in general across all of their measures, and that there is a recommendation currently out for comment to use video-conferencing in this particular measure. The developer also noted that telehealth is acceptable for one of the other two visits.
- The Committee voted to pass the measure on the validity subcriterion.

---

3. Feasibility: H-8; M-12; L-0; I-0

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

---

4. Use and Usability: H-6; M-9; L-5; I-1

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

---

5. Related and Competing Measures: N/A

Standing Committee Recommendation for Endorsement: Y-13; N-8

---

6. Public and Member Comment:

- This measure received one comment from the developer requesting that the Committee reconsider the validity criteria based on the new information that they provided. Based on the Committee's recommendation, NCQA conducted a second-round evidence review and cited additional randomized control studies showing that children on ADHD medications who received follow up visits (providing medication management and monitoring services) within a few weeks to a year had improved clinical outcomes. The developer also noted AAP's continued support of the timeframe for follow-up as well as their own efforts to consider the use of telehealth for this measure. Due to this additional information, the Committee decided to revote on this measure.
- During the post-comment call, the Committee discussed the new information submitted and decided to revote on the measure. Following the post-comment call, the Committee voted to recommend the measure for continued endorsement.

---

7. Consensus Standards Approval Committee (CSAC) Review (June 29, 2017): Y-16; N-0

Decision: Approved for continued endorsement

8. Appeals

No appeals received.

Measures with Endorsement Decision Deferred

The following measure submitted for the Standing Committee's review during the project has been deferred for future consideration:

0008 Experience of Care and Health Outcomes (ECHO) Survey

Submission

Description: The ECHO is a survey that includes 5 multiple item measures and 12 single item measures:
Multiple Item Measures:
Getting treatment quickly
-Get treatment as soon as wanted when it was needed right away
-Get appointments as soon as wanted
-Get professional help by telephone
How well clinicians communicate
-Clinicians listen carefully
-Clinicians explain things in an understandable way
-Clinicians show respect
-Clinicians spend enough time
-Feel safe with clinicians
-Patient involved as much as wanted in treatment
Perceived improvement
-Compare ability to deal with daily problems to 1 year ago
-Compare ability to deal with social situations to 1 year ago
-Compare ability to accomplish things to 1 year ago
-Compare ability to deal with symptoms or problems to 1 year ago
Getting treatment and information from the plan
-Getting new clinician
-Delays in treatment while wait for plan approval
-Getting necessary treatment
-Understanding information about treatment in booklets or on the web
-Getting help when calling customer service
-Filling out paperwork
Informed about treatment options
-Told about self-help or consumer run programs
-Told about different treatments that are available for condition
Single Item Measures:

-Overall rating of counseling and treatment (MCO and MBHO)

-Overall rating of the health plan (MCO only)

-Wait more than 15 minutes past appointment time to see clinician

-Told about medication side effects

-Talk about including family & friends in treatment

-Given as much information as wanted about how to manage condition

-Given information about rights as a patient

-Patient feels that he or she could refuse a specific type of treatment

-Was information revealed that should have been kept private

-Cultural competence -Care responsive to language, race, religious, ethnic

-Amount helped by treatment

-Plan provides information about how to get treatment after benefits used up

The measures are based on reports of care experiences over the previous six months from adult (18 years of age or older) patients receiving behavioral healthcare (mental health and substance abuse treatment) and the organization that provides or manages their treatment and health outcomes.

Each measure score is the mean of the responses to the survey questions from patients receiving care at a particular health plan or managed behavioral health organization.

More detail can be found at: http://www.ahrq.gov/cahps/surveys-guidance/echo/about/survey-measures.html

Numerator Statement: No changes form original specification: The ECHO survey measures patient-centered care by asking about patient experiences with behavioral healthcare (mental health and substance abuse treatment) and the organizations that provide or manage the person´s treatment and health outcomes.

Denominator Statement: All survey respondents, or for selected items, all respondents who respond appropriately to screening questions.

Exclusions: No changes: Patients who received behavioral health services only in primary care settings (e.g. psychotropic medications from their primary care physician) are not included.

Adjustment/Stratification: N/A

Level of Analysis: Health Plan

Setting of Care: Behavioral Health: Outpatient

Type of Measure: Outcome: PRO

Data Source: Patient Reported Data

Measure Steward: Agency for Healthcare Research and Quality

STANDING COMMITTEE MEETING 03/01/2017

1. Importance to Measure and Report:

(1a. Evidence, 1b. Performance Gap, 1c. Composite - Quality Construct)

Rationale:

- The Committee noted the importance of patient experience measures, especially to behavioral health. The developer said there has been a resurgence of interest in the instrument in the last

year and there are several large studies currently underway. In addition, they are currently in the process of field testing which may result in a major update of the measure.
- The developer could not provide data on performance gap at this time, but the Committee noted this is one of the few measures of patient experience for behavioral healthcare.
- The Committee provided the developer with several ideas for partners who might be able to provide them with needed data (e.g., ACORN, specific state programs).

---

2. Scientific Acceptability of Measure Properties:

(2a. Reliability - precise specifications, testing; 2b. Validity - testing, threats to validity; 2d. Composite – Empirical Analysis for Construction)

Rationale:

- The developer described how the measure was developed, particularly around the use of focus groups to talk to patients about what they think quality means as well as for cognitive testing of the instrument.
- The Committee suggested development of a clear logic model that helps explain the various patient-reported outcomes included within the measure.
- The Committee suggested the developer reconsider the exclusion of patients treated in primary care settings.

---

3. Feasibility: N/A

(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)

Rationale:

- The Committee provided the developer with several suggestions of how to go about determining use of the measure.
- The developer noted several state projects that are using the measure that might be sources of data.

---

5. Related and Competing Measures

- No related or competing measures noted.

Standing Committee Recommendation for Endorsement: N/A

6. Public and Member Comment:

- This measure received two supportive comments. One comment encouraged the developer to prioritize revisions and updates to the measure using lessons learned from three existing beneficiary oriented measure sets – CAHPS; National Core Indicators; and Personal Outcome Measures.

Rationale for deferral

Shortly before the in-person meeting and in agreement with the Committee Co-Chairs, the NQF decided to defer consideration of endorsement for this measure because there was insufficient information for the Committee to consider. The developer explained that they do not currently have data on scores and usage, but are in the process of performing some field testing. The Committee agreed that this type of measure that captures patient experience is very important, and they further agreed that they preferred to give feedback to the developer at this time about the type of information they would need to see in order to consider continued endorsement. NQF expects to review this measure for consideration of endorsement after the measure is updated as part of its annual review in 2018.

Measures Not Recommended

3172 Continuity of Pharmacotherapy for Alcohol Use Disorder

Submission

Description: Percentage of adults 18-64 years of age with pharmacotherapy for alcohol use disorder (AUD) who have at least 180 days of treatment and a Proportion of Days Covered (PDC) of at least 0.8

Numerator Statement: Individuals in the denominator who have at least 180 days of treatment and a PDC of at least 0.8 for AUD medications

Denominator Statement: Individuals 18-64 years of age who had a diagnosis of AUD and at least one claim for an AUD medication

Exclusions: There are no denominator exclusions.

Adjustment/Stratification: N/A

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

Setting of Care: Clinician Office/Clinic, Behavioral Health : Outpatient

Type of Measure: Process

Data Source: Claims (Other), Pharmacy

Measure Steward: RAND Corporation

STANDING COMMITTEE MEETING 03/01/2017

1. Importance to Measure and Report: Did not meet the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-0**; **M-7**; **L-9; I-3;** 1b. Performance Gap: **N/A**

Rationale:

- The developer provided recommendations from the VA/DoD 2015 guideline on the management of substance use disorders regarding specific medications to offer for AUD.
- The Committee expressed concern about the evidence for the 180-day timeframe for continuation of medication. The developer noted the timeframe was based on FDA trial lengths.
- The Committee regarded the evidence on the individual medications to be of varied strength and quality, stating that some of the individual medications had little evidence to support the timeframe of the measure or even the efficacy of the medication itself. Committee members stated that often guidelines will suggest the use of medications for when everything else has failed.
- The Committee expressed concern that the medications are used to reduce the number of days of alcohol use, but do not necessarily help patients to stop using alcohol altogether. The Committee also noted that while the medications may lead to decreased alcohol use, relapses are not specifically associated with discontinuation of the medication.
- The Committee expressed concern that some of the medications are not approved by the FDA for alcohol use disorder. The developer stated that guidelines often support the off-label use of older medications, and that there will likely not be studies that would be required to go through the FDA process to get such approvals. The Committee also noted that some of the medications have other uses (e.g., gabapentin for neuropathy), and so patients using these medications for

other reasons who appropriately stop taking those medications would be captured in this measure.
- The Committee also expressed concern that the evidence for using medication alone for alcohol use disorder is not strong (as it is for opioid use disorder). The Committee noted that cognitive-behavioral therapies can be equally effective, and they questioned the importance to measure medication use in isolation for alcohol use disorder. The developer noted that this measure does not question the choice to go on medication or not, but to say that if someone is prescribed a medication, there should be an effort to try to ensure adherence.
- Ultimately, the measure did not pass the evidence subcriterion; the Committee did not recommend the measure for endorsement.

---

2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **N/A** 2b. Validity: **N/A**

---

3. Feasibility: N/A

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

---

4. Use and Usability: N/A

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

---

5. Related and Competing Measures: N/A

Standing Committee Recommendation for Endorsement: **N/A**

6. Public and Member Comment:

- No comments were received on this measure.

3207 Medication Reconciliation on Admission

Submission

Description: The average completeness of the medication reconciliation process within 48 hours of admission to an inpatient facility.

Numerator Statement: This measure does not have a traditional numerator. The numerator is a facility-level score of the completeness of the medication reconciliation process within 48 hours of admission. This score is calculated by averaging the scores of the three components of the medication reconciliation process. The components include:

1) Comprehensive prior to admission (PTA) medication information gathering and documentation

2) Completeness of critical PTA medication information

3) Reconciliation action for each PTA medication

Denominator Statement: The denominator for the composite measure includes admissions to an inpatient facility from home or a non-acute setting with a length of stay greater than or equal to 48 hours.

Exclusions: This measure does not have any denominator exclusions.

Adjustment/Stratification: N/A

Level of Analysis: Facility

Setting of Care: Behavioral Health : Inpatient

Type of Measure: Composite

Data Source: Other, Paper Records

Measure Steward: Centers for Medicare & Medicaid Services, Contracting Officer's Representative (COR)

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: Did not meet the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-1**; **M-6**; **L-15; I-1;** 1b. Performance Gap: **N/A**

Rationale:

- The developer provided evidence in the form of a 2012 systematic review of hospital-based medication reconciliation practices and individual related studies new since the systematic review. The developer also noted The Joint Commission National Patient Safety Goals for hospitals that includes a goal to "maintain and communicate accurate patient medical information." This goal specifically includes aspects related to medication information.
- The Committee expressed concern that the evidence was weak for this measure focus, noting that in the 2012 systematic review, only 6 of the 26 studies were rated as good quality. Further, the review did not discriminate whether the reconciliation occurred at admission, transfer between units, or at discharge. The developer stated that studying medication errors and measuring preventable adverse drug events can be challenging.
- The Committee also noted that while national organizations may say medication reconciliation is important, they do not see clear evidence that specifically links each of the components of the measure with enhanced outcomes. The developer stated the measure is consistent with The Joint Commission's National Patient Safety Goals, but the Committee noted these are not evidenced based recommendations. Further, Committee members noted that studies of the medication reconciliation process are usually conducted in acute care facilities, and not in inpatient psychiatric facilities.
- Committee members recommended providing more evidence about how each of the components will lead to improvements.
- Ultimately, the measure did not pass the evidence subcriterion; the Committee did not recommend the measure for endorsement.

2. Scientific Acceptability of Measure Properties:

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

2a. Reliability: **N/A**. Validity: **N/A**

3. Feasibility: N/A

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

4. Use and Usability: N/A

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

5. Related and Competing Measures: N/A

Standing Committee Recommendation for Endorsement: N/A

6. Public and Member Comment:

- This measure received four comments, all of which agreed with the Committee's decision not to recommend the measure. Two commenters agreed that it is important to know a patient's medication history however; they argue that the structure and complexity of the measure make it unacceptably burdensome. Another commenter shared the Committee's concerns that the evidence for the measure focus was weak and that adequate links were not demonstrated between the three components of the proposed measure and improved outcomes. The developer for this measure provided a memo for the Committee's consideration that includes background on the measure, the feedback that was received during the in-person meeting, and their responses to that feedback.
    - Developer response: Thank you for your comments on the measure. We plan to incorporate feedback from the NQF Behavioral Health Standing Committee, the Technical Expert Panel, and other key stakeholders who have provided public comments when we re-specify the measure. To address the concerns related to the complexity of the measure calculation, burden, and evidence for each component, we will restructure the measure to have a single score rather than a composite score and reduce the number of data elements to align with existing measures that evaluate the medication reconciliation process in other settings.

3229 Patient Panel Adult Smoking Prevalence

Submission

Description: Percentage of adults (age 18 years or older) who are tobacco smokers at time of most recent encounter during the measurement period.

Numerator Statement: Patients age 18 years and older who had a qualifying encounter with a provider during the measurement period AND were indicated as smokers as of the most recent qualifying encounter during the measurement period.

Denominator Statement: Patients age 18 years and older who had a qualifying encounter with a provider during the measurement period AND were screened for smoking within 24 months prior to the measurement period end date AND screening occurred during or prior to the patient's mo

Exclusions: Patients were excluded if they were <18 years old. Additionally, they were excluded from being screened for smoking status if they had limited life expectancy, had a medical reason, or had smoking status missing (details in exclusion analysis Section 2b3).

Adjustment/Stratification: N/A

Level of Analysis: Clinician : Individual

Setting of Care: Clinician Office/Clinic, Other, Behavioral Health : Outpatient

Type of Measure: Outcome

Data Source: Electronic Health Record (Only)

Measure Steward: Centers for Medicare & Medicaid Services

STANDING COMMITTEE MEETING 02/28/2017

1. Importance to Measure and Report: The measure meets the Importance criteria

(1a. Evidence: 1b. Performance Gap, 1c. High Priority)

1a. Evidence: **H-9**; **M-10**; **L-3; I-1;** 1b. Performance Gap: **H-13**; **M-9**; **L-0**; **I-1**

Rationale:

- The Committee recognized the measure focus has a strong evidence base in the form of clinical practice guidelines, USPSTF recommendations, and a systematic review showing the overall evidence to be of high quality, quantity, and consistency. The Committee also found evidence that there are interventions that can impact the desired outcome (e.g., association between advice to quit and smokers actually quitting).
- The Committee noted variation in provider-level prevalence rates, ranging from 0.0 percent to 69.2 percent, and a mean prevalence of 13.2 percent. (Lower values are better in that they reflect a lower prevalence of smoking.)

---

2. Scientific Acceptability of Measure Properties: Did not meet the Scientific Acceptability criteria

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

2a. Reliability: **H-3**; **M-10**; **L-10**; **I-0;** 2b. Validity: **H-1**; **M-2**; **L-18**; **I-2**

Rationale:

- The developer demonstrated high reliability in testing (average reliability 0.899) when tested among providers who reported smoking status for at least 10 patients and at least 50 percent of all their patients.

- The Committee was concerned about the potential for providers to "game" the system; the measure excludes all patients who do not have a smoking status recorded. The Committee noted that providers might score well on the measure by not reporting smoking status for their smokers. The Committee further noted that 26.5 percent of patients were excluded in testing due to missing smoking status, and expressed concern for how this affected the validity of the measure, since the missing data could skew the results. The developers noted that this would cause the provider to score poorly on other measures related to screening, and the Committee suggested the measures might be combined to avoid such "gaming."
- The Committee also expressed concern that providers would be punished for their patients relapses in spite of their efforts to encourage their patients to quit. They also raised issues about a patient's smoking status being attributed to the most recent physician, even though the patient may have recently changed physicians.
- Several Committee members suggested the measure be reconfigured as a measure of percent change in smoking status, and the developer agreed this could be a direction to go in the future.
- The Committee expressed their support for this type of measure, noting it was an important first step toward a population-based outcome measure for smoking, but that more work was needed on the specifications to ensure validity.
- Ultimately, the measure did not pass the validity subcriterion; the Committee did not recommend the measure for endorsement.

---

3. Feasibility: N/A

(3a. Data generated during care; 3b. Electronic sources; and 3c. Data collection can be implemented (eMeasure feasibility assessment of data elements and logic)

---

4. Use and Usability: N/A

(4a. Accountability/transparency; and 4b. Improvement – progress demonstrated; and 4c. Benefits outweigh evidence of unintended negative consequences)

---

5. Related and Competing Measures: N/A

Standing Committee Recommendation for Endorsement: N/A

---

6. Public and Member Comment:

- One comment was received in support of the Committee's decision not to recommend the measure.

Measures Withdrawn from Consideration

One measure previously endorsed by NQF was not re-submitted for maintenance of endorsement during the endorsement evaluation process. Endorsement for this measure will be removed.

Measure	Reason for withdrawal
1364 Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation	Retired by developer

Appendix B: NQF Behavioral Health Portfolio and Related Measures

NQF Number	Measure Title
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement
0008	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)
0026	Measure pair - a. Tobacco use prevention for infants, children and adolescents, b. Tobacco use cessation for infants, children and adolescents
0027	Medical Assistance With Smoking Cessation
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
0104	Major Depressive Disorder: Suicide Risk Assessment
0105	New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)
0418	Screening for Clinical Depression
0518	Depression Assessment Conducted
0557	HBIPS-6 Post discharge continuing care plan created
0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge
0560	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification
0576	Follow-Up After Hospitalization for Mental Illness
0640	HBIPS-2 Hours of physical restraint use
0641	HBIPS-3 Hours of seclusion use
0710	Depression Remission at Twelve Months
0711	Depression Remission at Six Months
0712	Depression Utilization of the PHQ-9 Tool
0722	Pediatric Symptom Checklist (PSC)
1364	Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
1651	TOB-1 Tobacco Use Screening
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment
1656	TOB-3 Tobacco Use Treatment Provided or Offered at Discharge and the subset measure TOB-3a Tobacco Use Treatment at Discharge
1661	SUB-1 Alcohol Use Screening

NQF Number	Measure Title
1663	SUB-2 Alcohol Use Brief Intervention Provided or Offered and SUB-2a Alcohol Use Brief Intervention
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
1880	Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder
1884	Depression Response at Six Months- Progress Towards Remission
1885	Depression Response at Twelve Months- Progress Towards Remission
1922	HBIPS-1 Admission Screening
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
1927	Cardiovascular Health Screening for People With Schizophrenia or Bipolar Disorder Who Are Prescribed Antipsychotic Medications
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)
1933	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)
1934	Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)
1937	Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)
2111	Antipsychotic Use in Persons with Dementia
2020	Adult Current Smoking Prevalence
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
2337	Antipsychotic Use in Children Under 5 Years Old
2483	Gains in Patient Activation (PAM) Scores at 12 Months
2599	Alcohol Screening and Follow-up for People with Serious Mental Illness
2600	Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
2601	Body Mass Index Screening and Follow-Up for People with Serious Mental Illness
2602	Controlling High Blood Pressure for People with Serious Mental Illness
2603	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Testing
2604	Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy
2605	Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Dependence
2606	Diabetes Care for People with Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)
2607	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)
2608	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)

NQF Number	Measure Title
2609	Diabetes Care for People with Serious Mental Illness: Eye Exam
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics
2801	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
2806	Pediatric Psychosis: Screening for Drugs of Abuse in the Emergency Department
3172	Continuity of Pharmacotherapy for Alcohol Use Disorder
3175	Continuity of Pharmacotherapy for Opioid Use Disorder
3185	Preventive Care and Screening-Tobacco Use-Screening and Cessation Intervention (eMeasure)
3205	Medication Continuation Following Inpatient Psychiatric Discharge
3207	Medication Reconciliation on Admission
3229	Patient Panel Adult Smoking Prevalence

Appendix C: Behavioral Health Portfolio—Use in Federal Programs

NQF Number	Measure Title	Federal Programs: Finalized as of March 21, 2017
0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: a. Initiation, b. Engagement	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Feedback Physician Quality Reporting System (PQRS) Value-Based Payment Modifier Program
0027	Medical Assistance With Smoking Cessation	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults
0028	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention	Medicare Shared Savings Program
0104	Major Depressive Disorder: Suicide Risk Assessment	Meaningful Use (EHR Incentive Program) - Eligible Professionals Physician Feedback Physician Quality Reporting System (PQRS) Value-Based Payment Modifier Program
0105	New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management, (b) Effective Acute Phase Treatment, (c) Effective Continuation Phase Treatment	Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults Meaningful Use (EHR Incentive Program) - Eligible Professionals Medicare Part C Display Measure; Physician Feedback Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Children's Health Insurance Program Reauthorization Act Quality Reporting; Meaningful Use (EHR Incentive Program) - Eligible Professionals;#Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
0418	Screening for Clinical Depression	Medicare Shared Savings Program
0518	Depression Assessment Conducted	Home Health Compare; Home Health Quality Reporting
0557	HBIPS-6 Post discharge continuing care plan created	Inpatient Psychiatric Hospital Quality Reporting
0558	HBIPS-7 Post discharge continuing care plan transmitted to next level of care provider upon discharge	Inpatient Psychiatric Hospital Quality Reporting

NQF Number	Measure Title	Federal Programs: Finalized as of March 21, 2017
0560	HBIPS-5 Patients discharged on multiple antipsychotic medications with appropriate justification	Inpatient Psychiatric Hospital Quality Reporting
0576	Follow-Up After Hospitalization for Mental Illness	Children's Health Insurance Program Reauthorization Act Quality Reporting; Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults; Inpatient Psychiatric Hospital Quality Reporting; Medicare Part C Display Measure; Physician Quality Reporting System (PQRS)
0640	HBIPS-2 Hours of physical restraint use	Inpatient Psychiatric Hospital Quality Reporting
0641	HBIPS-3 Hours of seclusion use	Inpatient Psychiatric Hospital Quality Reporting
0710	Depression Remission at Twelve Months	Medicare Shared Savings Program
0712	Depression Utilization of the PHQ-9 Tool	Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
1365	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	Children's Health Insurance Program Reauthorization Act Quality Reporting; Meaningful Use (EHR Incentive Program) - Eligible Professionals; Physician Feedback; Physician Quality Reporting System (PQRS); Value-Based Payment Modifier Program
1651	TOB-1 Tobacco Use Screening	Inpatient Psychiatric Hospital Quality Reporting
1654	TOB - 2 Tobacco Use Treatment Provided or Offered and the subset measure TOB-2a Tobacco Use Treatment	Inpatient Psychiatric Hospital Quality Reporting
1661	SUB-1 Alcohol Use Screening	Inpatient Psychiatric Hospital Quality Reporting
1879	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Physician Quality Reporting System (PQRS)

Appendix D: Project Standing Committee and NQF Staff

STANDING COMMITTEE

Peter Briss, MD, MPH, (Co-Chair)
National Center for Chronic Disease Prevention and Health Promotion
Chamblee, Georgia

Harold Pincus, MD (Co-Chair)
New York-Presbyterian Hospital, The University Hospital of Columbia and Cornell
New York, New York

Robert Atkins, MD, MPH
Aetna Medicaid
Louisville, Kentucky

Mady Chalk, PhD, MSW
Treatment Research Institute
Washington, District of Columbia

Shane Coleman, MD, MPH
Behavioral Health Division Southcentral Foundation
Anchorage, Alaska

David Einzig, MD
Children's Hospital And Clinics Of Minnesota
Saint Paul, Minnesota

Julie Goldstein Grumet, PhD
Education Development Center/Suicide Prevention Resource Center/National Action Alliance for Suicide Prevention
Washington, District of Columbia

Charles Gross, PhD
Anthem, Inc.
Hanover, Maryland

Constance Horgan, ScD
The Heller School for Social Policy and Management, Brandeis University
Waltham, Massachusetts

Lisa Jensen, DNP, APRN
Office of Nursing Services, Veteran's Health Administration
North Salt Lake, Utah

Dolores (Dodi) Kelleher, MS, DMH
D Kelleher Consulting
Alameda, California

Kraig Knudsen, PhD
Ohio Department of Mental Health and Addiction Services
Columbus, Ohio

Michael R. Lardieri, LCSW
Northwell Health, Behavioral Health Services Line
Glen Oaks, New York

Tami Mark, PhD, MBA
RTI International
Bethesda, Maryland

Raquel Mazon Jeffers, MPH, MIA
The Nicholson Foundation
Hopewell, New Jersey

Bernadette Melnk, PhD, RN, CPNP/FAANP, FNAP, FAAN
The Ohio State University
Columbus, Ohio

Laurence Miller, MD
University of Arkansas for Medical Sciences
Little Rock, Arkansas

Brooke Parish, MD
Blue Cross Blue Shield of New Mexico
Albuquerque, New Mexico

David Pating, MD
Kaiser Permanente
San Francisco, California

Vanita Pindolia, PharmD
Henry Ford Health
Detroit, Michigan

Rhonda Robinson Beale, MD
Blue Cross of Idaho
Woodland Hills, California

Lisa Shea, MD, DFAPA
Care New England Health System
Providence, Rhode Island

Andrew Sperling, JD
National Alliance on Mental Illness
Arlington, Virginia

Jeffery Susman, MD
Northeast Ohio Medical University
Rootstown, Ohio

Michael Trangle, MD
Regions Hospital
Minnetonka, Minnesota

Bonnie Zima, MD, MPH
Los Angeles (UCLA) Semel Institute for Neuroscience and Human Behavior
Los Angeles, California

Leslie S. Zun, MD, MBA
Sinai Health System
Chicago, Illinois

NQF STAFF

Helen Burstin, MD, MPH
Chief Scientific Officer

Elisa Munthali, MPH
Acting Senior Vice President

Tracy Lustig, DPM, MPH
Senior Director

Kirsten Reed
Project Manager

Desmirra Quinnonez
Project Analyst

Appendix E: Measure Specifications

0027 Medical Assistance With Smoking and Tobacco Use Cessation

STATUS

Submitted

STEWARD

National Committee for Quality Assurance

DESCRIPTION

The three components of this measure assess 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 patients 18 years of age and older who are 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 patients 18 years of age and older who are 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 patients 18 years of age and older who are current smokers or tobacco users and who discussed or were provided cessation methods or strategies during the measurement year.

TYPE

Process

DATA SOURCE

Patient Reported Data CAHPS Health Plan Survey 5.0H, Adult Version; Medicare CAHPS

http://www.ahrq.gov/cahps/index.html

Available at measure-specific web page URL identified in S.1 No data dictionary

LEVEL

Health Plan, Integrated Delivery System

SETTING

Clinician Office/Clinic, Other In addition to clinician visits, some respondents may recall contacts with an “other health provider” (the wording used in the survey question), which may include contacts with nurses or health plan staff.

NUMERATOR STATEMENT

Advising Smokers and Tobacco Users to Quit:

Patients who indicated that they received advice to quit smoking or using tobacco from their doctor or health provider

Discussing Cessation Medications:

Patients who indicated that their doctor or health provider recommended or discussed smoking or tobacco cessation medications

Discussing Cessation Strategies:

Patients who indicated their doctor or health provider discussed or provided smoking or tobacco cessation methods and strategies other than medication

NUMERATOR DETAILS

For the commercial product line:

- Advising Smokers and Tobacco Users to Quit:

The number of patients in the denominator who indicated that they received advice to quit smoking or tobacco use from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q47: “In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

- Discussing Smoking Cessation Medications:

The number of patients in the denominator who indicated that their doctor or health provider recommended or discussed medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q48: “In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

- Discussing Cessation Strategies:

The number of patients in the denominator who indicated that their doctor or health provider discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q49: “In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for all questions:

Never, Sometimes, Usually, Always

For the Medicaid product line:

- Advising Smokers and Tobacco Users to Quit:

The number of patients in the denominator who indicated that they received advice to quit smoking or tobacco use from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q40: “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

- Discussing Smoking Cessation Medications:

The number of patients in the denominator who indicated that their doctor or health provider recommended or discussed medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q41: “In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

- Discussing Cessation Strategies:

The number of patients in the denominator who indicated that their doctor or health provider discussed or provided methods and strategies other than medication to assist with quitting smoking or using tobacco by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q42: “In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for all questions:

Never, Sometimes, Usually, Always

For the Medicare product line:

- Advising Smokers or Tobacco Users to Quit

The number of patients in the denominator who indicated that they received advice to quit smoking or using tobacco from a doctor or other health provider by answering “Sometimes” or “Usually” or “Always” to CAHPS question Q66 : “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for all questions:

Never, Sometimes, Usually, Always, I had no visits in the last 6 months

DENOMINATOR STATEMENT

Patients 18 years and older who responded to the CAHPS survey and indicated that they were current smokers or tobacco users during the measurement year or in the last 6 months for Medicaid and Medicare.

DENOMINATOR DETAILS

In order to be included in the denominator for each rate, patients must answer both the question about current cigarette/tobacco use and the relevant numerator question (eg, for the Advising Smokers and Tobacco Users to Quit rate, patients must answer the question about current cigarette/tobacco use and the question about how often they were advised to quit by a doctor or other health provider).

For the commercial product line:

- Advising Smokers and Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q46 and by answering Q47 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q46: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q46: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q47: “In the last 12 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q47: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Medications

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q46 and by answering Q48 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q46: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q46: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q48: “In the last 12 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

Response options for Q48: “Never” OR “Sometimes” OR “Usually” OR “Always”

- Discussing Cessation Strategies

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q46 and by answering Q49 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q46: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q46: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q49: “In the last 12 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for Q49: “Never”, “Sometimes”, “Usually”, “Always”

For the Medicaid product line:

- Advising Smokers and Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q39 and by answering Q40 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q39: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q39: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q40: “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q40: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Medications

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q39 and by answering Q41 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q39: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q39: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q41: “In the last 6 months, how often was medication recommended or discussed by a doctor or health provider to assist you with quitting smoking or using tobacco? Examples of medication are: nicotine gum, patch, nasal spray, inhaler, or prescription medication.”

Response options for Q41: “Never”, “Sometimes”, “Usually”, “Always”

- Discussing Cessation Strategies

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q39 and by answering Q42 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q39: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q39: “Every day”, “Some days”, “Not at all”, “Don´t know”

Q42: “In the last 6 months, how often did your doctor or health provider discuss or provide methods and strategies other than medication to assist you with quitting smoking or using tobacco? Examples of methods and strategies are: telephone helpline, individual or group counseling, or cessation program.”

Response options for Q42: “Never”, “Sometimes”, “Usually”, “Always”

For the Medicare product line:

- Advising Smokers or Tobacco Users to Quit

The number of patients who responded to the survey and indicated that they were current smokers or tobacco users by answering “Every day” or “Some days” to CAHPS question Q65, had one or more visits during the last 6 months, and by answering Q66 with any response (“Never” or “Sometimes” or “Usually” or “Always”).

Q65: “Do you now smoke cigarettes or use tobacco every day, some days, or not at all?”

Response options for Q65: “Not at all”, “Some days”, “Every day”, “Don’t know”

Q66: “In the last 6 months, how often were you advised to quit smoking or using tobacco by a doctor or other health provider in your plan?”

Response options for Q66: “Never”, “Sometimes”, “Usually”, “Always”, “I had no visits in the last 6 months”

The Medicare results for the Advising Smokers and Tobacco Users to Quit Rate requires a minimum denominator of at least 30 responses.

EXCLUSIONS

None

EXCLUSION DETAILS

N/A

RISK ADJUSTMENT

No risk adjustment or risk stratification

123834| 140881

123834| 140881

STRATIFICATION

None

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1: Identify the eligible population of commercial, Medicaid and Medicare CAHPS respondents

Step 2: Identify the denominator for each component.

Step 3: Identify the numerator for each component.

Step 4: Calculate the rate as numerator/denominator.

For the commercial and Medicaid product lines, rolling averages are calculated using the formula below.

Rate = (Year 1 Numerator + Year 2 Numerator)/(Year 1 Denominator + Year 2 Denominator)

NCQA calculates a result when the denominator is 100 individuals or more.

If the health plan did not report results in the prior year (Year 1), but reports results for the current year and achieves a denominator of 100 or more, NCQA calculates a rate.

For the Medicare product line, this is collected by the Centers for Medicare & Medicaid Services through the Medicare CAHPS Survey. This is collected on an annual basis. 123834| 140881

0576 Follow-Up After Hospitalization for Mental Illness (FUH)

STATUS

Submitted

STEWARD

National Committee for Quality Assurance

DESCRIPTION

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

- The percentage of discharges for which the patient received follow-up within 30 days of discharge

- The percentage of discharges for which the patient received follow-up within 7 days of discharge.

TYPE

Process

DATA SOURCE

Claims (Only) This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information

Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

No data collection instrument provided Attachment 0576_FUH_Value_Sets.xlsx

LEVEL

Health Plan, Integrated Delivery System

SETTING

Clinician Office/Clinic, Behavioral Health : Inpatient, Behavioral Health : Outpatient

NUMERATOR STATEMENT

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

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

NUMERATOR DETAILS

For both indicators, a follow-up visit includes outpatient visits, intensive outpatient visits or partial hospitalizations that occur on the date of discharge. Any of the following meet criteria for a follow-up visit:

- A visit (FUH Stand Alone Visits Value Set; FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set; FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a mental health practitioner (see definition below).

- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a mental health practitioner.

- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a diagnosis of mental illness (Mental Illness Value Set).

- Transitional care management services (TCM 7 Day Value Set).

The following meets criteria for only the 30-Day Follow-Up indicator:

- Transitional care management services (TCM 14 Day Value Set)

(See corresponding Excel document for the value sets referenced above)

Mental Health Practitioner Definition:

A practitioner who provides mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a

master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.

- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).

DENOMINATOR STATEMENT

Discharges from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness during the first 11 months of the measurement year (i.e., January 1 to December 1) for patients 6 years and older.

DENOMINATOR DETAILS

An acute inpatient discharge with a principal diagnosis of mental illness (Mental Illness Value Set) on or between January 1 and December 1 of the measurement year.

To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on patients. If patients have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute facility readmission or direct transfer:

If the discharge is followed by readmission or direct transfer to an acute inpatient care setting for a principal diagnosis of mental health (Mental Health Diagnosis Value Set) within the 30-day follow-up period, count only the last discharge.

To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the admission date for the stay.

*Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with value sets. See value sets located in question S.2b.

EXCLUSIONS

Exclude from the denominator for both rates, patients who receive hospice services during the measurement year.

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was for non-mental health.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

EXCLUSION DETAILS

Exclude patients who use hospice services or elect to use a hospice benefit any time during the measurement year, regardless of when the services began. These patients may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data

(Hospice Value Set).

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions to a nonacute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.

3. Identify the admission date for the stay.

Exclude discharges followed by readmission or direct transfer to an acute inpatient care setting within the 30-day follow-up period if the principal diagnosis was for non-mental health (any principal diagnosis code other than those included in the Mental Health Diagnosis Value Set). To identify readmissions to an acute inpatient care setting:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).

3. Identify the admission date for the stay.

These discharges are excluded from the measure because rehospitalization or transfer may prevent an outpatient follow-up visit from taking place.

- See corresponding Excel document for the Value Sets referenced above in S.2b.

RISK ADJUSTMENT

No risk adjustment or risk stratification

123834| 140881

123834| 140881

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7).

Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9).

Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5).

Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2. 123834|140881

COPYRIGHT / DISCLAIMER

N/A

3132 Preventive Care and Screening: Screening for Depression and Follow-Up Plan

STATUS

Submitted

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

Percentage of patients aged 12 years and older screened for depression on the date of the 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

TYPE

Process

DATA SOURCE

Electronic Health Record (Only) No specific data source/data collection instrument.

No data collection instrument provided Attachment NQF_0418_Coding_Table_S2b._CMS_2.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Clinician Office/Clinic

NUMERATOR STATEMENT

Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen

NUMERATOR DETAILS

Within the eMeasure specification, value sets contain various codes to indicate clinical quality actions. (See attached code table for S2.b)

Definitions included in relation to the numerator include the following:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of adolescent depression screening tools (12 – 17 years) include but are not limited to: Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), Patient Health Questionnaire (PHQ-9), Pediatric Symptom Checklist (PSC-17), PRIME MD-PHQ2.

Examples of adult depression screening tools (18 years and older) include but are not limited to Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, PRIME MD-PHQ2.

Follow-Up Plan - Documented follow-up for a positive depression screening must include one or more of the following:

•Additional evaluation for depression

•Suicide Risk Assessment

•Referral to a practitioner who is qualified to diagnose and treat depression

•Pharmacological interventions

•Other interventions or follow-up for the diagnosis or treatment of depression

The measure specification defines the numerator as:

AND:

- OR:

o AND: Most Recent: "Occurrence A of Risk Category Assessment: Adolescent Depression Screening (result)" during ("Encounter, Performed: Depression Screening Encounter Codes" during "Measurement Period")

o AND: "Occurrence A of Risk Category Assessment: Adolescent Depression Screening (result: Negative Depression Screening)"

o AND: Age< 18 year(s) at: "Measurement Period"

- OR:

o AND: Most Recent: "Occurrence A of Risk Category Assessment: Adolescent Depression Screening (result)" during ("Encounter, Performed: Depression Screening Encounter Codes" during "Measurement Period")

o AND: "Occurrence A of Risk Category Assessment: Adolescent Depression Screening (result: Positive Depression Screening)"

o AND: Union of:

"Intervention, Performed: Additional evaluation for depression - adolescent"

"Intervention, Order: Referral for Depression Adolescent"

"Medication, Order: Depression medications - adolescent"

"Intervention, Performed: Follow-up for depression - adolescent"

"Procedure, Performed: Suicide Risk Assessment"

<= 1 day(s) starts after or concurrent with start of "Occurrence A of Risk Category Assessment: Adolescent Depression Screening"

o AND: Age< 18 year(s) at: "Measurement Period"

• OR:

o AND: Most Recent: "Occurrence A of Risk Category Assessment: Adult Depression Screening (result)" during ("Encounter, Performed: Depression Screening Encounter Codes" during "Measurement Period")

o AND: "Occurrence A of Risk Category Assessment: Adult Depression Screening (result: Negative Depression Screening)"

o AND: Age>= 18 year(s) at: "Measurement Period"

• OR:

o AND: Most Recent: "Occurrence A of Risk Category Assessment: Adult Depression Screening (result)" during ("Encounter, Performed: Depression Screening Encounter Codes" during "Measurement Period")

o AND: "Occurrence A of Risk Category Assessment: Adult Depression Screening (result: Positive Depression Screening)"

o AND: Union of:

"Intervention, Performed: Additional evaluation for depression - adult"

"Intervention, Order: Referral for Depression Adult"

"Medication, Order: Depression medications - adult"

"Intervention, Performed: Follow-up for depression - adult"

"Procedure, Performed: Suicide Risk Assessment"

<= 1 day(s) starts after or concurrent with start of "Occurrence A of Risk Category Assessment: Adult Depression Screening"

AND: Age>= 18 year(s) at: "Measurement Period"

DENOMINATOR STATEMENT

All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period

DENOMINATOR DETAILS

Within the eMeasure, the denominator is defined as the initial patient population, which the specification defines as: "Patient Characteristic Birthdate: birth date" >= 12year(s) starts before start of "Measurement Period" AND: "Occurrence A of Encounter, Performed: Depression

Screening Denominator Encounter Codes” (See attached code table for S2.b for specific value set codes included)

EXCLUSIONS

Patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder are excluded.

Patients with any of the following are excepted: patient reason(s), patient refuses to participate, or medical reason(s); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (for example: certain court appointed cases or cases of delirium).

EXCLUSION DETAILS

Within the eMeasure specification, value sets contain relevant codes to capture the exclusions. (See attached code table for S2.b for specific coding). The specification defines denominator exclusions as:

OR “Diagnosis: Depression diagnosis” satisfies all:

- starts before start of (“Encounter, Performed: Depression Screening Encounter Codes” during “Measurement Period”)
- overlaps (“Encounter, Performed: Depression Screening Encounter Codes” during “Measurement Period”)

OR “Diagnosis: Bipolor diagnosis” satisfies all:

- starts before start of (“Encounter, Performed: Depression Screening Encounter Codes” during “Measurement Period”)
- overlaps (“Encounter, Performed: Depression Screening Encounter Codes” during “Measurement Period”)

The specification defines denominator exceptions as:

OR:

- AND: Union of:
  - "Risk Category Assessment not done: Medical or Other reason not done" for "Adolescent Depression Screening"
  - "Risk Category Assessment not done: Patient Reason refused" for "Adolescent Depression Screening"
  - during "Encounter, Performed: Depression Screening Encounter Codes"
- AND NOT: "Risk Category Assessment: Adolescent Depression Screening" during "Measurement Period"

OR:

- AND: Union of:
  - "Risk Category Assessment not done: Medical or Other reason not done" for "Adult Depression Screening"
  - "Risk Category Assessment not done: Patient Reason refused" for "Adult Depression Screening"
  - during "Encounter, Performed: Depression Screening Encounter Codes"

- AND NOT: "Risk Category Assessment: Adult Depression Screening" during "Measurement Period"

RISK ADJUSTMENT

No risk adjustment or risk stratification

108116| 138697| 141592| 124369| 142428

108116| 138697| 141592| 124369| 142428

STRATIFICATION

No stratification.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

eMeasure PERFORMANCE CALCULATION –

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD), Denominator Exclusions (B) and Denominator Exceptions (C).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (B): Number of patients with valid exclusions

Denominator Exceptions (C): Number of patients with valid exceptions.

1) Identify the patients who meet the eligibility criteria for the denominator (PD) which includes patients who are 12 years and older with appropriate encounters as defined by encounter codes or encounter value set during the reporting period.

2) Determine whether a Denominator Exclusion (B) applies and subtract those patients from the denominator.

3) Identify which of those patients meet the numerator criteria (A)

4) For those patients who do not meet the numerator criteria, determine whether an appropriate Denominator Exception (C) applies and subtract those patients from denominator (PD).

[Numerator (A) /[Performance Denominator (PD) - Denominator Exclusions (B) – Denominator Exceptions (C)] 108116| 138697| 141592| 124369| 142428

COPYRIGHT / DISCLAIMER

Due to technical limitations, registered trademarks are indicated by (R) or [R] and unregistered trademarks are indicated by (TM) or [TM].

Ad.7 Disclaimers: These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

3148 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

STATUS

Submitted

STEWARD

Centers for Medicare & Medicaid Services

DESCRIPTION

Percentage of patients aged 12 years and older screened for clinical depression on the date of the 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.

TYPE

Process

DATA SOURCE

Claims (Only), Registry No specific data source/data collection instrument.

No data collection instrument provided Attachment NQF_0418_Coding_Table_S2b._3148_PQRS_134.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Clinician Office/Clinic

NUMERATOR STATEMENT

Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

NUMERATOR DETAILS

Numerator Quality-Data Coding Options for Reporting Claims and Registry Satisfactorily:

G8431: Screening for clinical depression is documented as being positive AND a follow-up plan is documented

OR

G8510 Screening for clinical depression is documented as negative, a follow-up plan is not required

G8432 Clinical depression screening not documented, reason not given

OR

G8511 Screening for clinical depression documented as positive, follow-up plan not documented, reason not given

Definitions in relation to the Numerator include:

Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.

Examples of depression screening tools include but are not limited to:

Adolescent Screening Tools (12-17 years) Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version(BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2

Adult Screening Tools (18 years and older)

Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan- Documented follow-up for a positive depression screening must include one or more of the following:

•Additional evaluation for depression

•Suicide Risk Assessment

•Referral to a practitioner who is qualified to diagnose and treat depression

•Pharmacological interventions

•Other interventions or follow-up for the diagnosis or treatment of depression

DENOMINATOR STATEMENT

All patients aged 12 years and older

DENOMINATOR DETAILS

The denominator is defined by the patient´s age, encounter date, denominator CPT or HCPCS codes.

Patients aged > = 12 years on date of encounter AND

90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

EXCLUSIONS

Not Eligible – A patient is not eligible if one or more of the following conditions are documented:

•Patient refuses to participate

•Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

•Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium

•Patient has an active diagnosis of Depression

•Patient has a diagnosed Bipolar Disorder

EXCLUSION DETAILS

Denominator Exclusions are identified with the following provider reported HCPCS numerator clinical quality codes:

G8433 Screening for clinical depression not documented, documentation stating the patient is not eligible

OR

G8940 Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible.

RISK ADJUSTMENT

No risk adjustment or risk stratification

108116| 138697| 141592| 124369

108116| 138697| 141592| 124369

STRATIFICATION

No stratification.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

PERFORMANCE CALCULATION – Claims and Registry

To calculate provider performance, complete a fraction with the following measure components: Numerator (A), Performance Denominator (PD) and Denominator Exclusions (B).

Numerator (A): Number of patients meeting numerator criteria

Performance Denominator (PD): Number of patients meeting criteria for denominator inclusion

Denominator Exclusions (B): Number of patients with valid exclusions

1) identify the patients who meet the eligibility criteria for the denominator (PD) which includes patients who are 12 years and older with appropriate encounters as defined by encounter codes or encounter value set during the reporting period.

2) identify which of those patients meet the numerator criteria (A)

3) for those patients who do not meet the numerator criteria, determine whether an appropriate exclusion applies (B) and subtract those patients from the denominator with the following calculation: Numerator (A)/[Performance Denominator (PD) - Denominator Exclusions (B)] 108116| 138697| 141592| 124369

COPYRIGHT / DISCLAIMER

Copyright statement: These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights´ Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services. These measures are in the public domain.

Limited proprietary coding is contained in the measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT [R]) or other coding contained in the specifications. CPT® contained in the Measures specifications is copyright 2004- 2015 American Medical Association. All Rights Reserved. These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

Ad.7 **Disclaimers:** This measure and specifications are provided "as is" without warranty of any kind. This measure does not represent a practice guideline.

3175 Continuity of Pharmacotherapy for Opioid Use Disorder

STATUS

Submitted

STEWARD

RAND Corporation

DESCRIPTION

Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment

TYPE

Process

DATA SOURCE

Claims (Other), Pharmacy For measure calculation, the following files from the Truven MarketScan® Commercial Database were used:

- Enrollment data
- Drug claims
- Medical claims

We used data from these files (including data from Standard Quarterly Updates) for calendar years 2010-2015. This database has long been a commonly used data source to study patterns of commercially insured patients. The database contains fully adjudicated, patient-level claims. All records in these files were used as input to identify individuals that met the measure's eligibility criteria. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015. The final analytic file for 2013-2014 contained a total of 43,812 episodes.

No data collection instrument provided Attachment NQF_3175_OUD_Code_Lists_1-12-17_To_NQF.xlsx

LEVEL

Health Plan, Population : Regional and State

SETTING

Clinician Office/Clinic, Behavioral Health : Outpatient

NUMERATOR STATEMENT

Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

NUMERATOR DETAILS

The measure numerator is calculated based on commercial claims data for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The measure numerator is defined as individuals in the denominator with at least 180 days of "continuous pharmacotherapy" with an OUD medication.

Continuous pharmacotherapy for OUD is identified on the basis of the days covered by the days' supply of all prescription claims for any OUD medication (see list below) or number of days for which the drug was dispensed in a physician office or treatment center with the exceptions noted in this paragraph. The period of continuous pharmacotherapy starts on the day the first claim for an OUD medication is filled/supplied (index date) and lasts through the days' supply of the last claim for an OUD medication. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period. If two or more prescription claims occur on the same day or overlap, the surplus based on the days' supplies accumulates over all prescriptions. However, if another claim is submitted after a claim for an injectable OUD medication or an oral OUD medication that is dispensed in an office or treatment center, the surplus from the day's supply for the injectable or office-dispensed medication is not retained.

An individual is considered to have continuous pharmacotherapy with OUD medication if there is no treatment gap of more than seven days. A gap is defined as a period during which the individual does not have oral OUD medication available based on the days' supply, or is more than 7 days overdue for having an injection of an extended-release OUD medication.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-dispensed oral medications (methadone and buprenorphine/naloxone) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the

NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office and is therefore identified based on either NDC or HCPCS codes.

Justification of Measure Definition: We define treatment continuity as (1) receiving at least 180 days of treatment and (2) no gaps in medication use of more than 7 days.

Our definition of minimum duration is based on the fact that the FDA registration trials for OUD drugs studied the effect of treatment over three to six months (US FDAa, undated; US FDAb, undated), and we have no evidence for effectiveness of shorter durations. In addition, several recommendations support a minimum six-month treatment period as the risk of relapse is the highest in the first 6-12 months after start of opioid abstinence (US FDAa, undated; US FDAb, undated; US DHHS, 2015). Longer treatment duration is associated with better outcomes compared to shorter treatments and the best outcomes have been observed among patients in long-term methadone maintenance programs ("Effective medical treatment of opiate addiction", 1998; Gruber et al., 2008; Moos et al., 1999; NIDA, 1999; Ouimette et al., 1998; Peles et al., 2013). Studies with long-term follow-up suggest that ongoing pharmacotherapy is associated with improved odds of opioid abstinence (Hser et al., 2015; Weiss et al., 2015). We did not specify a maximum duration of treatment, as no upper limit for duration of treatment has been empirically established (US DHHS, 2015).

We opted for using a treatment gap of more than seven days in our definition, given that the measure includes three active ingredients with different pharmacological profiles. There is substantial evidence for an elevated mortality risk immediately after treatment cessation (Cornish et al., 2010; Cousins et al., 2016; Davoli et al, 2007; Degenhardt et al., 2009; Gibson & Degenhardt, 2007; Pierce et al., 2016). Research suggests that methadone tolerance is lost after three days and this three-day threshold has been used in other observational methadone studies and in developing a United Kingdom treatment guideline which recommends revaluating patients for intoxication and withdrawal after a three-day methadone treatment gap (Cousins et al., 2016; Cousins et al., 2011; "Drug Misuse and Dependence—Guidelines on Clinical Management", 1999). Across all the medications, the mortality risk is highest in the first four weeks out of treatment, with many studies showing an increase in mortality in days 1-14 after treatment cessation.

Citations

Cornish R, Macleod J, Strang J, Vickerman P, Hickman M. Risk of death during and after opiate substitution treatment in primary care: prospective observational study in UK General Practice Research Database. BMJ. 2010;341:c5475.

Cousins G, Teljeur C, Motterlini N, McCowan C, Dimitrov BD, Fahey T. Risk of drug-related mortality during periods of transition in methadone maintenance treatment: a cohort study. J Subst Abuse Treat 2011; 41: 252–60.

Cousins G, Boland F, Courtney B, Barry J, Lyons S, Fahey T. Risk of mortality on and off methadone substitution treatment in primary care: a national cohort study. Addiction. 2016;111(1):73-82.

Davoli M, Bargagli AM, Perucci CA, et al. Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multisite prospective cohort study. Addiction. 2007;102:1954-9.

Degenhardt L, Randall D, Hall W, Law M, Butler T, Burns L. Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: risk factors and lives saved. Drug and alcohol dependence. 2009;105:9-15.

"Drug Misuse and Dependence—Guidelines on Clinical Management." Scottish Office Department of Health, Welsh Office, Social Services Northern Ireland. London: Stationery Office, 1999.

Effective medical treatment of opiate addiction. National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. JAMA.1998;280:1936-1943.

Gibson AE, Degenhardt LJ. Mortality related to pharmacotherapies for opioid dependence: a comparative analysis of coronial records. Drug Alcohol Rev. 2007; 26(4), 405-410.

Gruber VA, Delucchi KL, Kielstein A, Batki SL. A randomized trial of 6-month methadone maintenance with standard or minimal counseling versus 21-day methadone detoxification. Drug and Alcohol Dependence. 2008;94(1-3):199-206.

Hser YI, Evans E, Grella C, Ling W, Anglin D. Long-term course of opioid addiction. Harvard Review of Psychiatry. 2015;23(2):76-89.

Moos RH, Finney JW, Ouimette PC, Suchinsky RT. A comparative evaluation of substance abuse treatment: I. Treatment orientation, amount of care, and 1-year outcomes. Alcohol Clin Exp Res. 1999;23(3):529-36.

National Institute on Drug Abuse (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide. NIH Publication No. 99–4180. Rockville, MD: NIDA, 1999, reprinted 2000

Ouimette PC, Moos RH, Finney JW. Influence of outpatient treatment and 12-step group involvement on one-year substance abuse treatment outcomes. J Stud Alcohol. 1998;59:513-522

Peles E, Schreiber S, Adelson M. Opiate-dependent patients on a waiting list for methadone maintenance treatment are at high risk for mortality until treatment entry. J Addict Med. 2013;7(3):177-82..

Pierce M, Bird SM, Hickman M, Marsden J, Dunn G, Jones A, et al. Impact of treatment for opioid dependence on fatal drug-related poisoning: a national cohort study in England. Addiction. 2016;111:298-308.

U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy. Review of Medication-Assisted Treatment Guidelines and Measures for Opioid and Alcohol Use. Washington, DC, 2015. Accessed November 9, 2016 at: https://aspe.hhs.gov/sites/default/files/pdf/205171/MATguidelines.pdf

U.S. Food and Drug Administration (FDA) (a). REVIA Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2013/018932s017lbl.pdf

U.S. Food and Drug Administration (FDA) (b). VIVITROL Label. Accessed November 24, 2016 at: http://www.accessdata.fda.gov/drugsatfda_docs/label/2006/021897lbl.pdf

Weiss RD; Potter JS; Griffin ML, et al. Long-term outcomes from the National Drug Abuse Treatment Clinical Trials Network Prescription Opioid Addiction Treatment Study. Drug and Alcohol Dependence. 2015;150:112-119.

DENOMINATOR STATEMENT

Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

DENOMINATOR DETAILS

The measure denominator is calculated for rolling two-year periods from 2010 to 2015: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. The denominator includes individuals

18-64 years of age during their treatment period who had a diagnosis code of OUD during an inpatient, intensive outpatient, partial hospitalization, outpatient, detoxification or emergency department encounter at any time during the measurement period. To meet the 180-day requirement and be eligible for the measure, the date on the first claim for an OUD medication must fall at least 180 days before the end of the measurement period.

The diagnosis codes used to identify individuals with OUD included:

- ICD-9: 304.0x, 305.5x
- ICD-10: F11.xxx

These codes and descriptions are contained in the sheets called "ICD-9 Diagnosis Codes" and "ICD-10 Diagnosis Codes" in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b.

OUD medications were identified using National Drug Codes (NDCs) for the following:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

And HCPCS codes for the following:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

The National Drug Codes (NDCs) for the oral medications and the HCPCS codes for the injectable medications and office-or treatment-center dispensed oral medications (methadone and buprenorphine) are contained in the sheets called "NDCs" and "HCPCS Codes", respectively, in the Excel file called "NQF 3175 OUD Code Lists" which is attached to this form under Item S.2b. Note that the NDC code list DOES NOT include NDC codes for methadone, as it can legally only be dispensed as OUD pharmacotherapy in licensed treatment centers. Buprenorphine can be dispensed through a pharmacy or in an office/treatment center and is therefore identified based on either NDC or HCPCS codes.

EXCLUSIONS

There are no denominator exclusions.

EXCLUSION DETAILS

There are no denominator exclusions.

RISK ADJUSTMENT

No risk adjustment or risk stratification

123001

123001

STRATIFICATION

Measure results may be stratified by:

- Age – Divided into four categories: 18-34, 35-44, 45-54, 55-64 years
- Gender: Male, Female
- State

- Health plan

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

The measure score is calculated for rolling two-year periods from 2010 to 2015. The steps described below are repeated for five rolling two-year periods: 2010-2011, 2011-2012, 2012-2013, 2013-2014, and 2014-2015. We present detailed results in the MIF for 2013-2014, as we have the most data for this time period, but we include measure scores for each of the two-year periods within 2010-2015.

DENOMINATOR: Individuals 18-64 years of age who had a diagnosis of OUD and at least one claim for an OUD medication

CREATE DENOMINATOR:

1. For each two-year period, identify individuals who are 18-64 years of age for the duration of the first year during which they appear in the period.

2. Of individuals identified in Step 1, keep those who had at least one encounter with any diagnosis (primary or secondary) of OUD in an outpatient setting, acute inpatient setting, or emergency department setting at any time during the two-year measurement period. The OUD diagnosis codes with descriptions are contained in the sheets called “ICD-9 Diagnosis Codes” and “ICD-10 Diagnosis Codes” in the Excel file called “NQF 3175 OUD Code Lists”, which is attached to this form under Item S.2b.

3. Of individuals identified in Step 2, keep those who have at least one claim with a National Drug Code (NDC) for any of the following oral OUD medications during the two-year period with a date at least 180 days before the end of the final calendar year of the measurement period:

- Buprenorphine
- Naltrexone (oral)
- Buprenorphine and Naloxone

Or a HCPCS code for any of the following OUD medications:

- Buprenorphine or Buprenorphine/naloxone, oral
- Methadone administration
- Naltrexone (extended-release injectable)

Claims for oral medications with negative, missing, or zero days’ supply were not included. The NDCs for the oral medications and the HCPCS codes for the injectable and office- or treatment center-dispensed medications are contained in the sheets called “NDCs” and “HCPCS Codes”, respectively, in the Excel file called “NQF 3175 OUD Code Lists,” which is attached to this form under Item S.2b.

4. Of individuals identified in Step 3, keep individuals who were continuously enrolled in a commercial health plan captured by our data for at least 6 months after the month with the first OUD medication claim in the measurement period, with no gap in enrollment. Individuals who are not enrolled for 6 months, including those who die during the period, are not eligible and are not included in the analysis. This is the denominator.

NUMERATOR: Individuals in the denominator who have at least 180 days of continuous pharmacotherapy with a medication prescribed for OUD without a gap of more than seven days

CREATE NUMERATOR:

For the individuals in the denominator, identify those who have at least 180 days of continuous pharmacotherapy with an OUD medication without a gap of more than seven days using the following method:

1. Determine the number of days for the PDC denominator. The start date is the service date (fill date) of the first prescription or injection/dispensing claim for an OUD medication in the two-year measurement period. The end date is defined as the earliest of:

- The date on which the individual exhausts their days' supply, including any pre-existing surplus, following their final claim (assuming daily use).
- The individual's death date.
- December 31st of the second year in the two-year period.

2. For each individual: Count the days during the observation period for which the individual was covered by at least one OUD medication based on the prescription drug or injection/dispensing claim service dates and days' supply.

2a. Sort OUD medication claims by individual's ID and service date. Scan the claims in order, calculating a rolling surplus which accumulates any remaining days' supply from other prior or same-day fills.

2b. Naltrexone injections contribute 30 days' supply unless another claim is found sooner, in which case the Naltrexone injection covers only the days up to the next claim.

2c. Methadone and buprenorphine/naloxone supply is determined by the start and end dates on the outpatient claims with the codes for in-office/treatment center dispensation of methadone (H0020) and buprenorphine/naloxone (J0571-J0575).

2d. Claims for Naltrexone injections and for licensed treatment center-dispensed methadone and office-dispensed buprenorphine/naloxone are not added to the surplus supply and only one such claim per day is counted.

2e. For claims with a days' supply that extends beyond the end of the measurement period, count only the days for which the drug was available to the individual during the measurement period.

3. Determine treatment gaps as periods, in which the individual has exhausted his/her available supply, defined as the days' supply from the most recent previous fill/dispensing and any pre-existing surplus available before that fill/dispensing.

4. Of the individuals in Step 2, count the number of individuals who have a period of 180 days or greater from the start date of the first claim for OUD medication to the end date of the last claim for OUD medication within the two-year period and who do not have a gap of more than seven days without OUD medication available. This is the numerator.

CALCULATE MEASURE SCORE:

1. Calculate the measure score by dividing the numerator by the denominator.

2. Calculate the measure score for each state. The state code on the claim record is used to identify individuals in each state. The measure score is then reported for each state that has at least 20 individuals in the denominator.

3. Calculate the measure score for each health plan. Health plan membership is approximated based on a combination of two variables found on the claim record, industry type and Metropolitan Statistical Area (MSA). A health plan identifier is assigned based on each unique combination of industry and MSA. The health plan identifier is used to group individuals into

health plans. The measure score is then reported for each health plan that has at least 20 individuals in the denominator. 123001

COPYRIGHT / DISCLAIMER

Disclaimers: This performance measure does not establish a standard of medical care and has not been tested for all potential applications.

3185 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

STATUS

Submitted

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user

TYPE

Process

DATA SOURCE

Electronic Health Record (Only) Not applicable.

No data collection instrument provided Attachment EP_CMS138v5_NQF0028_ValueSets_20160401.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient Occupational therapy evaluation, speech and hearing evaluation, ophthalmological services visit

NUMERATOR STATEMENT

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the 24 month period

Definitions:

Tobacco Use – Includes any type of tobacco

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

For EHR:

HQMF eMeasure developed and is attached to this submission in fields S.2a and S.2b.

NUMERATOR GUIDANCE:

If a patient uses any type of tobacco (ie, smokes or uses smokeless tobacco), the expectation is that they should receive tobacco cessation intervention: either counseling and/or pharmacotherapy.

If tobacco use status of a patient is unknown, the patient does not meet the screening component required to be counted in the numerator and should be considered a measure failure. Instances where tobacco use status of "unknown" is recorded include: 1) the patient was not screened; or 2) the patient was screened and the patient (or caregiver) was unable to provide a definitive answer. If the patient does not meet the screening component of the numerator but has an allowable medical exception, then the patient should be removed from the denominator of the measure and reported as a valid exception.

As noted above in a recommendation statement from the USPSTF, the current evidence is insufficient to recommend electronic nicotine delivery systems (ENDS) including electronic cigarettes for tobacco cessation. Additionally, ENDS are not currently classified as tobacco in the recent evidence review to support the update of the USPSTF recommendation given that the devices do not burn or use tobacco leaves. In light of the current lack of evidence, the measure does not currently capture e-cigarette usage as either tobacco use or a cessation aid.

DENOMINATOR STATEMENT

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

For EHR:

HQMF eMeasure developed and is attached to this submission in fields S.2a and S.2b.

EXCLUSIONS

Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

EXCLUSION DETAILS

Time Period for Data Collection: At least once during the 24 month period

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure.

These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention, exceptions may include documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason). Where examples of exceptions are included in the measure language, value sets for these examples are developed and included in the eMeasure. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For EHR:

HQMF eMeasure developed and is attached to this submission in fields S.2a and S.2b.

DENOMINATOR EXCEPTION GUIDANCE:

The medical reason exception only applies to the screening data element of the measure; once a patient has been screened, there are no allowable medical reason exceptions for not providing the intervention.

If a patient has a diagnosis of limited life expectancy, that patient has a valid denominator exception for not being screened for tobacco use or for not receiving tobacco use cessation intervention (counseling and/or pharmacotherapy) if identified as a tobacco user.

RISK ADJUSTMENT

No risk adjustment or risk stratification

113780| 140560

113780| 140560

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 113780| 140560

COPYRIGHT / DISCLAIMER

3205 Medication Continuation Following Inpatient Psychiatric Discharge

STATUS

Submitted

STEWARD

Centers for Medicare & Medicaid Services, Contracting Officer's Representative (COR)

DESCRIPTION

This measure assesses whether psychiatric patients admitted to an inpatient psychiatric facility (IPF) for major depressive disorder (MDD), schizophrenia, or bipolar disorder filled a prescription for evidence-based medication within 2 days prior to discharge and 30 days post-discharge. The performance period for the measure is two years.

TYPE

Process

DATA SOURCE

Claims (Only) Medicare administrative data from Parts A, B, and D claims.

No data collection instrument provided Attachment Med_Continuation_Data_Dictionary_161216.xlsx

LEVEL

Facility

SETTING

Behavioral Health : Inpatient

NUMERATOR STATEMENT

The numerator for this measure includes:

1. Discharges with a principal diagnosis of MDD in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

2. Discharges with a principal diagnosis of schizophrenia in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

3. Discharges with a principal diagnosis of bipolar disorder in the denominator population for which patients were dispensed evidence-based outpatient medication within 2 days prior to discharge through 30 days post-discharge

NUMERATOR DETAILS

The following are the evidence-based medications by class for the treatment of MDD, schizophrenia, and bipolar disorder. The route of administration includes all oral formulations and the long-acting (depot) injectable of the medications listed in this section, except where noted. Active ingredients for the oral medications listed are limited to oral, buccal, sublingual,

and translingual formulations only. Obsolete drug products are excluded from NDCs with an inactive date more than three years prior to the beginning of the measurement period.

MEDICATIONS FOR TREATMENT OF MDD

Monoamine Oxidase Inhibitors

-isocarboxazid

-phenelzine

-selegiline (transdermal patch)

-tranylcypromine

Selective Serotonin Reuptake Inhibitors (SSRI)

-citalopram

-escitalopram

-fluoxetine

-fluvoxamine

-paroxetine

-sertraline

Serotonin Modulators

-nefazodone

-trazodone

-vilazodone

-vortioxetine

Serotonin Norepinephrine Reuptake Inhibitors (SNRI)

-desvenlafaxine

-duloxetine

-levomilnacipran

-venlafaxine

Tricyclic and Tetracyclic Antidepressants

-amitriptyline

-amoxapine

-clomipramine

-desipramine

-doxepin

-imipramine

-maprotiline

-nortriptyline

-protriptyline

-trimipramine

Other Antidepressants

-bupropion

-mirtazapine

Psychotherapeutic Combinations
-amitriptyline-chlordiazepoxide
-amitriptyline-perphenazine
-fluoxetine-olanzapine
MEDICATIONS FOR TREATMENT OF SCHIZOPHRENIA
First-generation Antipsychotics
-chlorpromazine
-fluphenazine
-haloperidol
-haloperidol lactate
-loxapine succinate
-molindone
-perphenazine
-pimozide
-prochlorperazine
-thioridazine
-thiothixene
-trifluoperazine
Second-generation (Atypical) Antipsychotics
-aripiprazole
-asenapine
-brexpiprazole
-cariprazine
-clozapine
-iloperidone
-lurasidone
-olanzapine
-paliperidone
-quetiapine
-risperidone
-ziprasidone
Psychotherapeutic Combinations
-amitriptyline-perphenazine
-fluoxetine-olanzapine
Long-Acting (Depot) Injectable Antipsychotics
-fluphenazine decanoate
-haloperidol decanoate
-aripiprazole
-aripiprazole lauroxil

-olanzapine pamoate
-paliperidone palmitate (1-month extended-release injection)
-paliperidone palmitate (3-month extended-release injection)
-risperidone microspheres
MEDICATIONS FOR TREATMENT OF BIPOLAR DISORDER
Anticonvulsants
-carbamazepine
-divalproex sodium
-lamotrigine
-valproic acid
First-generation Antipsychotics
-chlorpromazine
-fluphenazine
-haloperidol
-haloperidol lactate
-loxapine succinate
-molindone
-perphenazine
-pimozide
-prochlorperazine
-thioridazine
-thiothixene
-trifluoperazine
Second-generation (Atypical) Antipsychotics
-aripiprazole
-asenapine
-brexpiprazole
-cariprazine
-clozapine
-iloperidone
-lurasidone
-olanzapine
-paliperidone
-quetiapine
-risperidone
-ziprasidone
Lithium Salts
-litium
-lithium carbonate

-lithium citrate

Psychotherapeutic Combinations

-fluoxetine-olanzapine

Long-acting (depot) Injectable Antipsychotics

-fluphenazine decanoate

-haloperidol decanoate

-aripiprazole

-aripiprazole lauroxil

-olanzapine pamoate

-paliperidone palmitate (1-month extended-release injection)

-paliperidone palmitate (3-month extended-release injection)

-risperidone microspheres

DENOMINATOR STATEMENT

The target population for this measure is Medicare fee-for-service (FFS) beneficiaries with Part D coverage aged 18 years and older discharged from an inpatient psychiatric facility with a principal diagnosis of MDD, schizophrenia, or bipolar disorder.

DENOMINATOR DETAILS

The denominator for this measure includes patients discharged from an IPF:

1. With a principal diagnosis of MDD, schizophrenia, or bipolar disorder (ICD codes provided below).

2. 18 years of age or older at admission.

3. Enrolled in Medicare fee-for-service Part A and Part B during the index admission and Parts A, B, and D at least 30-days post-discharge.

4. Alive at discharge and alive during the follow-up period.

5. With a discharge status code indicating that they were discharged to home or home healthcare.

ICD-9-CM and ICD-10-CM codes to identify MDD, schizophrenia, and bipolar disorder:

MDD

ICD-9-CM:

296.20, 296.21, 296.22, 296.23, 296.24, 296.25,

296.30, 296.31, 296.32, 296.33, 296.34, 296.35,

298.0, 311

ICD-10-CM:

F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0,

F33.1, F33.2, F33.3, F33.40, F33.41, F33.9

Schizophrenia

ICD-9-CM:

295, 295.0, 295.00, 295.01, 295.02, 295.03, 295.04, 295.05,

295.1, 295.10, 295.11, 295.12, 295.13, 295.14, 295.15,

295.2, 295.20, 295.21, 295.22, 295.23, 295.24, 295.25,
295.3, 295.30, 295.31, 295.32, 295.33, 295.34, 295.35,
295.4, 295.40, 295.41, 295.42, 295.43, 295.44, 295.45,
295.5, 295.50, 295.51, 295.52, 295.53, 295.54, 295.55,
295.6, 295.60, 295.61, 295.62, 295.63, 295.64, 295.65,
295.7, 295.70, 295.71, 295.72, 295.73, 295.74, 295.75,
295.8, 295.80, 295.81, 295.82, 295.83, 295.84, 295.85,
295.9, 295.90, 295.91, 295.92, 295.93, 295.94, 295.95

ICD-10-CM:

F20.0, F20.1, F20.2, F20.3, F20.5, F20.81, F20.89,
F20.9, F25.0, F25.1, F25.8, F25.9

Bipolar disorder

ICD-9-CM:

296.00, 296.01, 296.02, 296.03, 296.04, 296.05, 296.06,
296.10, 296.11, 296.12, 296.13, 296.14, 296.15, 296.16,
296.40, 296.41, 296.42, 296.43, 296.44, 296.45, 296.46,
296.50, 296.51, 296.52, 296.53, 296.54, 296.55, 296.56,
296.60, 296.61, 296.62, 296.63, 296.64, 296.65, 296.66,
296.7, 296.80, 296.81, 296.82, 296.89

ICD-10-CM:

F30.10, F30.11, F30.12, F30.13, F30.2, F30.3, F30.4,
F30.8, F30.9, F31.0, F31.10, F31.11, F31.12, F31.13,
F31.2, F31.30, F31.31, F31.32, F31.4, F31.5, F31.60,
F31.61, F31.62, F31.63, F31.64, F31.70, F31.71, F31.72,
F31.73, F31.74, F31.75, F31.76, F31.77, F31.78, F31.81,
F31.89, F31.9, F32.8

EXCLUSIONS

The denominator for this measure excludes discharged patients who:

1. Received Electroconvulsive Therapy (ECT) during the inpatient stay or follow-up period.
2. Received Transcranial Magnetic Stimulation (TMS) during the inpatient stay or follow-up period.
3. Were pregnant during the inpatient stay.
4. Had a secondary diagnosis of delirium.
5. Had a principal diagnosis of schizophrenia with a secondary diagnosis of dementia.

EXCLUSION DETAILS

1. ECT During Inpatient Stay or Follow-Up Period

Rationale: Some patients who receive ECT during the inpatient stay or follow-up period may have failed pharmacotherapy and would not fill an evidence-based prescription post-discharge.

Source: Identified from Part A and Part B claims data if treatment occurred on a date between the admission date and 30 days post-discharge.

2. TMS During Inpatient Stay or Follow-Up Period

Rationale: Some patients who receive TMS during the inpatient stay or follow-up period may have failed pharmacotherapy and would not fill an evidence-based prescription post-discharge.

Source: Identified from Part A and Part B claims data if treatment occurred on a date between the admission date and 30 days post-discharge.

3. Pregnant During Inpatient Stay

Rationale: Some of the evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder are contraindicated during pregnancy.

Source: Identified from Part A claims data from the index admission.

4. Secondary Diagnosis of Delirium

Rationale: Some of the evidence-based medications for the treatment of MDD, schizophrenia, and bipolar disorder are contraindicated for patients with delirium.

Source: Identified from Part A claims data from the index admission.

5. Principal Diagnosis of Schizophrenia with Secondary Diagnosis of Dementia

Rationale: APA Practice guidelines suggest caution in the use of antipsychotics in dementia patients so not all dementia patients would fill an evidence-based medication (antipsychotic) following discharge for schizophrenia.

Source: Identified from Part A claims data from the index admission.

RISK ADJUSTMENT

No risk adjustment or risk stratification

126054

126054

STRATIFICATION

The measure is not stratified.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

Denominator:

1. Pull all IPF discharges from the Part A data.

2. Include IPF discharges for patients who were at least 18 years of age at admission.

3. Identify interim claims having the same beneficiary, provider, admission dates or having an admission date within 1 day of the discharge date of the previous claim, and having a discharge status code of “Still patient.” Collapse or combine the interim claims into one hospital stay using the admission date from the earliest claim and the discharge date from the latest claim. The data values from the latest claim are used for the newly combined hospital stay.

4. De-duplicate the IPF inpatient discharges dataset by Patient ID, Sex, Provider ID, Admission Date, and Discharge Date.

5. Remove the IPF inpatient discharges for patients who do not have Part A and Part B coverage at admission, during the entire stay, at discharge, and during the 30 days post-discharge.

6. Remove the IPF inpatient discharges that do not have a principal diagnosis of MDD, bipolar disorder, or schizophrenia using value sets containing ICD-9 codes for each of the disease conditions.

7. Remove the IPF inpatient discharges for patients who expired during the hospital stay or within 30 days of discharge.

8. Remove the IPF inpatient discharges for patients who do not have Part D coverage during the 30 days post-discharge.

9. Remove the IPF inpatient discharges for patients who were not discharged to home or home health.

10. Exclude IPF inpatient discharges with a secondary diagnosis of pregnancy or delirium.

11. Exclude IPF inpatient discharges having schizophrenia as the principal diagnosis with a secondary diagnosis of dementia.

12. Exclude IPF inpatient discharges with ECT or TMS during the hospital stay or within 30 days post-discharge.

Numerator:

1. Pull all Part D claims for the evidence-based medications used for the treatment of MDD, schizophrenia, and bipolar disorder.

2. Pull all Part A and Part B claims for antipsychotic long-acting injectables (LAIs) and add them to the Part D medication claims for schizophrenia and bipolar disorder.

3. Compare the medication claims to the denominator file of eligible IPF inpatient discharges and remove any claims that occur more than 2 days prior to the discharge date.

4. Determine which claims occur within the follow-up period (2 days prior to discharge through 30 days post-discharge) for each of the 3 disease conditions.

5. Total the denominator cases having at least one medication claim corresponding to the disease condition during the follow-up period. 126054

COPYRIGHT / DISCLAIMER

Not applicable

3225 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

STATUS

Submitted

STEWARD

PCPI Foundation

DESCRIPTION

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation intervention if identified as a tobacco user

TYPE

Process

DATA SOURCE

Claims (Only), Claims (Other), Registry Not applicable.

No data collection instrument provided No data dictionary NQF0028_CMS138v5_ValueSets_Details.xlsx

LEVEL

Clinician : Group/Practice, Clinician : Individual

SETTING

Clinician Office/Clinic, Home Health, Other, Behavioral Health : Outpatient Occupational therapy evaluation, speech and hearing evaluation, ophthalmological services visit

NUMERATOR STATEMENT

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user

NUMERATOR DETAILS

Time Period for Data Collection: At least once during the 24 month period

Definitions:

Tobacco Use – Includes any type of tobacco

Tobacco Cessation Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy

For Administrative Claims/Registry:

CPT Category II code 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

CPT Category II code 1036F: Current tobacco non-user

OR

CPT Category I code- Smoking and tobacco use cessation counseling

*The following codes are applicable if the patient screened positive for smoking/tobacco use and counseling was provided.

99406: Smoking/tobacco counseling 3-10 minutes

99407: Smoking/tobacco counseling greater than 10 minutes

DENOMINATOR STATEMENT

All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period

DENOMINATOR DETAILS

Time Period for Data Collection: 12 consecutive months

For Administrative Claims/Registry:

Patient age >= 18 years

AND

At least two visits during the measurement period (CPT):

90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

OR

At least one visit during the measurement period (CPT/HCPCS):

92521, 92522, 92523, 92524, 92540, 92557, 96160, 96161, 92625, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, G0438, G0439

EXCLUSIONS

Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

EXCLUSION DETAILS

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The PCPI exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure 0028, exceptions may include medical reasons for not screening for tobacco use (eg, limited life expectancy, other medical reason). Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

For Administrative Claims/Registry:

CPT Category II code with modifier 4004F-1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason)

RISK ADJUSTMENT

No risk adjustment or risk stratification

113780| 140560

113780| 140560

STRATIFICATION

Consistent with CMS' Measures Management System Blueprint and national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, PCPI

encourages the results of this measure to be stratified by race, ethnicity, administrative sex, and payer and have included these variables as recommended data elements to be collected.

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).

2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator

4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reason). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the exception rate (ie, percentage with valid exceptions) should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. 113780| 140560

COPYRIGHT / DISCLAIMER

AMA and PCPI encourage use of the Measures by other healthcare professionals, where appropriate.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the PCPI and its members and former members of the AMA-PCPI disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

Disclaimers: See copyright statement above.

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

STATUS

Submitted

STEWARD

National Committee for Quality Assurance

DESCRIPTION

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.

TYPE

Process

DATA SOURCE

Claims (Only), Pharmacy

LEVEL

Health Plan, Integrated Delivery System

SETTING

Clinican Office/Clinic

NUMERATOR STATEMENT

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

NUMERATOR DETAILS

RATE 1. INITIATION PHASE NUMERATOR

An outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the earliest prescription dispensing date for a new ADHD medication. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit.

RATE 2. CONTINUATION AND MAINTENANCE PHASE NUMERATOR

Children who are numerator compliant for Rate 1. Initiation Phase, AND have documentation of at least two follow-up visits with any practitioner from 31–300 days (9 months) after the earliest prescription dispensing date for a new ADHD medication.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Telephone Visits Value Set.

DENOMINATOR STATEMENT

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

DENOMINATOR DETAILS

RATE 1. INITIATION PHASE DENOMINATOR

Children age 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year. who were dispensed a new ADHD medication during the 12-month Intake Period (Table ADD-A). Patients must have all of the following:(1) A 120-day (4-month) negative medication history on or before the Index Prescription Date. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

(2) Continuous enrollment for 120 days prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

(3) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set)

Due to the extensive volume of codes associated with identifying the denominator for this measure, we are attaching a separate file with code value sets. See code value sets located in question S.2b.

Table ADD-A: ADHD Medications

CNS stimulants: Amphetamine-dextroamphetamine, dexmethylphenidate, dextroamphetamine, lisdexamfetamine, methamphetamine, methylphenidate

Alpha-2 receptor agonists: Clonidine, guanfacine

Miscellaneous: Atomoxetine

RATE 2. CONTINUATION AND MAINTENANCE PHASE DENOMINATOR

Children who meet the eligible population criteria for Rate 1. Initiation Phase who have been continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date. Patients must have all of the following:

(1) The patient must have filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].)

Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.

Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

(2) Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

EXCLUSIONS

Children who had an acute inpatient encounter for mental health or chemical dependency following the Index Prescription Start Date

Children with a diagnosis of narcolepsy: Many of the medications used to identify patients for the denominator of this measure are also used to treat narcolepsy. Children with narcolepsy who are pulled into the denominator are then removed by the narcolepsy exclusion.

Children using hospice services during the measurement year. Children in hospice may not be able to receive the necessary follow-up care.

EXCLUSION DETAILS

Exclude from the denominator for both rates, children who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date

Exclude from the denominator for both rates, children with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

Exclude from the denominator for both rates patients who use hospice services or elect to use a hospice benefit any time during the

measurement year, regardless of when the services began. These members may be identified using various methods, which may include but are not limited to enrollment data, medical record or claims/encounter data

(Hospice Value Set).

RISK ADJUSTMENT

No risk adjustment or risk stratification

STRATIFICATION

N/A

TYPE SCORE

Rate/proportion better quality = higher score

ALGORITHM

INITIATION PHASE: ELIGIBLE POPULATION

Step 1: Identify all children in the specified age range (Children 6-12 years of age: 6 as of March 1 of the measurement year; 12 years as of February 28 of the measurement year) who were dispensed an ADHD medication (Table ADD-A) during the 12-month Intake Period.

Step 2: Test for Negative Medication History. For each member identified in step 1, test each ADHD prescription for a Negative Medication History. The Index Prescription Start Date is the dispensing date of the earliest ADHD prescription in the Intake Period with a Negative Medication History.

Step 3: Calculate continuous enrollment. Patients must be continuously enrolled for 120 days (4 months) prior to the Index Prescription Start Date through 30 days after the Index Prescription Start Date.

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 30 days after the Index Prescription Start Date. An acute inpatient encounter (Acute Inpatient Value Set) in combination with any of the following meet criteria: A principal mental health diagnosis (Mental Health Diagnosis Value Set) AND/OR A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Determine the number of patients in the eligible population with an outpatient, intensive outpatient or partial hospitalization follow-up visit with a practitioner with prescribing authority, within 30 days after the Index Prescription Start Date. Any of the following code combinations billed by a practitioner with prescribing authority meet criteria:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Note: Do not count a visit on the Index Prescription Start Date as the Initiation Phase visit.

Step 6: Calculate a rate (number of children receiving a follow-up visit with a prescriber within 30 days of the Index Prescription Start Date).

CONTINUATION AND MAINTENANCE PHASE: ELIGIBLE POPULATION

Step 1: Identify all patients who meet the eligible population criteria for Rate 1—Initiation Phase.

Step 2: Calculate continuous enrollment. Patients must be continuously enrolled in the organization for 120 days (4 months) prior to the Index Prescription Start Date and 300 days (10 months) after the Index Prescription Start Date.

Step 3: Calculate the continuous medication treatment. Using the patients in step 2, determine if the member filled a sufficient number of prescriptions to provide continuous treatment for at least 210 days out of the 300-day period after the Index Prescription Start Date. The definition of "continuous medication treatment" allows gaps in medication treatment, up to a total of 90 days during the 300-day (10-month) period. (This period spans the Initiation Phase [1 month] and the C&M Phase [9 months].) Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication. Regardless of the number of gaps, the total gap days may be no more than 90. The organization should count any combination of gaps (e.g., one washout gap of 14 days and numerous weekend drug holidays).

Step 4: Exclude patients who had an acute inpatient encounter for mental health or chemical dependency during the 300 days (10 months) after the Index Prescription Start Date. An acute inpatient encounter in combination with any of the following meet criteria:

A principal mental health diagnosis (Mental Health Diagnosis Value Set).

A principal diagnosis of chemical dependency (Chemical Dependency Value Set).

Step 5: Identify all patients in the eligible population who meet the following criteria:

(1) Numerator compliant for Rate 1—Initiation Phase, and

(2) At least two follow-up visits from 31–300 days (9 months) after the Index Prescription Start Date with any practitioner.

One of the two visits (during days 31–300) may be a telephone visit (Telephone Visits Value Set) with any practitioner. Any of the following code combinations identify follow-up visits:

ADD Stand Alone Visits Value Set.

ADD Visits Group 1 Value Set with ADD POS Group 1 Value Set.

ADD Visits Group 2 Value Set with ADD POS Group 2 Value Set.

Telephone Visits Value Set.

Step 6: Calculate a rate (number of children receiving two follow-up visits with any practitioner from 31-300 days after the Index Prescription Start Date).

ADDITIONAL EXCLUSION:

Exclude from the denominator for both rates, patients with a diagnosis of narcolepsy (Narcolepsy Value Set) any time during their history through December 31 of the measurement year

NOTE

(1) Patients who have multiple overlapping prescriptions should count the overlap days once toward the days supply (whether the overlap is for the same drug or for a different drug).

(2) Organizations may have different methods for billing intensive outpatient encounters and partial hospitalizations. Some methods may be comparable to outpatient billing, with separate claims for each date of service; others may be comparable to inpatient billing, with an admission date, a discharge date and units of service. Organizations whose billing methods are comparable to inpatient billing may count each unit of service as an individual visit. The unit of service must have occurred during the period required for the rate (e.g., within 30 days after or from 31–300 days after the Index Prescription Start Date).

Appendix F: Pre-Evaluation Comments

Comments received as of February 28, 2017.

0008 Experience of Care and Health Outcomes (ECHO) Survey

Submitted by D.E.B. Potter

I am speaking to you today as an individual, not as a representative of HHS or ASPE. Since 2011, I have also been an Ex-Officio Member of the Measure Applications Partnership (MAP) Duals Eligible Beneficiary Workgroup.

I would like to talk today about the first measure on the Agenda for tomorrow's Behavioral Health (BH) Standing Committee meeting.

The CAHPS® behavioral health experience with care measure – ECHO—(NQF 0008) is (like several other CAHPS® measures) included in the MAP Dual Eligible Beneficiary Family of Measures. In 2015 the MAP Duals Workgroup under took a measure alignment exercise to identify the users of measures in the Duals Family of measures. Based upon the 6/25/15 version of the MAP tool (no longer on MAP site) several of the states involved in the Medicare/Medicaid Financial Alignment Demonstration use the ECHO to assess performance. NQF obtained data on ECHO's use by abstracting information from the Memorandums of Understanding signed between CMS and the states. In 2015 the following states were using the ECHO.

- California Capitated State Demo
- Illinois Capitated State Demo
- Massachusetts Capitated State Demo
- Michigan Capitated State Demo
- New York Capitated State Demo
- Ohio Capitated State Demo
- South Carolina Capitated State Demo
- Texas Capitated State Demo
- Virginia Capitated State Demo

As of 2017 all of these Demos were on-going (although VA's will end this year).

Zainulbhai et al, (Commonwealth Issue Brief, March 2014, pub 1734,Vol 2) further identified the ECHO (and the CAHPS® Plan measure) as CMS Core Measures for the Demonstration (capitated plans).

In the Worksheet provided on the ECHO (NQF 0008) for this meeting it is noted that "no recent data on performance results were provided for the 17 PRO-PMs included." Based upon ECHO's required use in CMS funded programs (that involved multiple health plans) I suggest that perhaps some recent data (for multiple years) do exist for the ECHO items, just not easily seen/obtainable by the public and/or the research community. Given the importance of having NQF endorsed PRO measures for the BH population, I (as an individual, not a reprehensive of HHS or ASPE) urge the BH Standing Committee

members, the ECHO Measure Steward and/or the NQF BH staff reach out (if not already done so) to CMS MMCO, these States and their health plans to determine if more recent PRO item data does exist and to request that data be submitted for Committee evaluation. NQF could begin that conversation with Alice Lind (member, and former Co- Chair, of the MAPS Dual Workgroup).

National Quality Forum
1030 15th St NW, Suite 800
Washington, DC 20005
http://www.qualityforum.org

ISBN 978-1-68248-056-4