TEP Evaluation of Measures

May 30, 2018 Meeting

June 8, 2018

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HSAG HEALTH SERVICES ADVISORY GROUP

Background

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) program, which is a pay-for-reporting program mandated by section 1886(s)(4) of the Social Security Act, requires the Centers for Medicare & Medicaid Services (CMS) to develop measures that improve the quality of inpatient psychiatric care and to communicate quality information to consumers to help them make informed decisions about their healthcare options. Health Services Advisory Group, Inc. (HSAG) was contracted by CMS to identify new measures that could be considered for use in the program and to maintain measures for the IPFQR program. To obtain input from experts on both the development and maintenance of the IPF measures under the current project, HSAG convened a Technical Expert Panel (TEP) of healthcare providers, clinicians, patients/caregivers, and experts in quality improvement.

HSAG completes summary reports of TEP proceedings to highlight discussions and document decisions. In addition, HSAG summarizes recommendations from the TEP and presents them to CMS for use in the decision-making process concerning measure prioritization, development, and testing. To ensure confidentiality of TEP members in all reports, discussion topics are summarized and the names of TEP members who make specific comments during the meetings are not disclosed.

Measure Development and Maintenance Team

The HSAG IPF Outcome and Process Measure Development and Maintenance Project team is composed of staff members from HSAG, the University of Florida, UF Health, and the National Committee for Quality Assurance (NCQA). Kyle Campbell, PharmD, Vice President for Pharmacy and Quality Measurement, and Megan Keenan, MPH, Project Director IPF Measure Development and Maintenance, lead the team.

Technical Expert Panel

In alignment with the CMS Measures Management System, the IPF 2017-2018 TEP includes healthcare providers, clinicians, patients/caregivers, and experts in quality improvement who represent a variety of viewpoints and backgrounds. The role of the TEP is to provide feedback on key methodological and clinical decisions related to the development and maintenance of quality measures for the IPF setting. The IPF 2017-2018 TEP provides regular feedback during key measure development milestones, such as after the completion of beta testing. The TEP members evaluate multiple measures over their term of service.

Technical Expert Panel Meeting

This report summarizes the discussion from the May 30, 2018 TEP meeting that focused on the *Inpatient Assessment of Depression Symptoms* measure. The measure was identified as a key measurement gap in the inpatient psychiatric facility (IPF) setting. The *Inpatient Assessment of Depression Symptoms* measure is related to the CMS Meaningful Measure objective of Strengthen Person and Family Engagement as Partners in Their Care, in the area of patient-reported functional outcomes. The concept was prioritized for development and testing because it included a significant portion of the IPF population, aligns with the standard for behavioral health care organizations (CTS.03.01.09) from The Joint Commission, and has demonstrated a performance gap indicating opportunity for improvement. Prior to the meeting, the TEP was provided with briefing materials which included the meeting agenda, the presentation slide handouts, a summary of the prior TEP Meeting, and the revised TEP Charter.

Summary of the Meeting

I. Opening Remarks and Updates from the Previous Meeting

Ms. Megan Keenan, Project Director, welcomed attendees, gave a brief outline of the meeting objectives, reviewed the agenda, and explained the ground rules for the meeting. She gave a brief update on revisions to the *Screening for Pregnancy* measure in response to feedback provided during the previous TEP meeting held February 26, 2108.

- Updates to specifications or documentation based on TEP feedback
  - Added exclusion for patients who leave against medical advice as a proxy for patient refusal
  - Simplified the language for the numerator requirement
  - Clarified abstraction instructions for hCG test to allow for point-of-care urine tests to address concern about freestanding facilities without in-house labs
  - Modified algorithm to include instances when the screening was performed, but not within the timeframe specified by the measure. This modification will not impact measure scoring but can be used by facilities to inform quality improvement activities.
  - Provided an estimate of number of females who are pregnant on admission to IPFs in report

II. Roll Call and COI Disclosures

The Co-chair of the TEP, Ms. Gayle Olano-Hurt, called the roll, and asked for declarations of conflict of interest. The meeting was attended by 17 voting members and one non-voting member of the 20 TEP members.

Potential conflicts of interest (COI) were disclosed as follows:

- Robert Cotes: Received research funding from Alkermes and Otsuka Pharmaceuticals
- Vikas Duvvuri: Will be joining an advisory board for Sage
- Nora Lott Haynes: Currently serving as a consultant on a NIMH project through Columbia
- Jessica Ross: Will be joining an advisory board of a startup

Name	Organization	Location	Present	Potential COI
Robert Cotes, MD	Grady Memorial Hospital	Atlanta, GA	Yes	As noted
Kathleen Delaney, PhD, PMH-NP, FAAN	Rush College of Nursing	Chicago, IL	Yes	No
Vikas Duvvuri, MD, PhD	Fremont Hospital	Fremont, CA	Yes	As noted
Nola Harrison, ACSW, LSCW, LSW-A	St. Anthony Hospital	Oklahoma City, OK	Yes	No
Nora Lott Haynes, Med, EdS	NAMI Savannah	Atlanta, GA	Yes	As noted
Gayle Olano-Hurt, MPA, CPHQ, PMC *Co-Chair of the TEP*	District of Columbia Hospital Association	Washington, DC	Yes	No
Mary Jane Krebs, FACHE	Spring Harbor Hospital	Westbrook, ME	Yes	No
Kathleen McCann, RN, PhD	National Association of Psychiatric Health Systems	Washington, DC	Yes	No
Marsden McGuire, MD, MBA *Non-voting Federal Representative*	Dept. of Veterans Affairs	Washington, DC	Yes	No
Margaret Paccione-Dyszlewski, PhD	Bradley Hospital	Riverside, RI	Yes	No

Name	Organization	Location	Present	Potential COI
Michael Peterson, MD, PhD *Co-Chair of the TEP*	University Hospital	Madison, WI	Yes	No
Nancy Purtell, MBA/HCM, RN	Hospital Corporation of America	Nashville, TN	Yes	No
Jessica Ross, MD, MS	UCSF and Zuckerberg SF General Hospital	San Francisco, CA	Yes	As noted
Elvira Ryan, MBA, BSN, RN	The Joint Commission	Oakbrook Terrace, IL	Yes	No
Lisa Shea, MD	Lifespan	Providence, RI	No	NA
Mary Kay Shibley, MSN, RN	Sharp Mesa Vista Hospital	San Diego, CA	Yes	No
Ann M. Sissler, MSW, LSW, ACSW	Westchester Medical Center	Valhalla, NY	Yes	No
Johan Smith, MBA	Universal Health Services, Horizon Health, Mental Health Outcomes	Lewisville, TX	No	NA
Julia Sullivan, MSN, RN-BC	Santa Fe College	Gainesville, FL	Yes	No
Michael Trangle, MD	HealthPartners/Regions Hospital	St. Paul, MN	Yes	No

III. Approval of Meeting Summary

Ms. Olano-Hurt, Co-chair of the TEP, opened the approval of the TEP meeting summary from the February 26, 2018 meeting. A motion to approve was made by Dr. Jessica Ross and seconded by Ms. Nora Lott Haynes. The summary was approved without changes.

IV. Ratification of the Revised TEP Charter

The Centers for Medicare & Medicaid Services (CMS) has extended the current measure development contract to February 15, 2019 and IPF TEP Charter has been revised to reflect this extension. HSAG plans to hold two TEP meetings during the extension: one in Q4 2018 and one in Q1 2019.

Dr. Michael Peterson, Co-chair of the TEP, opened the ratification process for the revised IPF TEP Charter.

Sixteen TEP members voted in unanimous agreement with the question: *Do you agree with the revised TEP Charter as currently written?* Two of the members voted by email and one member who joined the meeting late did not vote.

V. New Procedures for Approval of TEP Summary

Dr. Shannon Runge reviewed the new procedure for obtaining the TEP approval of the meeting summary to facilitate timely posting of the TEP Summary. She explained that seven business days after the TEP Meeting, HSAG will send TEP members an email containing the Draft TEP Meeting Summary and a SurveyMonkey link. TEP members are asked to review the TEP Meeting Summary within five business days and submit approval or any suggestions for revisions via SurveyMonkey. If any members suggest substantive changes, HSAG will revise the TEP Meeting Summary and re-submit to the TEP for final approval.

There were no questions or comments from the TEP members.

VI. Overview of the *Inpatient Assessment of Depression Symptoms* measure

Dr. Shannon Runge, the project lead, reviewed the *Inpatient Assessment of Depression Symptoms* measure with an overview of the measure modifications for use in the IPF, the goals of the measure, and the benefits of use of the PHQ-9.

VII. Presentation of Supporting Evidence

Dr. Regina Bussing, Clinical Lead for the measure, continued by providing an update to the evidence supporting the measure concept that was presented in a previous meeting (October 2017). She addressed the evidentiary support for the concept of measurement-based care and the value of engaging the patient in their care by using a patient-reported outcome measure (PROM) such as the PHQ-9. Clear support for engaging patients by using PROMs is in the 2018 revisions to the Joint Commission of Behavioral Health Care Outcomes Measure Standard, CTS.03.01.09, which requires organizations to assess outcomes through use of a standardized tool or instrument.

She presented current literature on the clinical utility of the PHQ-9 in psychiatric practices and cited the relevant clinical practice guidelines. There is robust evidence that supports the sensitivity, specificity, reliability, and validity of the tool. The PHQ-9 has been validated in psychiatric patients with a variety of primary diagnoses, including major depression disorder, bipolar disorder, and psychotic disorder.

She presented the patient and caregiver perspective from a focus group conducted by HSAG in 2017. The focus group was comprised of 24 patients and six caregivers who have had experience with psychiatric hospitalizations. They responded to questions about the *Inpatient Assessment of Depression Symptoms* measure and completed the PHQ-9 as part of their participation. Most participants completed the PHQ-9 in a few minutes or less and found the items on the PHQ-9 helpful for understanding their symptom severity. They indicated that they saw value in giving the PHQ-9 at admission and at discharge.

Dr. Bussing noted that there are gaps in the evidence for use in the inpatient setting because the majority of the measurement-based care literature is limited to outpatient settings, the PHQ-9 has not been formally validated with the shorter one-week timeframe reference, and the ability of the PHQ-9 to detect change over brief periods of time has not yet been established. She requested that TEP members send any additional relevant studies or information, particularly relating to gap areas, to Dr. Runge.

Topic: Modifications to the PHQ-9

Comment: One TEP member was concerned about the lack of evidence to support the one-week time frame and questioned whether the one-week timeframe is sufficient to see a meaningful change.

Comment: Several panelists commented that the available evidence is in the outpatient setting and inquired how we will we determine the clinical utility in the inpatient setting.

> Team Response: Clinical utility in the inpatient setting and improvement during inpatient stays will be tested during field testing over the next few months.

Topic: Target Population

Comment: Several TEP members questioned the use of the PHQ-9 as a screening tool for all patients in the inpatient population and suggested limiting the use of the tool to depressed patients.

> Team Response: A decision has not been made on who will be included in the cohort. Field testing will include all patients admitted to the test sites to inform the selection of appropriate inclusion and exclusion criteria.

Comment: A TEP member suggested that in reviewing the Beard paper, which describes the PHQ-9 being validated for different disorders, there were 50 people with psychotic disorders out of the 1,023 total patients in the sample. He noted that most of those patients had unipolar depression suggested that there is a limited amount of data on using the PHQ-9 for people with psychotic disorders. The TEP member also suggested there may be an issue relating to the specificity of the PHQ-9 for a patient who has a psychotic disorder and that PHQ-9 may be detecting negative symptoms relating to psychosis rather than a depressive episode. He recommended that the team consider the unintended consequences of using PHQ-9, because the treatment of negative symptoms for a person with psychosis is different from the treatment of depression symptoms for a person with a depressive disorder.

> Team Response: The team will consider whether it is appropriate to include patients with psychotic disorders during field testing.

Comment: One member referred to the wording in the proposed rule referring to the development of a PROM assessment for patients admitted for depression. The rule did not state other diagnoses.

> Team Response: The proposed rule is asking for feedback about the future development of PROM-based measures and the wording is not intended to be an exact statement of the measure under discussion.

VIII. Alpha Testing Results

Dr. Almut Winterstein, Senior Researcher for the project, presented the alpha testing results. Alpha testing was conducted on 105 patient admissions. The test facility had not previously used PROMs routinely at admission or discharge. They administered the modified version of the PHQ-9 that uses a 1-week timeframe, which will be referred to as the Patient Health Questionnaire 9 modified for the inpatient setting, or PHQ-9-I. She reviewed two questions that were added to the PHQ-9-I for the testing. One question ascertained whether the patient received assistance completing the PHQ-9-I, such as the help of a family member or friend, nurse or other hospital staff member, or a doctor. The other question was a patient self-report of the degree of improvement in depressive symptoms from admission to discharge. Dr. Winterstein also described two clinician-administered assessments – the BPRS (Brief Psychiatric Rating Scale) and the Mini Mental Status Exam (MMSE) – that were used to determine the severity of psychotic symptoms and cognitive impairment in patients. However, she noted that only one patient was admitted with cognitive impairment during alpha testing.

Summary of Key Findings from Alpha Testing

- 48 of 105 patients (46%) completed the PHQ-9-I at both admission and discharge.
  - 26% patients completed the PHQ-9-I at admission only.
  - 20% did not complete PHQ-9-I at admission or at discharge.
- The most frequent reasons for not completing were involuntary admission, psychosis, and agitation.
  - A comparison of patients who had psychosis with depression to patients who had psychosis without depression showed psychosis patients with depression appear to have higher completion rates, higher PHQ-9-I scores, and lower BPRS scores.
- Most of the patients who completed the PHQ-9-I at admission and at discharge showed a marked improvement in the PHQ-9-I score with a median score on of 17 on admission and 4.5 at discharge.
- Patients who were voluntarily admitted were more likely to complete PHQ-9-I on admission and discharge and have higher scores.

Topic: Discharge Score Bias

Comment: A panelist inquired whether the alpha testing was done in a locked unit. The panelist noted that for patients to be discharged from locked units, they must not be actively suicidal, and one question of the PHQ-9-I specifically evaluates suicidality. Patients may not respond honestly to this question if they want to leave the unit.

Team Response: The alpha testing unit is a locked unit. The completion of the PHQ-9-I was not linked to the discharge decisions. However, this issue will be evaluated further during development of the outcome measure.

Topic: Exclusion Criteria

The TEP provided feedback on the possibilities for exclusion criteria such as, transfers, leaving against medical advice (AMA), and psychosis diagnosis.

Comment: Several TEP members suggested exclusions for discharge against medical advice (AMA) or unplanned medical transfer because the facility would not always have the opportunity to complete the PHQ-9-I at discharge.

Comment: One TEP member commented on the differences in handling transfers between units within hospitals and freestanding facilities. Transfers within a hospital may show the admission date is the original admission date, and the discharge date is the final discharge date, and the transfer happens internally. A freestanding psychiatric facility handles the transfer as a discharge from one facility and admission to another.

Comment: One panelist noted that the Hospital Based Inpatient Psychiatric (HBIPS) measures account for patients who leave unexpectedly such as patients who elope and were discharged, or patients who failed to return from leave, or patients who went to a court hearing and did not return. The member recommended that the project team review these definitions.

Comment: A member inquired whether psychosis and schizoaffective disorder would be exclusions.

Comment: A TEP panelist commented that patients who are involuntarily admitted are likely to have severe psychosis, which precludes completion of the PHQ-9-I at admission. However, these patients improve and could complete the tool at discharge. The tool can provide information and have a lot of utility.

Comment: The TEP patient representative indicated a preference for as few exclusions as possible because they found the PHQ-9-I to be a valuable tool for most patients, regardless of diagnosis or reason for admission. Another TEP panelist noted that the original PHQ-9 is used in their outpatient offices, primary care practices, and medical center and suggested that it does make sense to do it on all patients coming into a psychiatric hospital, even though some of them may not be able to complete it, because providers could detect something that they can treat.

Team Response: From a clinical perspective it might make sense to screen everybody, as there may be patients who have undiagnosed depression that is detected by the PHQ-9-I. There may be a need for exclusion criteria to allow for the situations where administering the tool is not possible.

Comment: A TEP co-chair summarized the TEP discussion of exclusion criteria and requested information on the next steps for testing the exclusions.

Team Response: HSAG will collect data to explore the proposed exclusion criteria discussed by the TEP.

Topic: Clinical Utility

Comments: Several panelists expressed the need to ensure that the measure has clinical utility and is practical for use in the IPF setting.

Comment: One TEP member noted that patients can improve over the course of an inpatient stay and that the PHQ-9-I can capture some of those aspects of improvement. They also noted that it can be useful to know if patients do not improve as a signal to take action to prevent a bad outcome after the patient leaves. They indicated that the PHQ-9-I could be utilized broadly across conditions, including early dementia, because the impairment factors and the hopelessness can be part of conditions other than depression.

Comment: One TEP member commented on the utility of the original PHQ-9 by describing how it is used in her organization. The original PHQ-9 is given to every patient. Patients may be unable to complete the PHQ-9 on admission but they do not withhold the PHQ-9 based on diagnosis or type of admission. The PHQ-9 helps begin a dialogue about the patient's symptoms, helps the patient become more aware of his or her symptoms, provides an opportunity for discussing the results of the tool, and helps guide the patient as far as setting treatment goals. Including the patient in this process helps them better define what they hope to achieve during the inpatient stay. The improvements that have been seen in patients are significant even with short lengths of stay. This may be attributed to the patient having a chance to really think about their depression and their symptoms. If a patient's original PHQ-9 score remains high or increases, this information has been used effectively by the treatment team for decision-making, including whether discharge is canceled or delayed. The score of the PHQ-9 is not the only consideration in this decision, but it has been a very useful tool to prompt discussion before a discharge occurs. The patients are also screened for suicide. Hospital staff also use the BPRS to obtain a clinician's perspective. This allow the staff to see if there are differences between the perceptions of patient versus the perceptions of the clinician.

The commenter continued to explain that patients with psychotic disorders may have complicated life challenges which can affect their depressive states and exacerbate psychotic symptoms. The patient may not realize the impact of these life events. From a trauma-informed care perspective, productive dialogue about these life events issues can be encouraged by the PHQ-9-I.

> Team Response: The team added that the original PHQ-9 was designed to look at the way depression affects various facets of life. Even if a patient does not have depression, the responses to individual items might help clinicians to focus treatment plans and assessments.

Comment: The patient representative TEP member voiced her support of the utility of the PHQ-9-I by sharing her experience. She noted that no rating scale was provided to her during any of her hospitalizations. However, she is regularly asked to complete the original PHQ-9 for every outpatient visit and the providers create a graph of the scores which has been extremely helpful to show her progression over time. She suggested that most mental illnesses can have depression symptoms and that is a credible reason to use the PHQ-9-I for all psychiatric inpatients. She also noted that improvement is possible during inpatient admissions. She felt that if screening is done for all patients, more depression would be treated, and suicides could be prevented.

> Team Response: The team thanked her for sharing her experience.
>
> TEP Member Response: A TEP member also indicated the importance of the utility to patients when weighing the burden of the quality measure.

Comment: A panelist asked if it is necessary to administer the PHQ-9-I twice during the inpatient stay.

Team Response: The admission PHQ-9-I can inform treatment decisions during the inpatient stay. The PHQ-9-I score at discharge would reflect the improvement that the facility was able to achieve and could inform the discharge plan.

IX. Beta Testing Plan

Dr. Runge gave an overview of the planned beta (field) testing sites: The beta testing sample includes 12 sites from ten different states. The bed size for these facilities range from 16 beds to 104 beds. Five are freestanding facilities and seven are units embedded in acute facilities. The test sites use a variety of record types that include paper, electronic, and hybrid. Some of the sites have experience using the original PHQ-9; however, because there is no standardized process for PROMs in IPFs, there is some variability in how the PHQ-9 is used.

- Goals: The objectives for beta testing are to continue to assess the feasibility of implementing the PHQ-9-I into the clinical workflow, to determine the reliability of the collection of the data element, to look at the validity and reliability of the performance scores, and to finalize the exclusion criteria.
- Denominator: The denominator is comprised of IPF admissions for patients 18 years and older. The following data will be collected to inform the exclusion criteria:
    - Length of stay
    - Primary and secondary diagnoses
    - Discharge status (e.g., AMA, transfer)
    - Admission type (e.g., voluntary, involuntary)
- Numerator: The numerator is the total number of IPF admissions for patients who complete the PHQ-9-I at admission and discharge.
    - Testing will determine the association of PHQ-9-I completion rates and PHQ-9-I scores by examining differences in admission source and type, whether the patient received assistance, and whether there are language barriers. Testing will also determine the appropriate time frame to provide the PHQ-9-I to patients at admission and discharge.

Topic: Additional Data Elements

The TEP discussed a number of additional data elements or concepts that could be collected or evaluated during beta testing. These included a chart review to compare patient-reported symptoms to clinician notes and treatment plan goals, patients with unplanned transfers, and patients who may leave unexpectedly.

Sub-Topic: Comparison of patient-reported symptoms to clinician notes and treatment goals

Comment: One TEP member suggested that the team consider comparing the patient's reported depression symptoms in relation to what is listed in the treatment plan goals. It would make sense to make sure that clinicians are hearing what is being reported by the patient and that this information is available in the treatment plan.

Team Response: The team will determine if this is feasible for the current testing cycle considering the added burden of this activity.

Sub-Topic: Patients with unplanned transfers

Comment: Another TEP member pointed out that unplanned transfers were discussed earlier in the meeting but were not listed in the presentation.

Team Response: The team will add a data element to capture transfers for beta-testing.

Sub-Topic: Patients who leave unexpectedly

Comment: One TEP member suggested the team include a data element that captures patient elopement, patients who failed to return from treatment, or patients who failed to return from a court hearing. This TEP member referred to the HBIPS-5 measure, which has a data element that collects this information.

Team Response: The team will align the data elements with HBIPS-5 to the extent possible for beta-testing.

Sub-Topic: Age of patients on admission

Comment: One TEP member suggested that patients turning 18 during the admission is an issue on adolescent units and creates quite a challenge in collecting data or obtaining age-based compliance when the patient is only an adult for a couple of days.

Team Response: The measure has a data element that requires the patient be 18 on the admission date; all patients younger than 18 would be excluded.

Two Process Suggestions from TEP Members:

Comment: One TEP member provided feedback on the process of communicating decisions made during measure development. The member suggested that some comments and concerns raised by the TEP members appear to not be used or considered while the team is developing the measures.

Team Response: Many changes are made to each measure during development, and it is our intention to keep the TEP fully informed of these changes. The Project Director's update at the beginning of each meeting provides a summary of the decisions that were made as well as changes that were made to the measures based on comments and recommendations from the TEP. The TEP feedback is an important part of this process and we incorporate as many of the TEP recommendations as possible.

Comment: A TEP member noted that when the TEP is asked to vote on face validity, they are considering the measure as a whole and may not remember a critical issue that could impact the vote. The members may need to keep their significant concerns in mind as considerations when it is time to vote for face validity.

X. Action Items from TEP Discussion

Inpatient Assessment of Depression Symptoms Measure

- Collect data during beta testing to test exclusions, including (but not limited to) diagnosis, length of stay, admission type (e.g., involuntary admissions), and discharge status (e.g., AMA, expired, eloped).
    - Align with data elements as defined in the HBIPS-5 measure that capture unplanned transfers and patients who leave unexpectedly from the facility.
    - Evaluate whether there is response bias from patients who are admitted to locked units, particularly at discharge to overstate improvement in an effort to be discharged sooner.
    - Consider the applicability of the PHQ-9-I for individuals with psychosis and whether this may have unintended consequences for these patients.
- Explore the feasibility of performing a comparison of patient-reported symptoms to clinician notes and treatment plan goals with the medical record.

XI. Post-Meeting Notes and Recommendations

Post-meeting communications from TEP members are carefully considered and included in the next meeting presentation as appropriate.

Summary of Measures in Review by the TEP September 2016 – February 2019

Screening for Pregnancy – Chart abstracted – Process measure

TEP Meeting Highlights

- April 2017 Meeting – TEP approved focus area of measure
- April 2017 Meeting – Measure developer presented alpha testing results
- November 2017 – Measure developer completed beta testing
- February 2018 Meeting – Measure developer presented beta testing results and TEP voted on face validity. Face validity vote: 94.4% (17/18) agreement

Timeline

- April – May 2018 – Conducted public comment period
- August 2018 – Review public comments with TEP

Inpatient Assessment of Depression Symptoms – Chart abstracted – Process measure

TEP Meeting Highlights

- April 2017 Meeting – TEP decided on PHQ-9 tool among patient-reported outcome measures
- October 2017 Meeting – TEP approved update to PHQ-9 time-reference
- May 2018 Meeting – Measure developer presented alpha testing results and discussed beta testing plan

Timeline

- June 2018 – February 2019 – Measure developer to conduct beta testing in 12 test sites

Follow-Up After Psychiatric Hospitalization – Claims-based – Intermediate outcome measure

Timeline

- May 2018 – July 2018 – Measure developer to conduct alpha testing with expert Workgroup
- August 2018 – Measure developer to present alpha testing results to TEP for evaluation
- August 2018 – October 2018 – Measure developer to conduct beta testing

New Measure Conceptualization

Timeline

- August 2018 Meeting – Measure developer to present proposed new measure concepts that address Meaningful Measures gap areas in the IPFQR program to the TEP