Measure Justification Form and Instructions

Project Title:

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Funding Opportunity: Measure Development for the Quality Payment Program (Mental Health/Substance Use Care).

Date:

Information included is current on September 8, 2020

Project Overview:

The Centers for Medicare & Medicaid Services (CMS) has entered a cooperative agreement with the American Psychiatric Association (APA) and the National Committee for Quality Assurance (NCQA) to develop provider-level measures for mental health and substance use. The cooperative agreement name is MACRA/Measure Development for the Quality Payment Program. The cooperative agreement number is #1V1CMS331640-02-00.

1. Measure Name/ Title (NQF Submission Form De.2.)

Improvement or Maintenance in Recovery for Individuals with a Mental and/or Substance Use Disorder.

2. Type of Measure (NQF Submission Form De.1., NQF Evidence Attachment 1a.1.)

Identify a measure type from the listed items. Patient-reported outcomes (PROs) include health-related quality of life, functional status, symptom burden, experience with care, and health-related behaviors. Use the same type identified on the MIF.

☐process
☐process: appropriate use
☐outcome
☐cost/resource use
☐efficiency
☒outcome: patient-reported outcome-based performance measure (PRO-PM)
☐structure
☐outcome: intermediate outcome
☐composite

3. Importance (NQF Importance Tab)

3.1 Evidence to Support the Measure Focus (for reference only) (NQF Evidence Attachment Subcriterion 1a).

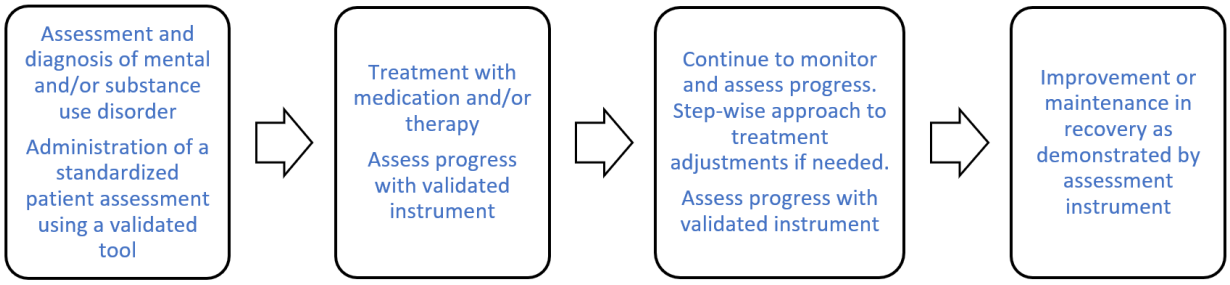
In randomized control trials (RCTs) and most longitudinal studies where recovery has been assessed, the Recovery Assessment Scale (RAS), a commonly used tool for gauging recovery, demonstrates sensitivity

to change over time and the studies show how interventions such as social support, group therapy and educational programs can help individuals achieve improved recovery ratings and sustained maintenance of long-term recovery

3.1.1 This is a Measure of: (should be consistent with type of measure entered in NQF Measure Submission Form De.1) (NQF Evidence Attachment 1a.1)

☐process:
☐process: appropriate use: *name the measured appropriate use.*
☐outcome: *name the outcome*.
☒outcome: PRO: Improvement or Maintenance in Recovery for Individuals with a Mental and/or Substance Use Disorder.
☐cost/resource use: *name the cost/resource*.
☐efficiency: *name the efficiency*.
☐structure: *name the structure.*
☐intermediate outcome: *name the intermediate outcome*.
☐composite: *name what is measured.*

3.1.2 Logic Model (NQF Evidence Attachment 1a.2)



3.1.3 Value and Meaningfulness (NQF Evidence Attachment 1a.3)

Studies have found that measurement-based care (MBC) with the use of a valid and reliable tool provides valuable information about recovery (Scott & Lewis, 2015). Assessing and monitoring recovery to measure how much a patient moves toward recovery provides significant value to both patients and clinicians. Studies have shown that treatment is enhanced through patient engagement, person-centered care that includes shared decision-making and bidirectional communication (Hsin, 2018). Along with enhanced treatment, it has been shown that individuals with a self-directed framework for recovery have improved long-term recovery rates (Stein, 2009). Systematic and routine measurement using RAS-24 affords the clinician the opportunity to monitor progress and focus on specific areas that require further attention. By SAMHSA's definition, incorporating the concept of recovery into the evaluation of mental health outcomes would expand the domains of quality measurement from traditional clinical outcomes focused on symptoms to areas focused more on personal empowerment and engagement in care (Pincus et al., 2016). Use of the RAS-24 has been shown to facilitate a dialogue between an individual and clinician. In assessing recovery, the focus shifts from symptoms to looking at factors that have been deemed important to quality of life (Personal confidence and hope, willingness to

ask for help, goal and success orientation, reliance on others, and not being dominated by symptoms) (Salzer & Brusilovskiy, 2014).

References:

Hsin, H., Fromer, M., Peterson, B., Walter, C., Fleck, M., Campbell, A., ... & Califf, R. Transforming psychiatry into data-driven medicine with digital measurement tools. *NPJ digital medicine*. 2018 Aug 22;1(1), 1-4.

Pincus, H. A., Scholle, S. H., Spaeth-Rublee, B., Hepner, K. A., & Brown, J. (2016). Quality Measures For Mental Health And Substance Use: Gaps, Opportunities, And Challenges. Health Affairs (Project Hope), 35(6), 1000–1008. https://doi.org/10.1377/hlthaff.2016.0027

Salzer, M. S., & Brusilovskiy, E. (2014). Advancing recovery science: reliability and validity properties of the Recovery Assessment Scale. Psychiatric Services (Washington, D.C.), 65(4), 442–453. https://doi.org/10.1176/appi.ps.201300089

Scott, K., & Lewis, C. C. (2015). Using Measurement-Based Care to Enhance Any Treatment. Cognitive and Behavioral Practice, 22(1), 49–59. https://doi.org/10.1016/j.cbpra.2014.01.010

Stein, F. (2009). Making the public mental health, developmental disabilities, and substance abuse system more accessible: an invitation to recovery. North Carolina Medical Journal, 70(1), 46–49.

3.1.4 Empirical Data (for outcome measures) – as applicable (NQF Evidence Attachment 1a.2)

In randomized control trials (RCTs) and most longitudinal studies where recovery has been assessed, the Recovery Assessment Scale (RAS), a commonly used tool for gauging recovery, demonstrates sensitivity to change over time and the studies show how interventions such as social support, group therapy and educational programs can help individuals achieve improved recovery ratings and sustained maintenance of long-term recovery (Barbic, Krupa, & Armstrong, 2009; Cook, Copeland, et al., 2012; Cook, Steigman, et al., 2012). In 12 longitudinal studies, the RAS scores were used as outcome variables. In these studies, the scores increased over time, which was associated with maintaining or showing improvement towards the goal of continued recovery (Salzer & Brusilovskiy, 2014). Individuals with a self-directed framework for recovery have improved long-term recovery rates (Stein, 2009).

References:

Barbic, S., Krupa, T., & Armstrong, I. (2009). A randomized controlled trial of the effectiveness of a modified recovery workbook program: preliminary findings. Psychiatric Services (Washington, D.C.), 60(4), 491–497. https://doi.org/10.1176/appi.ps.60.4.491

Cook, J. A., Copeland, M. E., Floyd, C. B., Jonikas, J. A., Hamilton, M. M., Razzano, L., … Boyd, S. (2012). A randomized controlled trial of effects of Wellness Recovery Action Planning on depression, anxiety, and recovery. Psychiatric Services (Washington, D.C.), 63(6), 541–547. https://doi.org/10.1176/appi.ps.201100125

Cook, J. A., Steigman, P., Pickett, S., Diehl, S., Fox, A., Shipley, P., … Burke-Miller, J. K. (2012). Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). Schizophrenia Research, 136(1–3), 36–42. https://doi.org/10.1016/j.schres.2011.10.016

Salzer, M. S., & Brusilovskiy, E. (2014). Advancing recovery science: reliability and validity properties of the Recovery Assessment Scale. Psychiatric Services (Washington, D.C.), 65(4), 442–453. https://doi.org/10.1176/appi.ps.201300089

Stein, F. (2009). Making the public mental health, developmental disabilities, and substance abuse system more accessible: an invitation to recovery. North Carolina Medical Journal, 70(1), 46–49.

3.1.5 Systematic Review of the Evidence (for intermediate outcome, process, or structure performance measures, include those that are instrument-based) – as applicable (NQF Evidence Attachment 1a.3)

Not applicable.

3.1.6 Other Source of Evidence – as applicable (NQF Evidence Attachment 1a.4)

Not applicable.

3.1.6.1 Briefly Synthesize the Evidence (NQF Evidence Attachment 1a.4.1)

Guideline Recommendations:

Clinical practice guidelines recommend the use of questionnaires as part of standard psychiatric treatment (APA, 2015; VA/DoD, 2019; VA/DoD, 2016). The American Psychiatric Association (APA) clinical guidelines specific to the treatment of major depressive disorder (MDD) and bipolar disorder emphasize the importance of consumer engagement and consumer self-report during essential treatment phases (APA, 2015; APA, 2010; APA, 2002). Additionally, the Department of Veterans Affairs/Department of Defense (VA/DoD) guidelines recommend use of standardized tools, including patient self-reported questionnaires. The guidelines indicate that these tools should be utilized as a part of the initial evaluation and to monitor patient response to treatment at regular intervals (e.g., every 1 to 4 weeks or after each change in treatment) (VA/DoD, 2019; VA/DoD, 2016). Using the RAS-24 questionnaire or assessment tool to track recovery is based on a clinical process model of recovery, wherein the RAS attempts to assess aspects of recovery with a special focus on hope and self-determination.

Recovery-Specific Information:

Recovery is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as “a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential” (SAMHSA, 2019). Unlike mental and substance use disorder prevalence, recovery is not reported nationally in the United States. It is estimated that 22.35 million adults in the United States have recovered from substance use disorder (Kelly, Bergman, Hoeppner, Vilsaint, & White, 2017).

Prevalence data for mental and substance use disorder recovery is limited due to the lack of quantitative methods of measurement that are not broadly in use. The challenge of measuring recovery is replacing traditional yardsticks of success – the alleviation of symptoms and discharge from services – with questions about whether people can do the things that give their lives meaning and purpose, irrespective of whether their problems continue and whether they continue to need help and support. Along with limited data on the prevalence of mental and substance use disorder recovery, minimal information is available on disparities related to recovery; research has found that minorities,

specifically black individuals, are at risk for poorer mental health treatment due to limited access to mental health care and increased symptom burden associated with mental illness (Aggarwal, Rosenheck, Woods, & Sernyak, 2012; Kreyenbuhl et al., 2017; Snowden, 2012).

RAS-24 Information:

Existing tools vary in their definitions of recovery, constructs measured and psychometric properties (Burgess, Pirkis, Coombs, & Rosen, 2011; Cavelti, Kvrgic, Beck, Kossowsky, & Vauth, 2012; Law, Morrison, Byrne, & Hodson, 2012; Salzer & Brusilovskiy, 2014; Shanks et al., 2013). One approach considers the individual's perspective on quality of life and is similar to more generic quality of life tools. Other approaches assess attitudes, beliefs and knowledge of the recovery process and represent perspectives of either the individual or clinician. The third approach considers the individual's perception of whether environment promotes recovery (e.g., specific policies, programs, and practices) (Salzer & Brusilovskiy, 2014) . Thus, no current 'gold-standard' measure of recovery exists (Law et al., 2012; Shanks et al., 2013).

In randomized control trials (RCTs) and most longitudinal studies where recovery has been assessed, the Recovery Assessment Scale (RAS), a commonly used tool for gauging recovery, demonstrates sensitivity to change over time and the studies show how interventions such as social support, group therapy and educational programs can help individuals achieve improved recovery ratings and sustained maintenance of long-term recovery (Barbic, Krupa, & Armstrong, 2009; Cook, Copeland, et al., 2012; Cook, Steigman, et al., 2012). In 12 longitudinal studies, the RAS scores were used as outcome variables. In these studies, the scores increased overtime which was associated with maintaining or showing improvement towards the goal of continued recovery (Salzer & Brusilovskiy, 2014). Individuals with a self-directed framework for recovery have improved long-term recovery rates (Stein, 2009).

The RAS was selected as the tool to accompany this measure after an extensive review of the tools used to measure recovery and after talking with our expert panels. The 24-item RAS assesses recovery from an individual's perspective with an emphasis on hope and self-determination and has robust psychometric properties. The domains covered in the tool are personal confidence, willingness to ask for help, goal orientation, reliance on others, and not feeling dominated by symptoms.

3.1.6.2 Process Used to Identify the Evidence (NQF Evidence Attachment 1a.4.2)

APA's Council on Quality Care charged its Workgroup on Performance and Quality Measurement to engage with APA staff to review CMS's 2017 Program-Specific Measure Priorities and Needs, Quality Measure Development Plan (MDP), and Meaningful Measures Framework to help define key strategic areas of focus as a starting point to select and outline measurement topics/conditions of interest. In consultation with this Workgroup, APA staff conducted a review to identify evidence related to Measurement-Based Care and its impact on patient outcomes (e.g., functioning, recovery, suicide), with guidance from Workgroup members on the most relevant literature.

3.1.6.3 Citation(s) for the Evidence (NQF Evidence Attachment 1a.4.3)

Aggarwal, N. K., Rosenheck, R. A., Woods, S. W., & Sernyak, M. J. (2012). Race and long-acting antipsychotic prescription at a community mental health center: a retrospective chart review. The Journal of Clinical Psychiatry, 73(4), 513–517. https://doi.org/10.4088/JCP.11m07161

American Psychiatric Association. The American Psychiatric Association practice guidelines for the treatment of patients with bipolar disorder. American Psychiatric Pub; April 2002.

American Psychiatric Association. The American Psychiatric Association practice guidelines for treatment of patients with major depressive disorder. American Psychiatric Pub; October 2010.

American Psychiatric Association. The American Psychiatric Association practice guidelines for the psychiatric evaluation of adults. American Psychiatric Pub; 2015 Jul 29.

Barbic, S., Krupa, T., & Armstrong, I. (2009). A randomized controlled trial of the effectiveness of a modified recovery workbook program: preliminary findings. Psychiatric Services (Washington, D.C.), 60(4), 491–497. https://doi.org/10.1176/appi.ps.60.4.491

Burgess, P., Pirkis, J., Coombs, T., & Rosen, A. (2011). Assessing the value of existing recovery measures for routine use in Australian mental health services. The Australian and New Zealand Journal of Psychiatry, 45(4), 267–280. https://doi.org/10.3109/00048674.2010.549996

Cavelti, M., Kvrgic, S., Beck, E. M., Kossowsky, J., & Vauth, R. (2012). Assessing recovery from schizophrenia as an individual process. A review of self-report instruments. European Psychiatry: The Journal of the Association of European Psychiatrists, 27(1), 19–32. https://doi.org/10.1016/j.eurpsy.2011.01.007

Cook, J. A., Copeland, M. E., Floyd, C. B., Jonikas, J. A., Hamilton, M. M., Razzano, L., … Boyd, S. (2012). A randomized controlled trial of effects of Wellness Recovery Action Planning on depression, anxiety, and recovery. Psychiatric Services (Washington, D.C.), 63(6), 541–547. https://doi.org/10.1176/appi.ps.201100125

Cook, J. A., Steigman, P., Pickett, S., Diehl, S., Fox, A., Shipley, P., … Burke-Miller, J. K. (2012). Randomized controlled trial of peer-led recovery education using Building Recovery of Individual Dreams and Goals through Education and Support (BRIDGES). Schizophrenia Research, 136(1–3), 36–42. https://doi.org/10.1016/j.schres.2011.10.016

Department of Veterans Affairs Department of Defense. VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide. 2013;2019. https://www.healthquality.va.gov/guidelines/MH/srb/VADODCP_SuicideRisk_Full.pdf; https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pd
Department of Veterans Affairs Department of Defense. VA/DoD clinical practice guideline for the management of major depressive disorder. 2016. https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf
fKelly, J. F., Bergman, B., Hoeppner, B. B., Vilsaint, C., & White, W. L. (2017). Prevalence and pathways of recovery from drug and alcohol problems in the United States population: Implications for practice, research, and policy. Drug and Alcohol Dependence, 181, 162–169. https://doi.org/10.1016/j.drugalcdep.2017.09.028

Kreyenbuhl, J., Dixon, L. B., Brown, C. H., Medoff, D. R., Klingaman, E. A., Fang, L. J., … Walsh, M. B. (2017). A Randomized Controlled Trial of a Patient-Centered Approach to Improve Screening for the Metabolic Side Effects of Antipsychotic Medications. Community Mental Health Journal, 53(2), 163–175. https://doi.org/10.1007/s10597-016-0007-5

Law, H., Morrison, A., Byrne, R., & Hodson, E. (2012). Recovery from psychosis: a user informed review of self-report instruments for measuring recovery. Journal of Mental Health (Abingdon, England), 21(2), 192–207. https://doi.org/10.3109/09638237.2012.670885

Salzer, M. S., & Brusilovskiy, E. (2014). Advancing recovery science: reliability and validity properties of the Recovery Assessment Scale. Psychiatric Services (Washington, D.C.), 65(4), 442–453. https://doi.org/10.1176/appi.ps.201300089

SAMHSA. (2019, January 14). Recovery and Recovery Support [Text]. Retrieved February 1, 2019, from https://www.samhsa.gov/find-help/recovery

Shanks, V., Williams, J., Leamy, M., Bird, V. J., Le Boutillier, C., & Slade, M. (2013). Measures of personal recovery: a systematic review. Psychiatric Services (Washington, D.C.), 64(10), 974–980. https://doi.org/10.1176/appi.ps.005012012

Snowden, L. R. (2012). Health and mental health policies' role in better understanding and closing African American-White American disparities in treatment access and quality of care. The American Psychologist, 67(7), 524–531. https://doi.org/10.1037/a0030054

Stein, F. (2009). Making the public mental health, developmental disabilities, and substance abuse system more accessible: an invitation to recovery. North Carolina Medical Journal, 70(1), 46–49.

3.2 Performance Gap – Opportunity for Improvement (NQF Measure evaluation criterion 1b)

3.2.1 Rationale (NQF Submission Form 1b.1.)

As a set of standard processes, measurement-based care (MBC) can increase patient engagement, ensure initiation of evidence-based treatments, and facilitate essential follow-up assessment and continuous care planning. For example, implementation of MBC with regular outcome assessments has been linked to improvements in service delivery and lower readmission rates (Slade et al, 2006), whereas infrequent outcome measurement did little to improve quality of care (Ashaye et al., 2003). Moreover, routine outcome measurement that was fed back to the clinician and used to make joint treatment decisions with the patient led to better reported quality of life (Priebe et al., 2002).

The planned Recovery outcome measure requires a completion of a baseline assessment using the RAS, an update on the patient's condition by completing a following-up assessment utilizing the RAS, and care plan adjustments based on those results. The recovery outcome measure will provide a better understanding of whether the individual is improving or maintaining his or her recovery. This measure would be completed in combination with the MBC process measures, which serve as a building block for this outcome measure.

Measurement around MBC can help drive widespread adoption, with its proven benefits, and overcome perceived barriers to implementation. As mental health care moves in the direction of value-driven incentives, it will be important for providers and organizations to implement MBC as an evidence-based framework to reduce variability in psychiatric treatment and improve patient outcomes.

References:

Sladeet al. (2006). Use of standardised outcome measures in adult mental health services: randomised controlled trial. The British Journal of Psychiatry: The Journal of Mental Science, 189, 330–336. https://doi.org/10.1192/bjp.bp.105.015412

Ashaye et al. Does standardized needs assessment improve the outcome of psychiatric day hospital care for older people? A randomized controlled trial. Aging Ment Health. 2003 May;7(3):195-9.

Priebe et al. The impact of routine outcome measurement on treatment processes in community mental health care: approach and methods of the MECCA study. Epidemiol Psychiatr Soc. 2002 Jul-Sept;11(3):198-205.

3.2.2 Performance Scores (NQF Submission Form 1b.2.)

This measure is currently undergoing testing; data will be provided upon completion and analysis of testing results.

3.2.3 Summary of Data Indicating Opportunity (NQF Submission Form 1b.3.)

Measuring recovery in an agreeable and meaningful manner is important for assessing quality of mental health care. While there are a variety of tools for assessing recovery, fewer than 17.9 percent of psychiatrists and less than 11.1 percent of psychologists routinely use standardized measurement tools to assess recovery from the individual perspective (Harding, Rush, Arbuckle, Trivedi, & Pincus, 2011). A quality measure derived using data from standardized recovery measures will help clinicians assess and treat individuals according to their needs and unique circumstances. While health outcomes and societal costs are hard to quantify, research demonstrates that investment in measures related to recovery would greatly benefit the overall health and meaningfulness of individual's lives as they work to improve or maintain their recovery (Pincus, Scholle, Spaeth-Rublee, Hepner, & Brown, 2016; Slade et al., 2006a).

References:

Harding, K. J. K., Rush, A. J., Arbuckle, M., Trivedi, M. H., & Pincus, H. A. (2011). Measurement-based care in psychiatric practice: A policy framework for implementation. Journal of Clinical Psychiatry, 72(8), 1136–1143. https://doi.org/10.4088/JCP.10r06282whi

Pincus, H. A., Scholle, S. H., Spaeth-Rublee, B., Hepner, K. A., & Brown, J. (2016). Quality Measures For Mental Health And Substance Use: Gaps, Opportunities, And Challenges. Health Affairs (Project Hope), 35(6), 1000–1008. https://doi.org/10.1377/hlthaff.2016.0027.

3.2.4 Disparities (NQF Submission Form 1b.4.)

This measure is currently undergoing testing; data will be provided upon completion and analysis of testing results.

3.2.5 Provide summary of data if no or limited data (NQF Submission Form 1b.5.)

Along with the lack of standard recovery tools presently in use, there is a lack of tools that are culturally appropriate, accessible and focused on self-directed goals of individuals seeking to maintain or improve their recovery status (SAMHSA, 2019; Stein, 2009). Many recovery tools focus on improvements in current systems rather than long-term self-determined goals of improvement. The tool for this measure must also support efforts to reduce disparities in recovery. Research has found minorities, specifically black individuals, are at risk for poorer mental health treatment due to limited accessibility to mental health care and increased symptom burden associated with mental illness (Aggarwal et al., 2012; Kreyenbuhl et al., 2017; Snowden, 2012). Along with these issues, early treatment termination by the individual against the advice of their treating provider as well as loss to follow-up are significantly higher with black individuals (Carson, Vesper, Chen, & Lê Cook, 2014; Delphin-Rittmon et al., 2015; Li, Eack, Montrose, Miewald, & Keshavan, 2011) . National data describing disparities in recovery by age, socioeconomic status, and gender do not exist yet.

References:

Aggarwal, N. K., Rosenheck, R. A., Woods, S. W., & Sernyak, M. J. (2012). Race and long-acting antipsychotic prescription at a community mental health center: a retrospective chart review. The Journal of Clinical Psychiatry, 73(4), 513–517. https://doi.org/10.4088/JCP.11m07161
Carson, N. J., Vesper, A., Chen, C.-N., & Lê Cook, B. (2014). Quality of follow-up after hospitalization for mental illness among patients from racial-ethnic minority groups. Psychiatric Services (Washington, D.C.), 65(7), 888–896. https://doi.org/10.1176/appi.ps.201300139
Delphin-Rittmon, M. E., Flanagan, E. H., Andres-Hyman, R., Ortiz, J., Amer, M. M., & Davidson, L. (2015). Racial-ethnic differences in access, diagnosis, and outcomes in public-sector inpatient mental health treatment. Psychological Services, 12(2), 158–166. https://doi.org/10.1037/a0038858
Kreyenbuhl, J., Dixon, L. B., Brown, C. H., Medoff, D. R., Klingaman, E. A., Fang, L. J., … Walsh, M. B. (2017). A Randomized Controlled Trial of a Patient-Centered Approach to Improve Screening for the Metabolic Side Effects of Antipsychotic Medications. Community Mental Health Journal, 53(2), 163–175. https://doi.org/10.1007/s10597-016-0007-5
Li, H., Eack, S. M., Montrose, D. M., Miewald, J. M., & Keshavan, M. (2011). Longitudinal Treatment Outcome of African American and Caucasian Patients with First Episode Psychosis. Asian Journal of Psychiatry, 4(4), 266–271. https://doi.org/10.1016/j.ajp.2011.08.004
SAMHSA. (2019, January 14). Recovery and Recovery Support [Text]. Retrieved February 1, 2019, from https://www.samhsa.gov/find-help/recovery
Snowden, L. R. (2012). Health and mental health policies' role in better understanding and closing African American-White American disparities in treatment access and quality of care. The American Psychologist, 67(7), 524–531. https://doi.org/10.1037/a0030054
Stein, F. (2009). Making the public mental health, developmental disabilities, and substance abuse system more accessible: an invitation to recovery. North Carolina Medical Journal, 70(1), 46–49.

4. Scientific Acceptability (NQF Scientific Acceptability Tab)

4.1 Data Sample Description (NQF Testing Attachment 1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.1.1 What Types of Data Were Used for Testing? (NQF Testing Attachment 1.1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

☐abstracted from paper record
☐administrative claims
☐clinical database/registry
☐abstracted from electronic health record (EHR)
☐electronic clinical quality measure (eCQM) Health Quality Measure Format (HQMF) implemented in EHRs
☐other (please describe) Click or tap here to enter text.

Measure tested with data from

☐abstracted from paper record

☐administrative claims
☐clinical database/registry
☐abstracted from EHRs
☐eCQM (HQMF) implemented in EHRs
☐other (please describe) Click or tap here to enter text.

4.1.2 Identify the Specific Dataset (NQF Testing Attachment 1.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.1.3 What Are the Dates of the Data Used in Testing? (NQF Testing Attachment 1.3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.1.4 What Levels of Analysis Were Tested? (NQF Testing Attachment 1.4.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

Measure specified to measure performance of *(must be consistent with data sources entered in 3.22)* (NQF Submission Form S.20)

☐individual clinician
☐group/practice
☐hospital/facility/agency
☐health plan
☐other (please describe) Click or tap here to enter text.

Measure tested at level of

☐individual clinician
☐group/practice
☐hospital/facility/agency
☐health plan
☐other (please describe) Click or tap here to enter text.

4.1.5 How Many and Which Measured Entities Were Included in the Testing and Analysis? (NQF Testing Attachment 1.5.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.1.6 How Many and Which Patients Were Included in the Testing and Analysis? (NQF Testing Attachment 1.6.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.1.7 Sample Differences, if applicable (NQF Testing Attachment 1.7.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.1.8 What Were the Social Risk Factors That Were Available and Analyzed? (NQF Testing Attachment 1.8.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.2 Reliability Testing **(for reference only)** (NQF Testing Attachment 2a.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.2.1 Level of Reliability Testing (NQF Testing Attachment 2a2.1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

☐critical data elements used in the measure (e.g., inter-abstractor reliability; data element reliability must address all critical data elements)
☐performance measure score (e.g., signal-to-noise analysis)

4.2.2 Method of Reliability Testing (NQF Testing Attachment 2a2.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.2.3 Statistical Results from Reliability Testing (NQF Testing Attachment 2a2.3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.2.4 Interpretation (NQF Testing Attachment 2a2.4.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.3 Validity Testing **(for reference only)** (NQF Testing Attachment 2b1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.3.1 Level of Validity Testing (NQF Testing Attachment 2b1.1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

☐critical data elements (Note: Data element validity must address all critical data elements.)
☐performance measure score
  ☐empirical validity testing
  ☐systematic assessment of face validity of performance measure score as an indicator of quality or resource use (i.e., is an accurate reflection of performance on quality or resource use and can distinguish good from poor performance)

4.3.2 Method of Validity Testing (NQF Testing Attachment 2b1.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.3.3 Statistical Results from Validity Testing (NQF Testing Attachment 2b1.3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.3.4 Interpretation (NQF Testing Attachment 2b1.4.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.4 Exclusions Analysis **(for reference only)** (NQF Testing Attachment 2b2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.4.1 Method of Testing Exclusions (NQF Testing Attachment 2b2.1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.4.2 Statistical Results from Testing Exclusions (NQF Testing Attachment 2b2.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.4.3 Interpretation (NQF Testing Attachment 2b2.3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5 Risk Adjustment or Stratification for Outcome or Resource Use Measures **(for reference only)** (NQF Testing Attachment 2b3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.1 Method of Controlling for Differences (NQF Testing Attachment 2b3.1.)

The method of controlling for differences in case mix is

☐no risk adjustment or stratification
☐statistical risk model with (specify number) risk factors
☐stratification by (specify number) risk categories
☐other (please describe) Click or tap here to enter text.

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.2 Rationale for Why There Is No Need for Risk Adjustment (NQF Testing Attachment 2b3.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.3 Conceptual, Clinical, and Statistical Methods (NQF Testing Attachment 2b3.3.a.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.4 Conceptual Model of Impact of Social Risks (NQF Testing Attachment 2b3.3b.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

☐published literature
☐internal data analysis
☐other (please describe) Click or tap here to enter text.

4.5.5 Statistical Results (NQF Testing Attachment 2b3.4a.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.6 Analyses and Interpretation in Selection of Social Risk Factors (NQF Testing Attachment 2b3.4b.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.7 Method Used to Develop the Statistical Model or Stratification Approach (NQF Testing Attachment 2b3.5.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.8 Statistical Risk Model Discrimination Statistics (e.g., c-statistic, R^2) (NQF Testing Attachment 2b3.6.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.9 Statistical Risk Model Calibration Statistics (e.g., Hosmer-Lemeshow statistic) (NQF Testing Attachment 2b3.7.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.10 Statistical Risk Model Calibration—Risk decile plots or calibration curves (NQF Testing Attachment 2b3.8.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.11 Results of Risk Stratification Analysis (NQF Testing Attachment 2b3.9.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.12 Interpretation (NQF Testing Attachment 2b3.10.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.5.13 Optional Additional Testing for Risk Adjustment (NQF Testing Attachment 2b3.11.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.6 Identification of Meaningful Differences in Performance **(for reference only)** (NQF Testing Attachment 2b.54.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.6.1 Method (NQF Testing Attachment 2b4.1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.6.2 Statistical Results (NQF Testing Attachment 2b4.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.6.3 Interpretation (NQF Testing Attachment 2b4.3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.7 Comparability of Multiple Data Sources/Methods **(for reference only)** (NQF Testing Attachment 2b5.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.7.1 Method (NQF Testing Attachment 2b5.1.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.7.2 Statistical Results (NQF Testing Attachment 2b5.2.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.7.3 Interpretation (NQF Testing Attachment 2b5.3.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.8 Missing Data Analysis and Minimizing Bias **(for reference only)** (NQF Testing Attachment 2b6.)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.8.1 Method (NQF Testing Attachment 2b6.1)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.8.2 Missing Data Analysis (NQF Testing Attachment 2b6.2)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

4.8.3 Interpretation (NQF Testing Attachment 2b6.3)

This measure is currently undergoing testing. Section 4 will be completed after testing and analyses are complete.

5. Feasibility (NQF Feasibility Tab)

This criterion assesses the extent to which the required data are readily available, retrievable without undue burden, and are implementable for performance measurement.

5.1 Data Elements Generated as Byproduct of Care Processes (NQF Measure evaluation criterion 3a./3a.1)

Data used in the measure are (check all that apply)

☒generated or collected by and used by healthcare personnel during provision of care (e.g., blood pressure, laboratory value, diagnosis, depression score)
☐coded by someone other than the person obtaining original information (e.g., Diagnosis-Related Group [DRG], International Classification of Diseases, 10th Revision [ICD-10] codes on claims)
☒abstracted from a record by someone other than the person obtaining original information (e.g., chart abstraction for quality measure or registry)
☐other (please describe) Click or tap here to enter text.

5.2 Electronic Sources (NQF Measure evaluation criterion 3b.)

5.2.1 Data Elements Electronic Availability (NQF Submission Form 3b.1.)

☐All data elements are in defined fields in EHRs.
☐All data elements are in defined fields in electronic claims.
☐All data elements are in defined fields in electronic clinical data such as clinical registry, nursing home MDS, and home health OASIS.
☐All data elements are in defined fields in a combination of electronic sources.
☒Some data elements are in defined fields in electronic sources.
☐No data elements are in defined fields in electronic sources.
☒Data are patient/family reported information; may be electronic or paper.

5.2.2 Path to Electronic Capture (NQF Submission Form 3b.2.)

All data are electronically captured in either EHR and/or online portal application. Even if PROM data are captured by pen and paper, the clinician is still expected to document the EHR with some notation of patient assessment with tool. Completed paper tools are expected to be scanned and uploaded to the EHR so that it is part of the electronic record.

5.2.3 eCQM Feasibility (NQF Submission Form 3b.3.)

Not Applicable.

5.3 Data Collection Strategy (NQF Measure evaluation criterion 3c.)

5.3.1 Data Collection Strategy Difficulties (optional) (NQF Submission Form 3c.1.)

The implementation of measurement-based care (MBC) can require significant changes in practice for clinicians. MBC entails routine use of assessment instruments, which may not be part of providers' usual workflow, and can require a different mode of interaction with patients. Patients also need to adjust to the need for timely completion of patient-reported outcome measures (PROMs), and clinicians need to work closely with their patients to explain the purpose and value of assessment tools and how they will be used to inform and adjust treatment approaches. For these reasons, adoption of MBC may take several months and require multiple QI initiatives (e.g., PDSA cycles). As described in section 6.1.2.1, APA and NCQA have conducted regular learning collaborative sessions during the development and testing of this measure set, providing technical assistance, answering questions, and working through challenges faced by participants. As MBC is more widely adopted as part of routine clinical practice, data collection difficulties are expected to become less of a barrier to implementation.

5.3.2 Fees, Licensing, Other Requirements (NQF Submission Form 3c.2.)

Not applicable.

6. Usability and Use (NQF Usability and Use Tab)

6.1 Use (NQF Measure evaluation criterion 4a.)

6.1.1 Current and Planned Use (NQF Submission Form 4.1.)

☒public reporting ***– planned use***
☐public health or disease surveillance
☒payment program ***– planned use***
☐regulatory and accreditation programs
☐professional certification or recognition program
☒quality improvement with external benchmarking to multiple organizations ***– planned use***
☐quality improvement internal to a specific organization
☐not in use
☐use unknown

6.1.1.1 Reasons for Not Publicly Reporting or Use in Other Accountability Application (NQF Submission Form 4a.1.2.)

Not Applicable.

6.1.1.2 Plan for Implementation (NQF Submission Form 4a.1.3.)

We are planning to submit the measure in 2021 for the CMS Qualified Clinical Data Registry (QCDR) program, with the intent of making it available for use in the Merit-Based Incentive Payment System (MIPS), as well as for Quality Improvement with benchmarking.

6.1.2 Feedback on the Measure by Those Being Measured or Others (NQF Measure evaluation criterion 4a2)

6.1.2.1 Technical Assistance Provided During Development or Implementation (NQF Submission Form 4a2.1.1.)

As part of the development and testing of this measure, the APA and NCQA are conducting regular learning collaborative webinar sessions. The project team has presented topics such as utilizing PsychPRO for measurement-based care, workflow successes and challenges, and overview of the suicide safety planning intervention. The webinars have had 5-15 participants in attendance, including psychiatrists, social workers, and office managers. The goal of the Learning Collaboratives is to encourage clinicians and participants to raise questions and work through problems they face administering PROMS to patients. These webinars are also an opportunity for practices to interact with each other and discuss barriers, progress, and successes. Participants have access to resources the team has developed such as the PROMs Description Guide, How to Talk to Patients About Measurement-Based Care, PsychPRO Patient Portal Guide, and Monthly Newsletters, housed on the participant resource website (https://www.psychiatry.org/psychiatrists/registry/qmdi-participant-resources). The project team also monitors the data produced by participants and has reached out to a subset to understand their progress, any challenges they face and how the project team can best support participating clinicians in adopting the MBC workflows.

Additionally, the team holds regular office hours and is available for ad-hoc appointments via email. The Learning Collaborative team provides technical assistance through screen-sharing and is available to clarify any questions about the measure concepts and specifications. Technical assistance is also provided through the PsychPRO registry. Users can contact the APA at any time with questions or concerns.

6.1.2.2 Technical Assistance with Results (NQF Submission Form 4a2.1.2.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.1.2.3 Feedback on Measure Performance and Implementation (NQF Submission Form 4a2.2.1.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.1.2.4 Feedback from Measured Providers (NQF Submission Form 4a2.2.2.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.1.2.5 Feedback from Other Users (NQF Submission Form 4a2.2.3.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.1.2.6 Consideration of Feedback (NQF Submission Form 4a2.3.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.2 Usability (NQF Measure evaluation criterion 4b)

6.2.1 Improvement (NQF Measure evaluation criterion 4b1.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.2.2 Unexpected Findings (NQF Measure evaluation criterion 4b2., NQF Submission Form 4b2.1.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

6.2.3 Unexpected Benefits (NQF Submission Form 4b2.2.)

This measure is currently undergoing testing. This section will be completed after testing and analyses are complete.

7. Related and Competing Measures (NQF Related and Competing Measures Tab)

If a measure meets other criteria and there are endorsed or new related measures (either the same measure focus or target population) or competing measures (both the same measure focus and same target population), the measures are compared to address harmonization and/or selection of the best measure.

7.1 Relation to Other NQF-Endorsed Measures (NQF Measure evaluation criterion 5, NQF Submission Form 5)

Are there related measures or competing measures?

☐yes
☒no

7.2 Harmonization (NQF Submission Form 5a., 5a.1., 5a.2.)

Not applicable.

7.3 Competing Measures (NQF Submission Form 5b., 5b.1.)

Not applicable.

Additional Information (NQF Additional Information Tab)

Appendix

No supplemental materials.

Other Additional Information

Ad.1. Working Group/Expert Panel Involved in Measure Development

Technical Expert Panel (TEP) Members	Consumer Family Panel (CFP) Members
Anna Ratzliff, MD, PhD – Co chair *University of Washington* Jerry Halverson, MD, DFAPA – Co chair *Rogers Behavioral Health* Jolene Ramussen, MSCE, *Texas Council of Community Centers*	Kimberly Buie *Consumer/Family Member Volunteer* William Emmett *Emmett Consulting* Mary Giliberti, JD *Mental Health America (MHA)*

Technical Expert Panel (TEP) Members	Consumer Family Panel (CFP) Members
Lisa Ryer, LCSW, *Rutgers University Behavioral Health Care* Tanni M. Bromley, MPAS, RPA-C *Landmark Health* William W. Bruck, MSN, APN, FNP-BC, CARN-AP *Seabrook-The Heart of Recovery* Caroline Carney, MD, MSc, FAPM, CPHQ *Magellan Health, RX Management* Lee Flowers, MD, MPH *Aspire Locums, LLC* Jill Harkavy Friedman, PhD *American Foundation for Suicide Prevention* Elizabeth W. McKune, Ed.D., PCMH-CCE *Passport Health Plan* Perry Meadows, MD, JD, MBA, FAAFP *Geisinger Health Plan* Kyaien O'Quinn Conner, PhD, LSW, MPH *University of South Florida* Barbra G. Rabson, MPH *Massachusetts Health Quality Partners* Arthur Robin Williams, MD, MBE *Columbia University* Jose P. Vito, MD, DFAPA *New York State Office of Mental Health* Shuba Samuel, PhD, RN, FNP-BC, APNP, CEN, CNE *Oscar G. Johnson VA Medical Center* Robert Schloesser, MD *Sheppard Pratt Health System* Thomas Smith, MD *New York State Office of Mental Health* Kari A. Stephens, PhD *University of Washington*	Jodi Kwarciany *National Alliance on Mental Illness (NAMI)* Carlos A. Larrauri *Consumer/Family Member Volunteer* Amanda MacDonald *Consumer/Family Member Volunteer* John H. Madigan, Jr. *American Foundation for Suicide Prevention* Philip Rutherford *Faces & Voices of Recovery* Marie D. Verna *Consumer/Family Member Volunteer* Lauryn Wicks *National Recovery Advocate* Phyllis Foxworth *Advocacy at Depression and Bipolar Support Alliance* Tymoteusz Kajstura *Consumer/Family Member Volunteer*

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2. First Year of Measure Release

Ad.3. Month and Year of Most Recent Revision

Ad.4. What is your frequency for review/update of this measure?

Ad.5. When is your next scheduled review/update for this measure?

Ad.6. Copyright Statement

Ad.7. Disclaimers

Ad.8. Additional Information/Comments