

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.)

Initiation and Update to Suicide Safety Plan for Individuals with Suicide Ideation, Behavior, or Suicide Risk.

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)

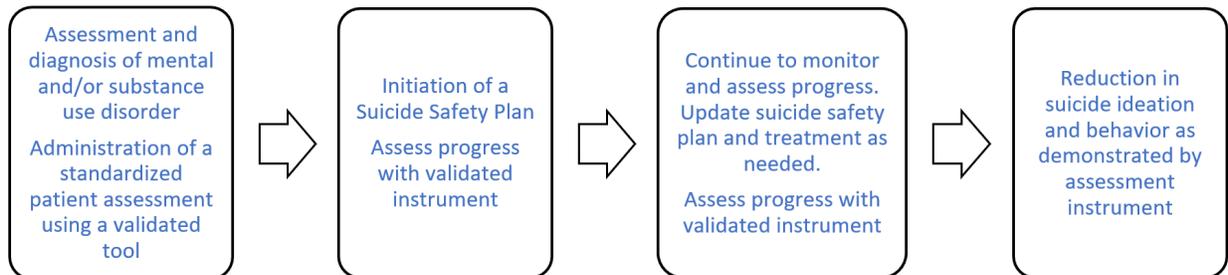
- 3.1 Evidence to Support the Measure Focus (for reference only) (NQF Evidence Attachment Subcriterion 1a).

There is compelling support for suicide safety planning interventions, suggesting that such interventions are associated with reductions in suicidal behavior and increased treatment engagement. Based on this evidence, a number of organizations have released guidelines, standards, or other recommendations supporting the development of suicide safety plans for patients at risk of suicide.

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: Initiation and Update to Suicide Safety Plan for Individuals with Suicide Ideation, Behavior, or Suicide Risk
- process: appropriate use: *name the measured appropriate use.*
- outcome: *name the outcome.*
- outcome: PRO: *PROs such as health-related quality of life, functional status, symptom or burden, experience with care, and health-related behaviors.*
- 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)

Several studies examining the acceptability and effectiveness of suicide safety planning interventions have showed good utilization of the plans when available and have found that patients tend to be satisfied with the intervention and that it increases their engagement in treatment. Individuals with suicidal ideation and behaviors also report that suicide safety plans help them maintain their safety and increase the likelihood of them remaining in care (Brodsky et al., 2018; Chesin et al., 2017; Stanley et al., 2016; Stanley et al., 2018).

References:

Brodsky BS, Spruch-Feiner A, Stanley B. The zero suicide model: Applying evidence-based suicide prevention practices to clinical care. *Front Psychiatry*. 2018;9:33. doi:10.3389/fpsyt.2018.00033

Chesin MS, Stanley B, Haigh EA, et al. Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans. *Arch Suicide Res*. 2017;21(1):127-137.

Goodman M, et al. An Open Trial of a Suicide Safety Planning Group Treatment: “Project Life Force”, Arch Suicide Res. 2020 Apr 14;1-14.

Little V, et al. Integrating Safety Plans for Suicidal Patients Into Patient Portals: Challenges and Opportunities. Psychiatric Services 2018; 69:618–619; doi: 10.1176/appi.ps.201700458

Skovgaard Larsen JL. MYPLAN - A Mobile Phone Application for Supporting People at Risk of Suicide. Crisis. 2016 May;37(3):236-40. doi: 10.1027/0227-5910/a000371. Epub 2016 Feb 2.

Stanley B, Chaudhury SR, Chesin M, et al. An emergency department intervention and follow-up to reduce suicide risk in the VA: Acceptability and effectiveness. Psychiatr Serv. Jun 1 2016;67(6):680-683.

Stanley B, Brown GK, Brenner LA, et al. Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. JAMA Psychiatry. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776

Zonana J, et al. The Impact of Safety Plans in an Outpatient Clinic. Crisis. 2018 Jul;39(4):304-309.

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

Not applicable.

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)

Please see response in 3.1.6

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

There is limited evidence available with regard to best practices for suicide prevention, but several studies have provided compelling support for suicide safety planning interventions, suggesting that such interventions are associated with reductions in suicidal behavior and increased treatment engagement. Based on this evidence, a number of organizations have released guidelines, standards, or other recommendations supporting the development of suicide safety plans for patients at risk of suicide.

These include:

- **U.S. Department of Veterans Affairs & Department of Defense**
 - VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide
 - <https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf>
 - **Recommendation #8:** We suggest completing a crisis response plan for individuals with suicidal ideation and/or a lifetime history of suicide attempts.
- **The Joint Commission**
 - National Patient Safety Goal NPSG.15.01.01: Reduce the risk for suicide.

- Suicide Prevention Resources to support Joint Commission Accredited organizations implementation of NPSG 15.01.01
 - EP6 - Evidence-based resources for safety planning, and follow up care upon discharge
- **National Action Alliance for Suicide Prevention**
 - National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. (2018). Recommended standard care for people with suicide risk: Making health care suicide safe. Washington, DC: Education Development Center, Inc.
 - https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
 - Recommended Standard Care Elements for People with Suicide Risk: Outpatient Mental Health and Substance Use Settings
 - Recommendation:
 - For all patients with elevated risk:
 - As part of the treatment plan, complete a collaborative safety plan during the same visit (see Appendix B for a list of recognized approaches).
 - As part of safety planning, provide information on telephone crisis lines, including the National Suicide Prevention Lifeline. Carry out steps to reduce access to lethal means, including asking family members and significant others to assist.
 - Engage the patient in treatment with a licensed professional, preferably one who has training in suicide, including risk assessment and safety planning (visit the Zero Suicide website for training resources recommended by suicide prevention professionals: www.zerosuicide.com).
 - Reassess risk and review and/or update the patient's safety plan at every visit until the risk is reduced.

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

A 2017 randomized control trial (RCT) by Bryan and colleagues evaluated the effectiveness of crisis response planning for the prevention of suicide attempts among active duty Army Soldiers (N=97) presenting for an emergency behavioral health appointment. Participants were randomly assigned to receive a contract for safety, a standard crisis response plan, or an enhanced crisis response plan. Crisis response planning was associated with a reduction in suicide attempts, more rapid decline in suicidal ideation, and fewer inpatient hospital days (Bryan et al, 2017).

A 2018 study by Stanley, Brown, and colleagues used a cohort comparison approach to determine whether a Safety Planning Intervention (SPI) administered in EDs with follow-up contact for suicidal patients was associated with reduced suicidal behavior and improved outpatient treatment engagement in the 6 months following discharge. Patients receiving a SPI were less likely to engage in suicidal behavior than those in usual care, had approximately half the odds of suicidal behavior over 6 months, and more than double the odds of attending at least one outpatient mental health visit (Stanley et al, 2018).

While the evidence base for suicide safety planning is still evolving, the compelling evidence of these interventions at helping to reduce suicide risk, suicide ideation and behavior and increasing patients' engagement in treatment outweighs the limited completed studies in the US in this area. However, the Zero Suicide Effort with its focus on suicide safety planning has stimulated a significant uptick of research efforts. Also, given the significant mortality, morbidity, and costs (e.g., ED visits, hospitalizations, reduced human capital, etc.) associated with suicide and suicide attempts, the results that have emerged from early studies of this intervention are extremely compelling, and show it to be one of the most promising approaches to suicide reduction that currently exist. Moreover, as opposed to other suicide prevention initiatives, which tend to be focused at the public health level (e.g., reduction in access to firearms and other lethal means, changes in packaging of medications, etc.), suicide safety planning is an intervention that can be implemented and measured at the individual clinician or clinical practice level.

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)

Bryan CJ, Mintz J, Clemans TA, et al. Effect of crisis response planning vs. Contracts for safety on suicide risk in U.S. Army soldiers: A randomized clinical trial. *J Affect Disord.* Apr 1 2017;212:64-72.

Brodsky BS, Spruch-Feiner A, Stanley B. The zero suicide model: Applying evidence-based suicide prevention practices to clinical care. *Front Psychiatry.* 2018;9:33. doi:10.3389/fpsyt.2018.00033

Chesin MS, Stanley B, Haigh EA, et al. Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans. *Arch Suicide Res.* 2017;21(1):127-137.

Goodman M, et al. An Open Trial of a Suicide Safety Planning Group Treatment: "Project Life Force", *Arch Suicide Res.* 2020 Apr 14;1-14.

Little V, et al. Integrating Safety Plans for Suicidal Patients Into Patient Portals: Challenges and Opportunities. *Psychiatric Services* 2018; 69:618–619; doi: 10.1176/appi.ps.201700458

Skovgaard Larsen JL. MYPLAN - A Mobile Phone Application for Supporting People at Risk of Suicide. *Crisis.* 2016 May;37(3):236-40. doi: 10.1027/0227-5910/a000371. Epub 2016 Feb 2.

Stanley B, Chaudhury SR, Chesin M, et al. An emergency department intervention and follow-up to reduce suicide risk in the VA: Acceptability and effectiveness. *Psychiatr Serv.* Jun 1 2016;67(6):680-683.

Stanley B, Brown GK, Brenner LA, et al. Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry.* 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776

Zonana J, et al. The Impact of Safety Plans in an Outpatient Clinic. *Crisis.* 2018 Jul;39(4):304-309.

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

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

Mental and substance use disorders are among the 25 leading causes of years lived with disability and contribute significantly to the global burden of disease (The US Burden of Disease Collaborators, 2018). Specifically, 19% of U.S. adults (46.6 million individuals aged 18 and older) have a mental illness and 7.6% (18.7 million individuals aged 18 and older) have a substance use disorder (McCance-Katz, 2017). Mental and substance use disorders often co-occur with about 8.5 million adults aged 18 and older in the US having both conditions (SAMHSA, 2018). Individuals with mental and/or substance use disorders are at high risk for suicide -- a leading cause of death in the US (Centers for Disease Control [CDC], 2018) and a preventable cause of lost lives. For the past 20 years death by suicide has increased significantly with more than 40,000 Americans dying by suicide each year (CDC, 2018; Curtin et al., 2016; Hedegaard et al., 2018) and reaching over 47,000 in 2018 (American Foundation for Suicide Prevention, 2018). Adding alarm to this issue is the even greater number of Americans who attempt suicide each year (ie, 20 to 25 times more than the number of suicide) and the resulting health consequences (Olfson et al., 2017) including the group's 2-4 times increased risk for dying by suicide (CDC, 2017; Olfson et al., 2017). An even greater proportion of Americans (~100X) have serious thoughts of suicide.

Suicide safety planning (SSP), which involves counseling the suicidal individual around reducing access to lethal means, teaching brief problem-solving and coping skills, and helping the individual increase social support and identify emergency contacts (Boudreaux et al., 2017; Stanley & Brown, 2012; Stanley et al., 2015; Stanley et al., 2016), is effective and critical in suicide prevention as echoed in recent clinical practice guidelines (Department of Veterans Affairs Department of Defense, 2013; 2019) and recommendations from the Joint Commission (The Joint Commission, 2016) and the National Action Alliance for Suicide Prevention ([Action Alliance]; National Action Alliance for Suicide Prevention, 2018). It has been identified as the best practice for suicide prevention by the American Foundation for Suicide Prevention ([AFSP]; ASFP, 2018) and the Suicide Prevention Resource Center ([SPRC]; Suicide Prevention Resources Center, 2009). In fact, this effective suicide prevention initiative has been found to be clinically useful and feasible by both suicidal individuals and clinicians, associated with reduction in suicidal behaviors. Individuals with suicidal ideation and behaviors also report that the SSP helps them maintain their safety and increases the likelihood of them remaining in care (Brodsky et al., 2018; Chesin et al., 2017; Stanley et al., 2016; Stanley et al., 2018).

This measure encourages the provision of evidence-based care to individuals presenting to a variety of health professionals across health settings for the assessment and care of their mental or substance use disorders. More specifically, the proposed measure aims to avert or reduce the risk of suicide and suicide attempts in this population that is at high risk for these outcomes. The measure emphasizes

patient-centered quality care, via collaboration between patients and their clinicians in the development of the suicide safety plan for those with suicide ideation, behavior, or risk – prevalent and preventable outcomes that affect thousands of Americans each year.

References:

American Foundation for Suicide Prevention. 2018. <https://afsp.org>

Boudreaux ED, Brown GK, Stanley B, Sadasivam RS, Camargo CA Jr, Miller IW. Computer administered safety planning for individuals at risk for suicide: Development and usability testing. *J Med Internet Res* 2017;19(5):e149

Brodsky BS, Spruch-Feiner A, Stanley B. The zero suicide model: Applying evidence-based suicide prevention practices to clinical care. *Front Psychiatry*. 2018;9:33. doi:10.3389/fpsy.2018.00033

Centers for Disease Control (CDC). QuickStats: Age-adjusted suicide rates by race/ethnicity — National Vital Statistics System, United States, 2015–2016. *MMWR Morb Mortal Wkly Rep* 2018;67:433. doi:10.15585/mmwr.mm6714a6

Centers for Disease Control (CDC). Suicide rates rising across the U.S.: Comprehensive prevention goes beyond a focus on mental health concerns. <https://www.cdc.gov/media/releases/2018/p0607-suicide-prevention.html>

Chesin MS, Stanley B, Haigh EA, et al. Staff views of an emergency department intervention using safety planning and structured follow-up with suicidal veterans. *Arch Suicide Res*. 2017;21(1):127-137.

Curtin SC, Warner M, Hedegaard H. Suicide rates for females and males by race and ethnicity: United States, 1999 and 2014. NCHS Health E-Stat. National Center for Health Statistics. April 2016.

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.pdf>

Hedegaard H, Curtin SC, Warner M. Suicide rates in the United States continue to increase. NCHS Data Brief, no 309. Hyattsville, MD: National Center for Health Statistics. 2018. <https://www.cdc.gov/nchs/products/databriefs/db309.htm>

McCance-Katz E. The National Survey on Drug Use and Health: 2017. <https://www.samhsa.gov/data/sites/default/files/nsduh-ppt-09-2018.pdf>.

Olfson M, Blanco C, Wall M, et al. National trends in suicide attempts among adults in the United States. *JAMA Psychiatry*. 2017;74(11):1095–1103. doi:10.1001/jamapsychiatry.2017.2582.

SAMHSA. (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health. HHS Publication No. SMA 18-5068, NSDUH Series H-53.

Retrieved from <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHFFR2017/NSDUHFFR2017.pdf>

Stanley B & Brown GK. Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*, 2012; 19(2), 256-264. doi:10.1016/j.cbpra.2011.01.001

Stanley B, Chaudhury SR, Chesin M, et al. An emergency department intervention and follow-up to reduce suicide risk in the VA: Acceptability and effectiveness. *Psychiatr Serv*. 2016;67(6):680-683. doi:10.1176/appi.ps.201500082.

Stanley B, Brown GK, Currier GW, Lyons C, Chesin M, & Knox KL. Brief intervention and follow-up for suicidal patients with repeat emergency department visits enhances treatment engagement. *American Journal of Public Health*, 2015; 105:1570-1572.

Stanley B, Brown GK, Brenner LA, et al. Comparison of the safety planning intervention with follow-up vs usual care of suicidal patients treated in the emergency department. *JAMA Psychiatry*. 2018;75(9):894–900. doi:10.1001/jamapsychiatry.2018.1776

Suicide Prevention Resources Center. 2009. <https://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians>

The Joint Commission. Sentinel Event Alert 56: Detecting and treating suicide ideation in all settings 2016; https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf. Accessed November 30, 2018.

The US Burden of Disease Collaborators. The state of US health, 1990-2016: Burden of diseases, injuries, and risk factors among US states. *JAMA*. 2018;319(14):1444–1472. doi:10.1001/jama.2018.0158.

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.)

The uptake and frequency of use of standardized PROMs associated with suicide ideation and behavior and clinician-rated assessments of suicide risk, including the use of safety plans, varies within and across behavioral health specialties as well as primary and emergency care, where suicidal persons most often present for care (Waldrop & McGuinness, 2017; Harding et al, 2011; Kilbourne et al, 2010). Currently, only hard-copy versions of safety planning documents have been used in most settings, with slow uptake of electronic versions. Hard-copy safety plans provided to patients are prone to misplacement, creating a barrier to their use and follow-up (Little et al, 2018). Even with use of suicide safety plans at an index visit, Gamarra et al. found that less than 50% of suicidal persons had explicit evidence of ongoing review or utilization of the safety plan in ongoing treatments (Gamarra et al, 2015). The development and implementation of the proposed quality measures related to safety planning and the review, update (if necessary), and utilization of those plans over the course of treatment may incentivize quality care that addresses the low rate of (re)assessment and poor outcomes. These quality measures will help to advance the Zero Suicide initiative set forth in the 2012 National Strategy for Suicide Prevention

(National Alliance for Suicide Prevention, 2018) and ultimately improve the quality of care for patients with suicide ideation, behaviors or suicide risk.

References:

Waldrop & McGuinness. Measurement-Based Care in Psychiatry. J Psychosoc Nurs Ment Health Serv. 2017 Nov 1;55(11):30-35.

Harding et al. Measurement-based care in psychiatric practice: a policy framework for implementation. J Clin Psychiatry. 2011 Aug;72(8):1136-43.

Kilbourne et al. Implementing composite quality metrics for bipolar disorder: towards a more comprehensive approach to quality measurement. Gen Hosp Psychiatry. 2010 Nov-Dec;32(6):636-43.

Little et al. Integrating Safety Plans for Suicidal Patients Into Patient Portals: Challenges and Opportunities. Psychiatric Services 2018; 69:618–619.

Gamarra, et al. Assessing variability and implementation fidelity of suicide prevention safety planning in a regional VA healthcare system. 2015. Crisis, 36: 433-439.

National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe. Washington, DC: Education Development Center, Inc.; 2018.

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.)

Researchers have found significant differences in suicide rates across age, race, ethnicity, and gender. For example, suicide and suicide attempts are more prevalent in American Indian/Alaskan Native populations than in other ethnic groups (Suicide Prevention Resource Center, 2019). Among young adults (age 18-24), males are five times more likely than females to die by suicide (Jiang et al, 2015). Among children age 13-17, white youths are approximately 50% more likely to die by suicide than black youths, while among children age 5-12, black youths are approximately twice as likely to die by suicide than white youths (Bridge et al, 2018).

References:

Bridge JA, et al. Age-Related Racial Disparity in Suicide Rates Among US Youths From 2001 Through 2015. JAMA Pediatr. 2018;172(7):697-699.

Suicide Prevention Resource Center: Racial and Ethnic Disparities (2019)
<https://www.sprc.org/scope/racial-ethnic-disparities>

Jiang C, et al. Racial and Gender Disparities in Suicide Among Young Adults Aged 18–24: United States, 2009-2013. NCHS Health E-Stats: September 2015
https://www.cdc.gov/nchs/data/hestat/suicide/racial_and_gender_2009_2013.htm.

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)

How are the needed data elements generated to compute measure scores?

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.)

This measure is under submission for the QCDR program.

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

The existing quality measures related to suicide screening focus only on mood disorders (e.g., Major Depressive Disorder and Bipolar Disorder), despite strong evidence that suicide risk is increased across all mental and substance use disorders as well as subthreshold mental and substance use conditions (APA, 2013). Furthermore, of the available suicide related quality measures, none address suicide safety planning or outcomes. Therefore, development of process and outcome quality measures related to

suicide prevention across a wider range of subthreshold and fully diagnosable mental and substance use disorders is imperative. Suicide screening alone is a good first step but should be used in conjunction with interventions that are evidence-based, such as SSP, which is reviewed and followed-up until the suicide risk is diminished and a reduction in suicidal ideation and behaviors attained (AFSP, 2018; National Action Alliance for Suicide Prevention, 2018). The proposed measures address the gap in quality measures related to the continuum of care and improvement in outcomes for individuals with suicidal ideation, behavior, or risk.

NQF # 104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

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

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
<p>Anna Ratzliff, MD, PhD – Co chair <i>University of Washington</i></p>	<p>Kimberly Buie <i>Consumer/Family Member Volunteer</i></p>
<p>Jerry Halverson, MD, DFAPA – Co chair <i>Rogers Behavioral Health</i> Jolene Ramussen, MSCE, <i>Texas Council of Community Centers</i></p>	<p>William Emmett <i>Emmett Consulting</i> Mary Giliberti, JD <i>Mental Health America (MHA)</i></p>
<p>Lisa Ryer, LCSW, <i>Rutgers University Behavioral Health Care</i></p>	<p>Jodi Kwarciany <i>National Alliance on Mental Illness (NAMI)</i></p>
<p>Tanni M. Bromley, MPAS, RPA-C <i>Landmark Health</i></p>	<p>Carlos A. Larrauri <i>Consumer/Family Member Volunteer</i></p>
<p>William W. Bruck, MSN, APN, FNP-BC, CARN-AP <i>Seabrook-The Heart of Recovery</i></p>	<p>Amanda MacDonald <i>Consumer/Family Member Volunteer</i></p>
<p>Caroline Carney, MD, MSc, FAPM, CPHQ <i>Magellan Health, RX Management</i></p>	<p>John H. Madigan, Jr. <i>American Foundation for Suicide Prevention</i></p>
<p>Lee Flowers, MD, MPH</p>	

Technical Expert Panel (TEP) Members	Consumer Family Panel (CFP) Members
<i>Aspire Locums, LLC</i>	
Jill Harkavy Friedman, PhD <i>American Foundation for Suicide Prevention</i>	Philip Rutherford <i>Faces & Voices of Recovery</i>
Elizabeth W. McKune, Ed.D., PCMH-CCE <i>Passport Health Plan</i>	Marie D. Verna <i>Consumer/Family Member Volunteer</i>
Perry Meadows, MD, JD, MBA, FAAFP <i>Geisinger Health Plan</i>	Lauryn Wicks <i>National Recovery Advocate</i>
Kyaien O’Quinn Conner, PhD, LSW, MPH <i>University of South Florida</i>	Phyllis Foxworth <i>Advocacy at Depression and Bipolar Support Alliance</i>
Barbra G. Rabson, MPH <i>Massachusetts Health Quality Partners</i>	Tymoteusz Kajstura <i>Consumer/Family Member Volunteer</i>
Arthur Robin Williams, MD, MBE <i>Columbia University</i>	
Jose P. Vito, MD, DFAPA <i>New York State Office of Mental Health</i>	
Shuba Samuel, PhD, RN, FNP-BC, APNP, CEN, CNE <i>Oscar G. Johnson VA Medical Center</i>	
Robert Schloesser, MD <i>Sheppard Pratt Health System</i>	
Thomas Smith, MD <i>New York State Office of Mental Health</i>	
Kari A. Stephens, PhD <i>University of Washington</i>	

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