Measure Justification Form and Instructions

INSTRUCTIONS: *This form is primarily for measure developers to use as a guide when submitting measures. Measure developers may use information from the Measure Justification Form (MJF) for other purposes, CMS may ask measure developers to complete the MJF for measures not submitted to National Quality Forum (NQF). Non-CMS Contracted Measure Developers or non-measure developers who elect to use the form for another purpose may edit the Project Overview section to reflect not having a measure development contract. Anyone completing this form may change instructions and language in italics. Any additional changes could negatively impact 508 compliance and result in delays in the CMS review process. For guidance about 508 compliance, CMS's Making Documents 508 Compliant website may be a helpful resource.*

The MJF tracks very closely to the NQF online measure submission Version 7.1 and references corresponding fields from that submission in the parentheses. The numbers used throughout this form correspond to the same numbered items on the NQF submission. With approval from the Contracting Officer's Representative (COR), measure developers may submit the NQF Submission Form in lieu of the MJF. The COR may ask measure developers to complete the MJF for measures not submitted to NQF.

PLEASE DELETE THIS SECTION AND THE FORM-SPECIFIC REFERENCES ON PAGE 19 BEFORE SUBMISSION.

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.)

Measurement-based Care Processes: Baseline Assessment, Monitoring and Treatment Adjustment.

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)

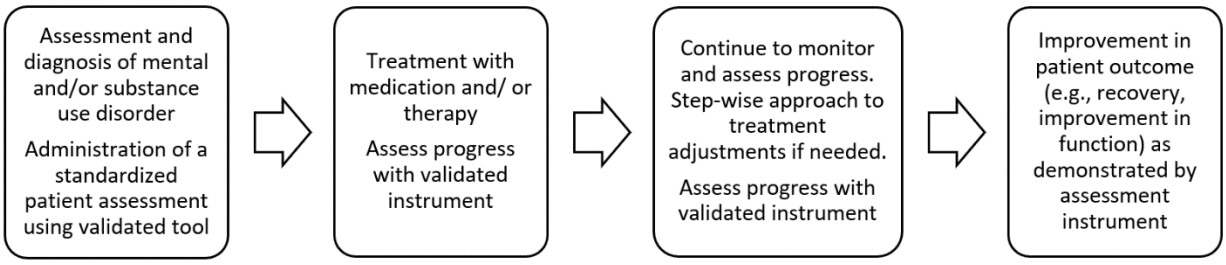
3.1 Evidence to Support the Measure Focus (for reference only) (NQF Evidence Attachment Subcriterion 1a).

MBC has been shown to be clearly linked to outcomes across mental and substance use disorder diagnoses. Thus, systematic methods for measuring the uptake and delivery of MBC could improve care and outcomes across mental or substance use disorders, settings, types of clinicians and patient groups, particularly those experiencing social disparity.

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: Measurement-based Care Processes: Baseline Assessment, Monitoring and Treatment Adjustment.
☐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)

The implementation and use of Measurement-based care (MBC) processes provides significant value to both patients and clinicians, helping to enhance communication and understanding of symptoms and treatment options for both parties.

For patients, MBC facilitates increased knowledge of their disorders and symptoms, leading to more informed, activated, and prepared patients who are better able to participate in shared decision-making and more aware of changes in their status over time. For clinicians, MBC assists in the detection of residual symptoms, helping to overcome clinical inertia, prompt changes in treatment plans if needed, and facilitates the use and operationalization of clinical decision algorithms.

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)

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, 2009; VA/DoD, 2010).

Measurement-Based Care (MBC) is a set of standard processes used to support engagement, diagnosis, condition monitoring, treatment adjustment, and the evaluation of outcomes with the use of questionnaires or standardized assessment tools or instruments for patient self-report. MBC is considered a core component of care for mental health and substance use conditions. A number of evidence reviews related to MBC (as gathering and using feedback from assessment instruments) have been conducted, as described below, although these do not offer grading of the evidence or recommendations.

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

MBC has been shown to be clearly linked to outcomes across mental and substance use disorder diagnoses (American Psychiatric Association, 2015; Pincus et al., 2016; Fortney et al.,2017). Thus, systematic methods for measuring the uptake and delivery of MBC could improve care and outcomes across mental or substance use disorders, settings, types of clinicians and patient groups, particularly those experiencing social disparity (Wray et al., 2018).

A 2009 meta-analysis reviewed studies examining feedback from outcome assessments (defined as providing mental healthcare professionals and/or patients with individual information on treatment outcome based on standardized measures) in specialist mental healthcare settings. 11 studies were

reviewed, showing that feedback of outcome had a small but statistically significant short-term effect on improving mental health outcomes (Knaup et al, 2016).

A 2015 meta-analysis examining the various levels of provider patient communication associated with administering and obtaining feedback from PROMS in mental health services. This meta-analysis found 27 empirical studies meeting the criteria for review, categorizing those studies by the 'level of intensity' of PROM feedback used, ranging from no feedback to PROM scores fed back to clinician and patient with a formalized structure to guide clinician-patient discussions and inform subsequent treatment. In general, positive impacts increased with higher levels of feedback and engagement, though not necessarily in a linear fashion. The authors suggest that their findings indicate that formalized clinician-patient PROM feedback was most strongly associated with improved outcomes, particularly for patients considered "not on track" or "at risk," presumably because clinicians were able to change or adjust treatment based on PROM results and feedback (Krageloh et al, 2015).

A 2016 systematic review examined the evidence for treatment effectiveness of feedback from standardized outcome measures in mental health settings. The review identified 27 studies comparing "feedback vs. no-feedback" conditions; in 15 of these studies, feedback improved treatment effectiveness on at least one outcome variable, while in 12 studies, there was no significant difference in treatment effectiveness. Of studies examining 'on-track' vs. 'not-on-track' patients, 73 percent showed that feedback increased treatment effectiveness (Gondek et al, 2016).

A 2017 review looked at the impact of measurement-based care on patient outcomes. The review found numerous high-quality studies showing that, while assessment alone is not associated with better patient outcomes, symptom severity assessed frequently and concurrent with clinical encounters, then followed up with treatment adjustments based on results, does consistently show improved outcomes compared with usual care (Fortney et al, 2017).

It is important to measure at key points on the continuum of MBC – from assessment through to outcome - since it is the implementation of the process as a whole that is effective in improving patient outcomes. For example, studies have demonstrated that screening alone is not effective. Individuals with depression randomized to screening did not have better outcomes than individuals randomized to no screening (Schmidt U et al., 2006). Alerting clinicians to positive screening results and providing them with treatment recommendations outlined in guidelines is no more effective than usual care (Fihn SD, 2004). Studies have also demonstrated that non-systematic assessment, either infrequent or not concurrent with a clinical encounter, is not effective. For example, individuals seeking treatment at an eating disorder clinic randomized to an intervention that fed back self-reported symptoms to their provider mid-way through treatment (i.e., counseling session 5 of 10) did not have better outcomes than individuals randomized to usual care (Guo et al., 2015). Furthermore, individuals receiving specialty care for mental disorders randomized to an intervention that fed back self-reported symptoms to their provider every three months (but not timed to coincide with a clinical encounter) had similar outcomes as those randomized to usual care (The Joint Commission, 2018) and primary care patients randomized to an intervention that assessed symptoms at 0, 3, 6 and 18 months and fed back self-reported symptoms to their provider at every encounter had similar outcomes as those randomized to usual care (Hatfield et. al., 2007). Although these studies are a decade old, the intent is the takeaway. Assessment that is not concurrent with an encounter or timely (e.g., within 24 hours of an encounter) does not maximally impact outcomes (Fortney et al., 2017.

In summary, this measure identifying three key actions, including baseline assessment, follow-up and care plan adjustment and calculating a performance rate for each, is designed to help ensure the full MBC process is used. Individual rate results are intended to help make improvements for each action.

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)

References:

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.

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
Fihn SD, McDonell MB, Diehr P, Anderson SM, Bradley KA, Au DH, Spertus JA, Burman M, Reiber GE, Kiefe CI, Cody M. Effects of sustained audit/feedback on self-reported health status of primary care patients. Am J Med. 2004 Feb 15;116(4):241-8.

Fortney et al. A Tipping Point for Measurement-Based Care. Psychiatric Services 2017; 68:179–188.

Gondek et al. Feedback from Outcome Measures and Treatment Effectiveness, Treatment Efficiency, and Collaborative Practice: A Systematic Review. Adm Policy Ment Health (2016) 43:325–343.

Guo T, Xiang YT, Xiao L, Hu CQ, Chiu HF, Ungvari GS, Correll CU, Lai KY, Feng L, Geng Y, Feng Y. Measurement-based care versus standard care for major depression: a randomized controlled trial with blind raters. Am J Psychiatry. 2015 Aug 28;172(10):1004-13.

Hatfield DR, et. al., *Administration and Policy in Mental Health*, 2007

Knaup et al. Effect of feedback of treatment outcome in specialist mental healthcare: meta-analysis. The British Journal of Psychiatry (2009) 195, 15–22.

Krageloh et al. Using Feedback From Patient-Reported Outcome Measures in Mental Health Services: A Scoping Study and Typology. Psychiatric Services 2015; 66:224–241.

Pincus et al. Quality Measures For Mental Health And Substance Use: Gaps, Opportunities, And Challenges. Health Aff (Millwood) . 2016 Jun 1;35(6):1000-8.

Schmidt U et. al. Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. The British Journal of Clinical Psychology, 2006; 45, 343–366.

The Joint Commission. behavioral health outcome measurement standard CTS.03.01.09. https://www.jointcommission.org/en/accreditation-and-certification/health-care-settings/behavioral-health-care/outcome-measures-standard/

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, 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 MBC process measure set assesses three key steps in MBC, including a baseline psychiatric evaluation with a suite of assessment tools, monitoring of the patient's condition using the appropriate assessment tools, and care plan adjustments where needed. The intent of this measure set is that all 3 MBC process measures be used and reported together, because singular focus on any one part of the process does not lead to improved outcomes. The process measures are intended to serve as building blocks for outcome measures focused on functioning and recovery.

Implementation of MBC, including development and use of process and outcome measures, results in more precise plans of care at the clinician level, and improvement in mental and behavioral health outcomes at both the individual patient and population levels. Performance measurement around MBC can help drive widespread adoption, with its proven benefits, and overcome perceived barriers to implementation. As mental healthcare 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:

Slade et 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 Psichiatr 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.)

There is widespread consensus in the field that measurement-based care (MBC) and the use of patient-reported rating scales in conjunction with evidence-based clinical practice guidelines has long been needed in order to bring the field in line with medical disease management. Unfortunately, MBC is not standard practice in behavioral health care, and the current non-systematic approach to the delivery of mental health care has created considerable variability in practice and has likely stalled recovery for many patients.

Only a small percentage of behavioral health clinicians routinely administer clinician-rated or patient-rated symptom rating scales, a key component of MBC, in their practices (17.9% of psychiatrists and 11.1% of psychologists) (Waldrop and McGuiness, 2017; Ashaye et al., 2003). Even fewer clinicians routinely use patient-reported measures of functional recovery in their practices. Understanding functional recovery from the patient's perspective and incorporating this information in clinical decision-making enhances the value of MBC. Frequent feedback via MBC significantly improves outcomes when compared to usual care (particularly when used in conjunction with practice guidelines), is feasible to implement on a large scale, and is highly acceptable to patients (Priebe et al., 2002; Harding et al., 2011). While the feasibility and acceptability of MBC among clinicians and patients has been established in recent years, significant variability in the implementation of MBC among behavioral health care clinicians and across settings remains (Harding et al, 2011; Kilbourne et al, 2011). Introduction of quality measurement related to MBC processes for behavioral health and other clinicians would improve quality of patient care across specialties.

The need to address measurement in this specialty performance gap, in order to drive implementation of practice that reduces variation in the field and improves patient outcomes, is evidenced by the recent focus on MBC by The Joint Commission and URAC (Joint Commission; URAC) and the adoption of depression-focused MBC performance measures in national programs (Minnesota Community Measurement; National Committee for Quality Assurance).

References:

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

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 Psichiatr Soc. 2002 Jul-Sept;11(3):198-205.

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.

The Joint Commission. behavioral health outcome measurement standard CTS.03.01.09. https://www.jointcommission.org/en/accreditation-and-certification/health-care-settings/behavioral-health-care/outcome-measures-standard/

URAC. https://www.urac.org/programs/measurement-based-care

Minnesota Community Measurement. http://mncm.org/driving-improvement-in-depression-care/

NCQA. http://www.ncqa.org/hedis-quality-measurement/hedis-learning-collaborative/hedis-depression-measures.

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.)

While there is little direct evidence of the impact of MBC on disparities, MBC as a process may help to reduce disparities in care. This is because as a practice, MBC introduces consistent, routine collection of standardized information, therefore variation in care due to any inherent cultural bias on the clinician's part is less impactful. Further, traditionally-disadvantaged populations who feel unheard may have a vehicle in MBC to express how they are feeling by answering questions, whereas without the tools they may not have felt comfortable expressing these feelings verbally. This is particularly true if the assessment tools were developed with cultural variation in mind.

Fortney et al. A Tipping Point for Measurement-Based Care. Psychiatric Services 2017; 68:179–188.

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.

For this measurement, specifically the data elements representing patient assessment data, we will not be adding any requirement for clinician attestation type data elements to electronic sources to avoid clinician documentation burden. Rather, specified data elements will be extracted in some instances from structured EHR fields that document patient assessment tool results, much like results from other testing or observation of patients (e.g., labs) or from clinical notes indicating patient assessment tool name and score. Clinical notes in EHRs can be queried with 'key words' or 'key phrases' to extract relevant information to populate data elements for the measure. With good clinical documentation of the care provided by the clinician, all data elements are expected to be available in electronic format from an EHR system.

Other electronic sources of data may include registry portals or other applications that collect patient reported outcome measures data when patients complete the assessment tools. These data can be combined with the EHR data to provide all data elements for the measure calculations.

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

This measure has been submitted for consideration for inclusion in 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

6.1.1.1 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

There are a variety of measures that address screening and/or assessment for mental or behavioral health issues, including substance use. However, all of these measures focus on a more narrow condition, or apply to more specific populations, than the Measurement-Based Care process measure proposed here. In addition, the potentially-related measures do not include the elements of a follow-up /monitoring assessment and adjustment of treatment plan. The MBC measure calls for each of these elements for all patients with a mental and/or substance use disorder.

- 104e: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- 2599: Alcohol Screening and Follow-up for People with Serious Mental Illness
- N/A (QCDR Measure): Anxiety Screening
- 1365e: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
- 0518: Depression Assessment Conducted
- 0712e: Depression Utilization of the PHQ-9 Tool
- 1922: HBIPS-1 Admission Screening for Violence Risk, Substance Use, Psychological Trauma History and Patient Strengths Completed
- 0418/0418e: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- 2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- N/A (QCDR Measure): Screening for Depression and Follow-up Plan in Home-Based Primary Care and Palliative Care Patients
- 2600: Tobacco Use Screening and Follow-up for People with Serious Mental Illness or Alcohol or Other Drug Dependence
- N/A: Unhealthy Alcohol Use Screening and Follow-Up

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