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.)

Reduction in Suicidal Ideation or Behavior Symptoms.

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).

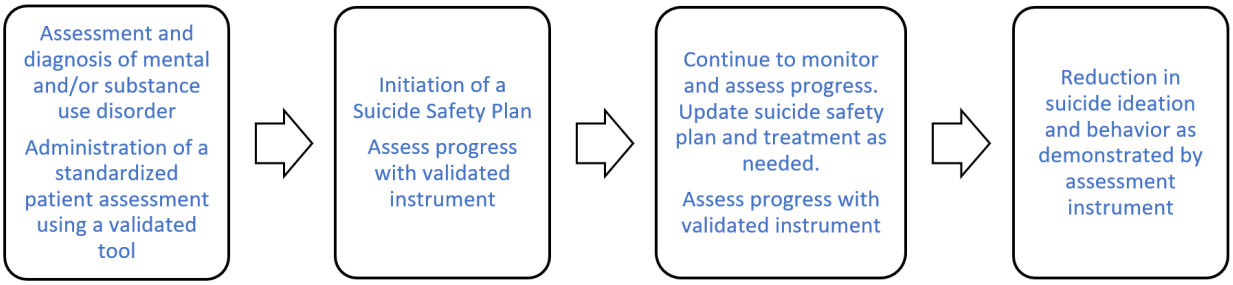
Suicide safety planning (SSP), which involves counseling the suicidal individual around reducing access to lethal means, teaching brief problem-solving and coping skills, and helping the individual increase social

support and identify emergency contacts, is effective and critical in suicide prevention as echoed in recent clinical practice guidelines as well as recommendations from the Joint Commission and the National Action Alliance for Suicide Prevention.

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: Reduction in Suicidal Ideation or Behavior Symptoms
☐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)

A study of the acceptability and effectiveness of suicide safety planning interventions showed that patients tend to be satisfied with the intervention, and that it increases their engagement in treatment (Stanley et al, 2016)

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)

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).

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. These include:

A 2017 randomized control trial (RCT) by Bryan and colleagues evaluating 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 using 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 1 outpatient mental health visit (Stanley et al, 2018).

A number of organizations have developed tools and resources for suicide prevention, including:

CDC: https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf

National Action Alliance for Suicide Prevention: https://theactionalliance.org/sites/default/files/clinicalcareinterventionreport.pdf.

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

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.

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.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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.

This measure encourages the provision of evidence-based care to individuals presenting to a number of health professionals across a variety of 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 associated outcome (i.e., suicide attempts) in this population that is at high risk for suicide and suicide attempts. The measure emphasizes patient-centered quality care, which is important for combating these prevalent and preventable outcomes that affect thousands of Americans each year.

References:

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

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

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.

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

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.)

Suicide is a preventable cause of lost lives, yet each year over 40,000 Americans die by suicide (Hedegaard, 2018). Americans at risk for suicide present to multiple settings within a month to a year of their deaths. Safety planning, means reduction, and connecting suicidal persons to treatment are effective and critical elements in suicide prevention (Suicide Prevention Resource Center, 2015; Betz et al, 2016; National Alliance for Suicide Prevention, 2018), as echoed in the most updated clinical practice guidelines for assessment and treatment of suicidal persons(DoD/VA, 2019).

References:

Hedegaard H, et al. Suicide Mortality in the United States, 1999–2017. NCHS Data Brief No. 330, November 2018. https://www.cdc.gov/nchs/products/databriefs/db330.htm

Suicide Prevention Resource Center, Department of Defense Strategy for Suicide Prevention. 2015. Retrieved from: https://www.sprc.org/resources-programs/defense-strategy-suicide-prevention-dssp

Betz et al. Lethal means access and assessment among suicidal emergency department patients. Depress Anxiety. 2016 Jun;33(6):502-11.

National Alliance for Suicide Prevention, Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe. 2018. Retrieved from: https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

U.S. Department of Veterans Affairs and U.S. Department of Defense Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (2019). Retrieved from: https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

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.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.2 Usability (NQF Measure evaluation criterion 4b)

6.2.1 Improvement (NQF Measure evaluation criterion 4b1.)

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

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

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

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

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

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

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

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

Are there related measures or competing measures?

☐yes
☒no

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
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* 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	Kimberly Buie *Consumer/Family Member Volunteer* William Emmett *Emmett Consulting* Mary Giliberti, JD *Mental Health America (MHA)* 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

Technical Expert Panel (TEP) Members	Consumer Family Panel (CFP) Members
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*	*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