

CONSUMER FAMILY PANEL SUMMARY OF ACTIVITIES

Date of meeting: June 6, 2019

Date of final summary document: July 29, 2019

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Background

In September 2018, the Centers for Medicare and Medicaid Services (CMS) awarded the American Psychiatric Association (APA) funding for measure development as part of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. APA entered into a cooperative agreement with CMS and contracted with the National Committee on Quality Assurance (NCQA) as the technical experts in measure development.

The goal of the funding award is to support the development of meaningful quality measures that fill CMS-designated high priority areas, including mental health and substance use disorders. These measures are intended to reduce data collection burden for providers who wish to systematically track care provision and quality of care for individuals treated for mental and substance use disorders. Further, the measures are intended to provide useful information to both patients and providers for informing care or quality improvement. The proposed quality measures will be subject to federal rulemaking for inclusion in CMS's value-based payment program, the Merit-Based Incentive Payment System (MIPS).

The APA Measure Development Initiative Consumer Family Panel

APA and NCQA convened the Consumer Family Panel (CFP). This panel comprises 10 participants who represent national patient advocacy organizations, individuals with experience receiving mental health treatment, and caregivers/family members. This stakeholder group will provide their unique and diverse perspectives related to their experience with the receipt of care for mental and/or substance use disorders. In order to ensure that the project's quality measures are patient-centered, three CFP members also serve as liaisons to APA's Measure Development Initiative Technical Expert Panel (TEP). The CFP liaisons are responsible for communicating patient and caregiver perspectives to the TEP.

Additional responsibilities of the CFP include:

1. Participating in educational webinars and in-person meetings on measure development and meaningful discussions on the quality measure topics,
2. Informing feasibility of the workflow (e.g., utilization of the measure during an encounter), data collection burden, and other issues posed by the quality measures under development.
3. Providing insight about the potential impact of the measures on the care provided from the perspective of individuals with mental or substance use disorders and caregivers/family members, such as informing tool selection for initial and continued use by carefully considering the phraseology, tone, number of items, and time to complete.
4. Evaluating the implementation of multiple assessment tools and iterations of the proposed quality measures throughout the course of the project.

June CFP Meeting Summary

This report summarizes the 2-hour CFP webinar convened on June 6, 2019.

The main goals of the Webinar were for CFP members to:

1. Review and provide feedback on the draft measure specifications for the measurement-based care (MBC) process measures
2. Review and provide feedback on 2 of the 5 MBC outcome measures ('Reduction in or maintenance of functioning for all patients seen for mental health and substance use care' and 'Recovery for all patients seen for mental health and substance use care').

In addition, the webinar was used to update panelists on the results of the CFP and TEP Post-Meeting Follow-up Surveys. The surveys inquired about the importance and usability of the MBC process and outcome measures as well as the list of potential assessment tools for each measure that were discussed during the previous CFP (March 21, 2019) and TEP (March 23, 2019) meetings.

To meet the goals for this webinar, the CFP worked through the descriptions and rationales for the measures, the results of the March post-meeting follow up surveys (described above), and the TEP's feedback on the quality measure specifications from the June 3 in-person TEP meeting.

Prior to the webinar, panelists received pre-meeting materials to prepare for the discussion. The pre-meeting materials included:

- CFP Meeting Agenda
- CFP Meeting Overview Memo
- Measure Descriptions and Rationale
- March 21, 2019 CFP Meeting Summary
- March Post-Meeting Survey Results from CFP and TEP
- Project Update (March 29 – June 3)

Opening Remarks and Updates from the Previous Meeting

Daniel Roman, NCQA's Senior Research Associate, provided a project update to the CFP and stated the goals (as listed above) for the June 6 CFP meeting. The update included an overview of the measure specifications discussed at the June 3 TEP meeting, feedback provided during the TEP's in-person meeting, and an overview of the survey results from the TEP and CFP meetings in March.

CFP Composition and Roll Call

The composition of the CFP is listed in Table 1. Following opening remarks and updates from the previous meeting, introductions were made by the panelists and the APA/NCQA measure development team. Panelists affirmed that there were no changes to their conflicts of interest. The measure development team was informed that 1 panel member [Volunteer Advocate 1; a CFP liaison to the TEP] was absent. To ensure that the absent panelist would be able to provide feedback on the draft measure specifications discussed during the Webinar, they were provided with the meeting transcript and slide deck. In addition, a one-on-one presentation conference call was scheduled so that the panelist could ask questions that would inform their decision-making process.

Table 1. Panelist information

Name and Credential	Organizational Affiliation or Role
Nathaniel Z. Counts, J.D. <i>CFP Liaison</i>	Organizational Representative from Mental Health America
William Emmet	Organizational Representative from Emmet Consulting
John H. Madigan, Jr.	Organizational Representative from American Foundation for Suicide Prevention
Philip Rutherford	Organizational Representative from Faces & Voices of Recovery
Andrew Sperling <i>CFP Liaison</i>	Organizational Representative from National Alliance on Mental Illness
<i>CFP Liaison</i> [Person prefers to remain anonymous]	Volunteer Advocate 1
[Person prefers to remain anonymous]	Volunteer Advocate 2
[Person prefers to remain anonymous]	Volunteer Advocate 3
Wayne E. Wirta	Organizational Representative from National Council on Alcoholism and Drug Dependence – New Jersey

Overview of Discussion Procedures and Summary of Content

After opening remarks, updates, and roll call, the measure development team facilitated discussion of each of the quality measures in turn—Standardized Assessment, Monitoring, Treatment/Care-Plan Adjustment, Functional Impairment, and, finally, Recovery. At the start of the discussion for each of the measures, the development team presented the TEP’s main issues and questions regarding each respective measure’s specifications from the June 3, 2019 TEP Meeting. CFP members discussed the measure specifications and provided their feedback.

A summary of the key points from the CFP discussions for each measure is provided in the following sections. Overall, the CFP discussions revealed many points of agreement/alignment with the suggestions of the TEP at their June TEP meeting (e.g., denominator specifications, exclusion specifications). Topics that generated much discussion among CFP members included: the use of proxy respondents; the need for evaluation of measure feasibility during alpha testing; whether the Functional Impairment measure should be split into two measures (one for reduction in functional impairment and one for maintenance of functional impairment); and potential overlap of the Functional Impairment and Recovery measures.

Summary of Discussion of Quality Measures

Standardized Assessment

Measure Name: Measurement-Based Care: Initial standardized assessment for all patients seen for mental health and/or substance use care.

Brief Measure Description: The percentage of individuals 18 years and older presenting with a mental and/or substance use disorder or indication, who have an initial assessment concurrent with or prior to an encounter in at least five (5) mental health domains including depression, anxiety, substance use, suicide risk and psychosis, as well as an initial assessment of global functioning and recovery.

Key discussion points:

General Specifications

- ***Implementing diagnostically specific or cross-cutting assessment tools.*** Comments from the panelists included their preference for using a validated cross-cutting assessment tool for implementation purposes, instead of a diagnostically specific tool. Relevant issues of employing a specific assessment tool versus a cross-cutting assessment tool will be examined during testing.

Exclusion Specification

- Panelists discussed appropriate exclusion criteria for this measure and agreed that exclusions might include:
 1. Individuals in crisis;
 2. Individuals refusing to complete the patient-reported assessment tool; or
 3. Individuals experiencing psychiatric (e.g., dementia, psychosis, intoxication, delirium, etc.) and/or physical impairments that restrict their ability to complete the patient-reported assessment tools. The definition of what constitutes short- or long-term impairment will be examined during testing.
- Additionally, one panelist emphasized the importance of evaluating the feasibility of proposed exclusion criteria, and the group suggested exploring this during alpha testing, given that refusals are oftentimes not documented in patients' charts. The measure development team communicated that providers participating in the quality measure testing process will be properly trained to engage patients in using the patient-reported assessment tools. The measure development team stated the training would be designed to ensure accurate capture of data by incorporating new data elements into the workflow.

Monitoring

Measure Name: Measurement-Based Care: Monitoring of symptoms, functioning, and recovery for all patients seen for mental health and/or substance use care

Brief Measure Description: The percentage of patients 18 years and older presenting with a mental and/or substance use disorder or indication who are monitored for improvement or maintenance of symptom severity, functional impairment and recovery over a twelve-month period using standardized assessments.

Key discussion points:

General Specifications

- **Role of proxies during assessments.** The CFP discussed whether caregivers and other proxy respondents should count towards this measure. One panelist mentioned that a psychiatric advanced directive—a written document highlighting a patient’s preferences for treatment in the case of incapacitation due to a psychiatric crisis—may be included in the medical chart and would indicate the patient’s decision-making proxy. It is important to note the directive does not limit proxies to one person. This was proposed as information to help define “proxy” for the quality measures developed under this initiative. Another panelist felt strongly that proxies be defined and utilized if the patient is unable to provide the information themselves. Multiple panelists agreed with the recommendation to harmonize the definition of *proxy as caregiver(s)* with that is used in the most recent version of the APA’s and the American Academy of Neurology’s jointly owned and managed *Dementia Management Quality Measurement Set*.
- Overall, panelists agreed it is sensible to maintain a broad population for this measure by including all adults with mental and/or substance use disorders. This viewpoint aligns with TEP’s consensus to measure a wide range of symptoms rather than only select specific diagnoses.

Exclusions Specification

- The CFP expressed a desire to avoid including overly prescriptive exclusion specifications, except for patients who refuse to complete the assessment tool or those who recently transferred to a different provider.

Numerator Specification

- Panelists expressed mixed thoughts about the minimum number of assessments required to meet the numerator for this measure. They articulated that while two assessments may suffice for certain patients, less stable patients may require more frequent monitoring. Some panelists indicated that encounter frequency may provide a way to determine severity, such that patients who see a provider on a weekly basis may be assessed more than two times during the measurement period; however, others who are seen less frequently would be monitored no less than 2 times during the measurement period.

Treatment/Care-Plan Adjustment

Measure Name: Measurement-Based Care: Treatment or care plan adjustment for all patients seen for mental health and/or substance use care.

Brief Measure Description: The percentage of patients 18 years and older with a mental and/or substance use disorder or indication who had their treatment or care plan adjusted.

Key discussion points:

- **Concerns about intent and use of the measure** Panelists described their concerns with providers applying unwarranted changes to patient care plans based on the providers' goal of earning a high-performance score on the quality measure. They also communicated concerns regarding the potential for providers to make more frequent medication adjustments, instead of psychotherapy modifications, understanding that it is less complicated to document medication adjustments. This could incentivize providers to disproportionately prescribe medication instead of evidence-based psychotherapeutic interventions due to the ease of documenting changes. Another panelist proposed changing the quality measure's title to demonstrate the measure's intent, which is for an individual and provider to engage in conversation regarding treatment and adjustments to the care plan based on the content of the conversation.

Functional Impairment

Measure Name: Reduction in or maintenance of functioning for all patients seen for mental health and substance use care

Brief Measure Description: The percentage of individuals aged 18 years or older with mental and/or substance use disorder who demonstrated a reduction in functional impairment (or maintained baseline level of functioning) based on results from a standardized assessment tool.

Key discussion points:

Denominator Specification

- **Broad-based denominator.** During the presentation of TEP recommendations on this quality measure, the CFP was informed that although the majority of TEP members supported a comprehensive denominator as recommended for Standardized Assessment and Monitoring quality measures, a subset of technical experts suggested confining the measure's denominator to particular mental and/or substance use disorders (e.g., anxiety, depression, and schizophrenia).
- The CFP discussed this issue and supported the TEP's consensus recommendation to include a wide breadth of diagnoses in the measure's denominator.
- The CFP discussed the potential to bifurcate this quality measure – one for the maintenance of baseline level of functioning and the other for reduction in functional impairment. Panelists were concerned that a single quality measure with both maintenance and reduction in functional impairment would be insufficient due to measurement constraints. The threshold for maintaining a certain level of functioning would be different based on the initial level. They expressed interest in learning the results of testing to potentially define maintenance and reductions in functioning. Panelists were concerned that changing the numerator would potentially impact the denominator as well.

Exclusions Specification

- Panelists recommended that the exclusion criteria remain broad.

Recovery

Measure Name: Recovery for all patients seen for mental and substance use disorder

Brief Measure Description: The percentage of individuals aged 18 years or older presenting with a mental and/or substance use disorder who demonstrated improvement or maintenance of recovery (as defined, prioritized, and/or reported by the individual) based on results from a standardized patient-reported assessment tool.

Key discussion points:

General Specifications

- ***Synonymity when measuring Recovery and Functional Impairment.*** The CFP addressed the potential for the Recovery quality measure to appear analogous to the Functional Impairment quality measure and noted providers and patients may require clarification on the difference between the two outcome measures. The CFP discussed potentially updating the title of the Recovery quality measure to convey the relevance of the assessment tool for everyone. Panelists debated whether recovery is a process or an outcome and suggested the quality measure should reflect more of an individual “regaining abilities” rather than demonstrating improvement or maintenance of recovery. To avoid confusing providers and individuals, a panelist suggested including the SAMHSA definition of recovery in the quality measure specifications to clarify the measure’s focus for end-users.
- ***Defining a minimum recovery threshold.*** The CFP was concerned about the potential for setting a minimum threshold for maintenance of recovery. Another panelist explained their apprehension that providers may accept “maintenance,” rather than “improvement,” for individuals who report their current recovery status as poor; they suggested setting a minimum threshold for maintenance in recovery. This will be further reviewed during testing.

Next Steps

The measure developers provided a high-level description of the Initiative’s next steps. They explained that even though the CFP’s October meeting agenda was still being fleshed out, the next meeting will cover the evidence-based treatment, symptom-reduction, and care experience measures.