CQMC
Core Quality Measures Collaborative

Meeting Summary

Behavioral Health Workgroup Web Meeting 2

The National Quality Forum (NQF) convened a web meeting for the Behavioral Health Workgroup on June 9, 2021.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff facilitated roll call and reviewed the meeting objectives:

- Continue discussion on ad hoc maintenance of the Behavioral Health Core Set
- Provide an update from the CQMC Speaker Series
- Discuss future opportunities for the Behavioral Health Core Set

Ad hoc Maintenance Considerations

NQF staff shared that the Workgroup would continue discussing three measures for potential addition. A co-chair thanked NQF staff for sending out details for measures #3541: Annual Monitoring for Persons on Long-Term Opioid Therapy, #1932: Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD), and #2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) to aid in the Workgroup's discussion.

Measures for Potential Addition

3541: Annual Monitoring for Persons on Long-Term Opioid Therapy

NQF staff shared the measure specifications and summarized the Workgroup's discussion from the previous meeting. The measure was noted as being used in the Marketplace QRS. The Workgroup was reminded that the current core set includes the National Committee for Quality Assurance's (NCQA) Pharmacotherapy for Opioid Use Disorder (POD) measure.

A co-chair shared that after reviewing the measure information that was shared by NQF, they noted that the measure testing was broad and included testing patients prescribed opioids for pain management rather than medication assisted therapy (MAT). The co-chair highlighted a concern regarding whether behavioral health specialists would be involved in monitoring patients using opioids for pain management or if these patients would be treated by primary care physicians. The co-chair also referenced previous feedback from the full Collaborative about the need to consider whether the core set should focus on care provided by specialists or on both care provided by specialists and care provided in the primary care setting.

A member expressed that the measure is generally better than other opioid use measures that strictly focus on dose and duration. The member, however, noted that research continues to demonstrate that individuals may or may not have access to pain management therapies depending on their race and ethnicity. It was noted that the measure could further exacerbate disparities and negatively affect health equity. The member shared that their association members have shared that in instances where long-term opioid use is appropriate and well managed, the use of such measures can lead to stigmatization of patients with substance use disorder or those who require opioid treatment for chronic conditions (e.g., sickle cell anemia, which mostly affects African Americans). The member also noted that the measure focuses on screening and does not include any recommended steps for follow-up, thus not addressing a key issue – access to treatment after a diagnosis of opioid misuse.

A co-chair inquired if any other workgroups had reviewed the measure. In response, NQF staff shared that the measure will be reviewed by the ACO/PCMH/Primary Care Workgroup when they meet in late June.

A Workgroup member who is also the measure steward addressed the concerns that were raised by members. On the issue of access, the member indicated that the measure is not a prescribing measure as it only targets patients who have accumulated over 90-days' supply and are truly on long-term opioid therapy. The member acknowledged the issue of stigmatization and shared that the recommendation is evidence-based, noting that the measure went through the NQF endorsement process with an evidence rating of 'high'. The member shared that despite a low bar of one test per year, up to mid-80 percent of patients were not receiving the safest care possible, which can be achieved via screening. The member highlighted that there are multiple resources available to guide physicians on the next steps regarding opioid therapy misuse.

A member noted that the measure was developed at the health plan level and expressed concerns over how reliable the measure would be at the clinician level. The member shared that for that reason they could not support inclusion of the measure in the core set for use at the clinician level. They expressed preference for measures that focus on the drug overdose epidemic. Another member shared that they also have concerns regarding the measure not being tested at the clinician level, and for that reason would not support its inclusion in the core set.

Another member requested clarification on how the measure may potentially limit access. In response a member shared that access issues arise due to the stigma that patients on long-term opioid therapy may feel if they know that they must undergo testing. The member shared patient feedback from their Center for Health Equity that showed that when long-term opioid patients present themselves, medical staff may automatically assume that they are drug abusers. A member representing another member-based organization shared that their feedback showed the opposite (i.e., the more drug screening is avoided, the more stigmatization it creates).

A co-chair asked the Workgroup whether the measure may be better suited for the ACO/PCMH/Primary Care measure set, as pain management would most likely be done by PCPs versus behavioral health specialists. A member agreed and shared that there is an opportunity for additional alignment between CQMC workgroups. A co-chair shared that one option for the future

may be that the Behavioral Health Workgroup weighs in via a consultative process on some of the ACO measures related to behavioral health care. Another Workgroup member supported this viewpoint, but noted that the Workgroup's discussion should be less about specialty versus primary care and more about the quality of the measure itself. The member supported looking at behavioral health measures from a person-centered perspective. The Workgroup agreed to include the measure on the voting list for potential inclusion into the core set.

1932: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)

NQF staff shared the measure specifications and summarized the Workgroup's discussion from the previous meeting. The measure is in the Medicaid and CHIP Behavioral Health core set.

A co-chair voiced support for the measure, emphasizing the link between metabolic syndrome and the use of antipsychotic medications. A Workgroup member highlighted that this measure appropriately highlights the connection and brings attention to this issue. It was noted the measure would encourage further communication to promote multidisciplinary care (e.g., patient care involving an endocrinologist, PCP, and psychiatrist).

A member noted that the measure specifications indicate a mean performance of 80 percent. The member inquired about more recent performance data that could help indicate whether there is still opportunity for improvement. NQF staff shared HEDIS data indicating Medicaid HMO performance rates of 81.7 percent in 2019; 80.6 percent in 2018, and 80.8 percent in 2017.

A member supported including the measure on the voting list and indicated that it would be complementary to measure 2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) if it were to be included in the core set.

A co-chair inquired how performance rates should be considered by the Workgroup when determining if the measure should be included in the core set. NQF staff shared that since the measure is NQF endorsed, the specific Standing Committee that reviewed this measure determined that there was a performance gap. The Workgroup agreed to include the measure on the voting list for potential addition.

2607: Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)

NQF staff shared the measure specifications and summarized the Workgroup's previous discussion. A co-chair shared that like the previous measure, this measure is important due to the risk for comorbidities and care needs of individuals with serious mental illness. A member shared that this measure is complementary to the diabetes screening measure.

A member expressed support for measure 0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%), stating that 0059 is more parsimonious because it focuses on the general population (including individuals with SMI). A member commented that people with SMI are

often excluded and discriminated against. The member indicated the need for a unified, person-centered measurement approach. The member suggested reaching out to the measure developer regarding unintended consequences.

A member expressed support for this measure based on its focus area, suggesting it is more aligned with the specific focus of the core set. The member added that the other measure (0059) would be applicable if the intent is to include and assess diabetes management in people with any type of mental illness. There was also discussion on whether an alternative would be to stratify measure 0059 to look at results for persons with SMI.

A co-chair raised the question of whether having a specific measure would result in more patients being included in assessments. A co-chair requested that NQF staff follow up with the measure steward about potential overlap of this measure with measure 0059: Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) and which populations the measures would include. NQF suggested that differences may be related to how the measures are implemented and in which programs they are used. NQF will follow up with the measure steward and provide any additional information to the Workgroup to aid in voting.

Measure Updates – Follow-Up from Meeting 1

3488: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence and 3489: Follow-Up After Emergency Department Visit for Mental Illness

NQF staff shared that both measures were recommended for addition to the Medicaid core set for 2022. Workgroup members had asked for additional information on why the CQMC Behavioral Workgroup had decided to include measure 3489 but not measure 3488 in the CQMC Behavioral Health core set. NQF staff shared that there was stronger support for 3489 due to its focus on mental health and the focus of the core set (behavioral health). During the voting from the previous cycle, a Workgroup member submitted a comment that measure 3488 was important but that it was better suited for the primary care or ACO setting and that the topic area may be covered by other measures. Another voting comment for measure 3489 suggested that a lag in claims can result in limited actionable data available in a timely manner to help inform care.

0028: Preventive Care & Screening: Tobacco Use: Screening and Cessation Intervention

NQF staff shared that NCQA confirmed that vaping/e-cigarettes are not included in the current measure. It was noted that the steward is navigating USPSTF and FDA guidance on this topic and will provide an update once additional details about updating the measure are determined. NQF staff will keep the Workgroup updated with additional information once it is available.

New CAHPS Mental Health Care Survey

In response to Workgroup discussion on the provider types that would be included in the measure, NQF staff shared that the steward stated that the new survey focuses on medication prescriptions and mental health counseling from different types of clinicians. The survey will ask individuals from whom services were received. It was noted that multiple mental health providers would be included in the measure.

A member shared with the Workgroup details of the Medicaid Home and Community-based Services (HCBS) program, which also has a CAHPS survey used in approximately 16 states. The member noted that the survey is also used by people with serious mental illness. The member raised opportunities for alignment and potential implementation challenges for the new CAHPS mental health survey.

Pharmacotherapy for Opioid Use Disorder (POD)

NQF staff advised that the measure was confirmed by the steward as telehealth eligible if encounters include relevant diagnosis and drug administration codes. NQF staff shared that they would incorporate the update into the notes section of the 2021 core set presentation.

Updates from the CQMC Speaker Series

The CQMC Speaker Series highlights work by developers and other stakeholders in areas of interest to the CQMC. It aims to promote proactive alignment and provide information to the workgroups about measures in the pipeline related to core set gaps areas and other ongoing measurement-related activities. As relevant information is presented during the Speaker Series, NQF will bring it forward for consideration by the appropriate workgroup(s).

The most recent Speaker Series focused on measurement-based care (MBC) and person-centered measurement and featured speakers from NCQA, American Psychiatric Association (APA), and Memphis Business Group on Health (MBGH)

NQF staff shared that during the meeting there was an acknowledgement that the behavioral health system is hard to navigate for purchasers, individual patients, and families, contributing to lack of access, high disability costs, and a multiplier effect on other co-morbidities. Measurement-based care (MBC) – where clinicians use validates ratings (e.g., PHQ-9) to track individual patient progress over time – may help improve the quality of behavioral health services. The uptake of MBC is limited by existing tools and training, workflow restrictions, etc., but it could be incentivized (e.g., by incorporating MBC in payment models).

A member representing MBGH shared more about a national initiative focused on engaging employers and purchasers across the U.S. in eight different markets, referred to as the Path Forward for Mental Health and Substance Use initiative. The initiative involves employers working with national experts to improve how mental health and substance use treatment is delivered. The member highlighted the importance of purchasers tracking changes for employees and their families and increasing access to the services and care they deserve. The member shared the initiative is planned to roll out to 32 different markets.

NQF staff introduced new APA measures funded by the Centers for Medicare & Medicaid Services (CMS) for use in the Merit-based Incentive Payment System (MIPS). A member from the APA shared that APA and NCQA were awarded a CMS grant to develop behavioral health measures for use in MIPS. These measures are currently undergoing testing, which is planned to conclude in summer 2021. The measures will be considered and reviewed for the CQMC core set next year once they are fully tested.

The measures include:

- Measurement-based Care Process: Baseline Assessment, Monitoring, and Treatment Adjustment;
- Improvement of Maintenance of Functioning for Individuals with a Mental and/or Substance Use Disorder;
- Improvement or Maintenance in Recovery for Individuals with a Mentals Health and/or Substance Use Disorder;
- Initiation and Update to Suicide Safety Plan for Individuals with Suicidal Ideation, Behavior of Suicide Risk; and
- Reduction in Suicide Ideation or Behavior Symptoms.

The member shared that the first measure (Measurement-based Care Process: Baseline Assessment, Monitoring, and Treatment Adjustment) is classified as a process measure. However, because of its focus on repeated measurement to improve outcomes in behavioral health, it can also be considered as an outcome measure. The measure was noted as being consistent with The Joint Commission's accreditation standards and the Path Forward initiative. The member shared that two of these measures, the Measurement-based Care Process and the Functioning measures, have been approved as QCDR measures for MIPS. The remaining measures are planned to be submitted to the MUC list for potential inclusion into MIPS.

NQF shared the NCQA's work on person-driven outcome measures. For these person-driven outcome measures, individuals or caregivers identify outcomes that matter the most to them. After identifying the person-driven outcome, providers and the individual iteratively revisit goals and monitor progress towards the specific outcome.

Examples of two options for measuring are:

- Use of a person-reported outcome measure. Example: The individual goal is 'I want to relieve back pain so I can work in the garden.' The provider maps the goal to a 'Pain Interference with Daily Activities' PROM.
- Goal attainment scaling. Example: The individual goal is 'I want to go outside once in the next three months.'. The patient rates progress on a scale from -2 ('My performance is much less than expected') to +2 ('My performance is much more than expected').

A member from NCQA shared the aim of these measures is to align patient goals and needs to the patient's treatment and care management plan.

A member voiced support for the work but highlighted the validity and reliability challenges that may be faced with these measures. The member referenced challenges with the HCBS experience survey for people with disabilities. Since the HCBS surveys are time and resource intensive, (e.g., 3 hours per client), many traditional healthcare providers do not utilize this survey. Resource limitations may make it difficult to get a representative sample of data from these types of in-depth measures and surveys. The member from NCQA concurred that there is a need to devise mechanisms to fit the

process into normal workflows. The member indicated that from experience, goal conversations with patients can take less than 10 minutes because patients are quite receptive and share their goals when they become aware that practitioners are interested in learning about their goals.

A member called attention to individuals with SMI receiving HBCS and emphasized the importance of bridging the gap between both community services and general healthcare services to ensure holistic patient-centered care.

A member inquired if NCQA plans to develop a more global health related quality PROM (similar to PROMIS Global-10) that could assess person-centered outcomes and be cross-cutting. In response, NCQA noted that many respondents preferred pursuing a specific goal versus achieving a generic globally "better" health rating. This may indicate that the goal-specific measures may be more helpful in providing patient-centered care.

Future Opportunities for the Behavioral Health Core Set

NQF staff encouraged the workgroup to think about the ideal state of the core set. NQF staff also presented several characteristics of the core set compared to the average across all CQMC core sets.

*	Behavioral Health Core Set	Overall Average *(calculated across 8 original sets updated in 2020)*
Total number of measures	11	14
Outcome measure	2 (18%)	39%
Patient reported outcome-based performance measures (PRO-PMs)	2 (18%)	12%
Cross-cutting measures	3 (27%)	13%
eCQMs	3 (27%)	27%
Clinician-level	6 (55%)	53%
NQF endorsed	10 (91%)	79%

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It was noted that the Behavioral Health core set meets and/or exceeds averages in most of these target areas. The Behavioral Health core set, however, has less outcome measures than other CQMC core sets, which likely reflects the general state of measurement for behavioral health and the number of outcome measures available.

NQF staff noted the CQMC aims to advance measurement in the following areas:

- Outcome measures,
- PRO-PMs,
- Cross-cutting measures,
- Measures that address disparities or social determinants of health (SDOH),
- Digital measures, and

- Clinician-level measures.

NQF staff solicited feedback from the workgroup on how the CQMC can progress towards these goals. A member opened discussion on the role of SDOH in the core set by noting that some state Medicaid agencies delivering long-term services and supports (LTSS) or HCBS are working on addressing SDOH and documenting progress; as these state agencies develop a process for measuring progress and assessing outcomes, they can be used to inform the CQMC's use of measures to assess SDOH. A co-chair noted that if other members of the group are aware of similar programs or SDOH-related measures, these should be shared with NQF and the Workgroup for consideration during a full core set maintenance year. A member shared that the Human Services Research Institute (HSRI) is the measure steward for the National Core Indicators, and that they have recently released a data brief illustrating the difference in outcomes for African-American individuals with intellectual and developmental disabilities (IDDs) vs. White individuals with IDDs.

A member shared that the use of PRO-PMs and PROMs is a priority for purchasers, as patients are the ultimate source of information on successful treatment and quality of outcomes. The member shared that purchasers would like to reward providers based on their ability to optimize health as assessed by patients, but recognize that challenges persist with workflow, burden, and lack of data infrastructure. The member encouraged health plans to implement staged incentives to promote adoption of these types of measures (e.g., 1-2 years rewarding the collection and reporting of data before shifting to incentives based on actual outcomes). A member emphasized the importance of PRO-PMs in providing person-centered care.

NQF also asked the Workgroup for additional feedback on the future of the Behavioral Health core set, including the overall focus and areas for opportunity. NQF staff shared that the current core set was created using a person-centered approach to encompass a broad range of care, but broad measures may be high-performing in the general population and it may be helpful to include more specialty-specific measures. NQF also highlighted opportunities for developing the set, including addition of MBC measures and automatically collecting behavioral health data electronically to reduce burden.

A co-chair shared additional background on the focus of the Behavioral Health group from last year. The Workgroup tried to address both broad treatment as well as specialty-specific concerns in the core set, but the Steering Committee and full Collaborative provided input that they had expected the Behavioral Health core set to address specialty concerns only. (Instead, the ACO and Pediatrics groups would determine the appropriate measures for the primary care setting). Another co-chair provided further context that due to the significant mental health provider shortage, a large portion of behavioral health interactions are taking care in the primary care setting instead of with specialists. There has been a gradual shift where specialists are handling serious mental illness (SMI) while primary care providers are handling more general mental health conditions.

Workgroup members discussed that the Behavioral Health core set should address the most important measures for high-quality behavioral health care regardless of treatment venue. A member also shared that the behavioral health system is not equipped to treat the primary care needs of

people with SMI, since specialists are focused on the treatment of serious persisistent mental illness, but both primary care and behavioral health specialty measures need to be considered together to address the health needs of the whole person.

Workgroup members discussed that the future core set should still include a mix of broad and specialty behavioral health measures, but it may be helpful to restructure the process, discussion, and reporting for these two categories of measures. For example, the Behavioral Health Workgroup may not be able to speak to the burden of depression screening on primary care physicians, but they can speak to the importance of early identification and treatment on outcomes. It may also be helpful to provide additional context on the intention of the measures in the core set presentation.

A co-chair noted that this discussion on the overall goals and focus of the Behavioral Health set will need to be discussed with the larger Collaborative before proceeding with additional work. NQF staff shared that they will bring this discussion to the Steering Committee for consideration and will follow up with the Workgroup with additional details. NQF will provide additional context for decision-making for future cycles of core set maintenance.

Next Steps

NQF staff shared that this was the final Behavioral Health Workgroup meeting for this year. NQF will circulate a voting survey for the three measures under consideration for addition to the core set, along with summaries of the discussion from Meetings 1 and 2. NQF will also follow up via email with the Workgroup with additional information on the future scope and context for the Behavioral Health core set. NQF closed the meeting by thanking the Workgroup for their participation and the co-chairs for their leadership.