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July 25, 2014

Ms. Angela J. Franklin
Senior Director, Performance Measurement
National Quality Forum
1030 15th Street NW, Suite 800
Washington DC 20005

RE: Recommended Behavioral Health Measures for Consideration

Dear Ms. Franklin:

The National Association of State Mental Health Program Directors (NASMHPD) is writing to suggest measures for consideration by the Behavioral Health Measures Workgroup and to provide feedback on the existing Behavioral Health NQF-Endorsed Maintenance Standards. We will not be formally submitting measures, but wanted to share our thoughts with the Behavioral Health workgroup before it begins its deliberations. NASMHPD is the member organization representing the state executives responsible for the $37 billion public mental health service delivery systems serving 7.2 million people annually in 50 states, 4 territories, and the District of Columbia.

With regard to the existing Behavioral Health NQF-Endorsed Maintenance Standards, we regard each of these measures as meaningful and appropriate. Clearly, there are many additional potential target areas for monitoring and measures and many potential measurement tools, but these standards are reasonable as a starting point.

Suicide Risk Assessment - We'd suggest that NQF Measure 1365, the Major Depressive Order Suicide Risk Assessment for Children and Adolescents (AMA-PCPI) is crucially important and should be retained, particularly given NQF's April 2014 permanent endorsement of NQF Measure 104, the Major Depressive Disorder: Suicide Risk Assessment for Adults (AMA-PCPI). It is crucial that suicide risk assessment in children and adolescents be evaluated using standards specifically applicable to the conditions and issues confronting children and adolescents, and that the evaluation of adult assessments not be utilized for this particularly vulnerable population.

Pediatric Symptom Checklist – NQF Measure 0722, the Pediatric Symptom Checklist (PSC) (Mass General Hospital) completed by parents should be retained, but that measure now has a youth-reported version that should also be included, either by expansion of the current endorsement to that version or by endorsement of that version as a separate measure. The youth version, like the parent-reported version, is available in multiple languages.

However, while the PSC is valuable and relatively efficient to use in the primary care setting, the Strengths and Difficulties Questionnaire (SDQ) is used in many more settings and is also available in multiple languages. The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioral screening questionnaire for children and adolescents 3 to 16 years old. Developed in the United Kingdom by Child Psychologist Robert N. Goodman, Professor of Brain and Behavioural Medicine at the Institute of Psychiatry in the Department of Child and Adolescent Psychiatry at King's College in London, it exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes questions for parents and teachers about 25 psychological attributes, some positive and others negative. These 25 items are divided between five scales, with five items each: 1) emotional symptoms, 2) conduct problems, 3) hyperactivity/inattention, 4) peer relationship problems, and 5) prosocial behavior. There is a separate questionnaire for self-reporting by adolescents.

It should be noted that the PSC does not satisfactorily screen for substance use issues. Another measure should be adopted in conjunction with the PSC that evaluates tools that specifically screen for those issues. We'd note the need for the continued endorsement of NQF Measure 1661, Alcohol Use Screening (Joint Commission) and NQF Measure 0004, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA), and NQF Measure 0110, Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance Use (Center for Quality Assessment and Improvement in Mental Health) as well as any available evaluation measures for evidence-based substance abuse screening tools included in the on-line SAMSHA National Registry of Evidence-Based Programs and Practices (NREPP) or at the University of Washington's Alcohol and Drug Abuse Institute website library of screening and assessment tools, using tools analogous to NQF Measures 1661 (generally) and 0110 (for schizophrenia).

Measures of Trauma History - NASMHPD members also believe there is a need to address the role of trauma in the lives of many citizens and the need for treatment to address that trauma. Trauma plays a significant role in the genesis and maintenance of disease, disability, and bad health over the lifespan. The reported results of the Centers for Disease Control and Prevention's Adverse Childhood Experiences (ACE) Study, which considers the long-term effects of childhood exposure to trauma and adversity—verbal, physical, or sexual abuse, as well as family dysfunction (e.g., an incarcerated, mentally ill, or substance-abusing family member; domestic violence; or absence of a parent because of divorce or separation)—suggests that the use of a trauma screen used by mental health and primary care professionals should be added to the process measure standards endorsed by NQF, for both children and adolescents in conjunction with parents or caregivers and for adults. The website of the National Child Traumatic Stress Network contains a number of trauma history screening tools for children, such as the Traumatic Events Screening Inventory for Children (TESI-C). A second process measure should be added for ascertaining the frequency with which individuals with active trauma symptoms are treated or referred for appropriate evidence-based treatments included in the SAMHSA National Registry.

Patient-Reported Outcomes - Any NQF-endorsed compilation of relevant measures of patient outcomes must include the Mental Health Statistics Improvement Program (MHSIP) Consumer Surveys used by the Substance Abuse and Mental Health Services Administration with consumers of publicly funded mental health services asks 36 questions in the five domains of Access (6 items), Quality/Appropriateness (9 items), Outcomes (8 items), Overall Satisfaction (2 items), and Participation in Treatment Planning (3 items). The Survey collects information on the respondent's perceptions of general satisfaction with services, voice in service delivery, satisfaction with staff, perception of outcome of services, access to services, and staff cultural sensitivity. The state agencies

receiving the Mental Health Block Grant are already required to report this information to SAMHSA, and endorsing the same survey for non-Block Grant recipients would provide a uniform, proven assessment tool that need not be built from scratch.[i]

Co-Occurring Somatic Disorders – A significant percentage of individuals with serious mental illness have co-occurring somatic conditions and disorders other than the diabetes addressed in NQF Measure 0003, Bipolar Disorder: Assessment for Diabetes (CQAIMH), NQF Measure 1934, Diabetes Monitoring for People with Diabetes and Schizophrenia (NCQA), and NQF Measure 1932, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) (NCQA). These physical conditions disorders often work in tandem to aggravate the accompanying mental illness, which in turn may aggravate the physical condition and disorders.

Approximately one in five patients hospitalized for a heart attack, for example, suffers from major depression, and evidence from multiple studies is that post–heart attack depression significantly increases one's risk for death: patients with depression are about three times more likely to die from a future attack or other heart problem.[ii] Depression and anxiety also are strongly associated with somatic symptoms such as headache, fatigue, dizziness, and pain, which are the leading cause of outpatient medical visits and often medically unexplained.[iii] They also are more often present in individuals with a number of other medical conditions not as well understood, including chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, and non-ulcer dyspepsia.[iv]

We recommend a search for measures that review whether there has been sufficient coordination of care for both physical and behavioral conditions and disorders, if not a measure of the degree to which that care has been integrated. For instance, a relevant measure might be the percentage of patients with a mental illness who have made a visit to a primary care provider within the previous year. Another might be the number and types of collaboration between primary care providers and behavioral health providers annually.

In addition to the full list of measures currently under review, we urge continued NQF endorsement of the following non-exclusive list of existing NQF behavioral health measures. While we recognize that a number of these measures were only recently endorsed, we urge NQF to give these measures some time for exposure before considering subsequent revisions or endorsement withdrawals.

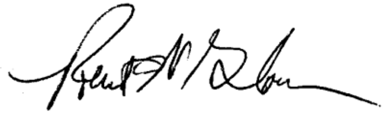
- NQF Measure 0418, Screening for Clinical Depression and Follow-Up Plan (CMS)
- NQF Measure 0105, Antidepressant Medication Management (NCQA)
- NQF Measure 0027, Medical Assistance with Smoking and Tobacco Use Cessation (NCQA)
- NQF Measure 0028, Tobacco Use: Screening and Cessation Intervention (AMA, PCPI)
- NQF Measure 0576, Follow-Up After Hospitalization for Mental Illness (NCQA)
- NQF Measure 1937, Follow-Up After Hospitalization for Schizophrenia (NCQA)
- NQF Measure 1768, Plan All Cause Readmission (NCQA)

We also recommend that NQF work with SAMHSA in formalizing a new measure for the assessment of the procedures outlined in SAMHSA's *Medicated Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, TIP 43*. An example could be a measure which reviews the percentage of patients diagnosed with Opioid Use Disorder who are put on Medication Assisted Treatment (MAT).

We appreciate your thoughtful consideration of the measures we suggest for determining the quality of

care provided to patients with mental illness and substance use treatment disorders. NASMHPD looks forward to an ongoing, engaging dialogue with NQF and the Behavioral Health Workgroup regarding these issues. If you have additional questions regarding the issues raised in this correspondence, please feel free to contact NASMHPD's Director of Policy and Health Care Reform, Stuart Gordon, at stuart.gordon@nasmhpd.org or 703-682-7552.

Sincerely,



Robert W. Glover, PhD.
Executive Director
National Association of State Mental Health Program Directors

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[i] Jerrell, PhD, J. "Psychometrics of the MHSIP Adult Consumer Survey," *Journal of Behavioral Health Services and Research* (2006).
[ii] Bush, DE, Ziegeldtein, RC, Patel, UV, Thombs, BD, Ford, DE, Fauerbach, JA, McCann, UD, Stewart, KJ, Tsilidis, KK, Patel, AL, Feuerstein, CJ, Bass, EB., "Post-Myocardial Infarction Depression. Summary. Rockville, MD: Agency for Healthcare Research and Quality"; AHRQ Publication Number 05-E018-1. Evidence Report/Technology Assessment Number 123 (2005).
[iii] Kroenke, K., "Patients presenting with somatic complaints: Epidemiology, psychiatric comorbidity and management", *International Journal of Methods in Psychiatric Research*, 12(1):34–43 (2003).
[iv] Henningsen, P, Zimmerman, T, Sattel, H., "Medically unexplained physical symptoms, anxiety, and depression: A meta-analytic review." *Psychosomatic Medicine,* 65(4):528–533 (2003).