NAPHS Comments
on National Quality Forum (NQF) IPF Standing Committee Behavioral Health 2016-17
Draft Report for Comment

Submitted April 2017

Overall Comment

We strongly support the committee recommendation that when a developer of a previously endorsed claims-based measure introduces an electronic-based version (eMeasure), NQF should consider adding an 'e' to the end of the original number to denote the eMeasure. Currently NQF renumbers both the original and the eMeasure. This creates confusion in the field and requires expensive retooling of EHRs and re-education of measure users.

O576 Follow-up After Hospitalization for Mental Illness (FUH)

We acknowledge the concern expressed during the Standing Committee meeting that the FUH measure was developed as a plan measure and has not been specified for acute care. We note that in the NQF Measures Application Partnership Final Report (*Maximizing the Value of Measurement: MAP 2017 Guidance,* March 15, 2017), NQF recommended that the measure be removed from the IPFQR payment program pending re-specification for acute care and resubmission for NQF endorsement. We support this recommendation and call for re-specification. We also support the committee concern about limiting the follow-up to a mental health practitioner only and the suggestion to broaden the definition. We know, especially with Medicare beneficiaries, it is possible that a person will return to the care of a primary care practitioner following hospitalization rather than establishing a new relationship with a specialist. It can also be very difficult to find a specialist with availability to treat this population. While we acknowledge that specialist intervention might be indicated and even desirable for many patients, we also acknowledge the reality that care with a generalist can be superior to a patient being lost to care. We recommend that the definition of acceptable practitioners be expanded.

3205 Medication Continuation Following Inpatient Psychiatric Discharge

We agree with the Committee's comments that there is evidence that lack of adherence to medication can lead to relapse and negative outcomes. We also agree that it is impossible for an inpatient facility to track medication continuation once a patient is discharged. Filling a prescription may be a type of proxy for adherence, although not an assurance that the medication was taken. We don't have a better measure to suggest. We agree with the exclusions. We expect that performance on the measure will be somewhat higher (based on the criteria that only patients with a Part D drug plan will be included) than for the total IPFQR population.

3207 Medication Reconciliation on Admission

We agree with the Committee's decision to not recommend the Medication Reconciliation on Admission measure. While we support the concept that it is important to know a patient's medication history, the structure and complexity of this measure makes it very burdensome. We agree with the Committee's

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observation that the evidence was weak for the measure focus and did not distinguish from the literature when the reconciliation occurred. Adequate links were not seen between the components identified in the proposed measure and improved clinical outcomes. The three components [comprehensive prior to admission (PTA) medication information gathering and documentation; completeness of critical PTA medication information—to include calling pharmacies, etc.; and reconciliation action with very specific detail for each PTA medication], and the associated scoring elements make the measure much too complicated to be useful. The developer stated that the measure is consistent with the best practices of The Joint Commission (TJC). The TJC National Patient Safety Goal on medication reconciliation (NPSG.03.06.01) lays out a rationale and process for obtaining information on the medications a patient is currently taking that all accredited hospitals must follow. The process is straightforward and produces important, useful, and accessible clinical information with reasonable resource utilization. The complex data collection and processing (such as averaging the scores of the three components) required in the proposed measure 3207 have not been demonstrated to add clinically useful information that is not obtained in the current requirements. The proposed measure requires very significant resource utilization without demonstrated clinical improvement.