MN Community Measurement (MNCM)
Measurement and Reporting Committee (MARC)
Wednesday, October 12, 2016
Meeting Minutes

Members Present: Barb Anderson, Cara Broich, Ariam De Leon, Peter Dehnel, Matt Flory, Tim Hernandez, David Homans, Jordan Kautz, Janet Keysser, Sue Knudson, Deb Krause, Robert Lloyd, Bill Nersesian, Chris Norton, Bruce Penner, Rahshana Price-Isuk, Jeff Rank, Allan Ross, David Satin, Mark Sonneborn, Brian Whited (MNCM Board member guest)
Alternates: Denise McCabe
MNCM Staff: Tina Frontera, Amy Krier, Collette Pitzen, Anne Snowden
Members Absent: Howard Epstein, Stefan Gildemeister, Jonathan Rose, Laura Saliterman

Topic	Discussion
Welcome & Introductions	Chris Norton called the meeting to order and welcomed committee members and observers. All MARC members and observers introduced themselves. Chris extended a special welcome to two new members of MARC: Deb Krause, vice president at the Minnesota Health Action Group, who is serving on MARC as a purchaser/consumer representative; and Barb Anderson, a BSN nurse and clinical data analyst with Mankato Clinic, who is serving on MARC as a non-metro medical group representative. Chris also welcomed Tim Hernandez back to MARC for another two-year term.
Approval of Minutes	The committee reviewed minutes from the September 2016 meeting. **Ariam De Leon made a motion to accept the minutes; Robert Lloyd seconded the motion. Motion passed.**
Recommendations from MNCM Depression Measure Development workgroup – for approval	Chris introduced the recommendation from the MNCM Depression Measure Development workgroup. In April 2016, MARC approved the convening of this workgroup. She introduced Collette Pitzen, Clinical Measure Developer at MNCM to present the recommendation. Collette reminded the committee that the workgroup was convened to address three specific areas of potential redesign for the Depression measure suite. The workgroup was well balanced with representation from primary care, pediatrics, adult and adolescent psychiatry. She thanked the workgroup members who were engaged, collaborative and remained patient-centered in their focus. Collette indicated that the redesign recommendations presented an opportunity to expand the current MNCM Depression measure suite to align with the proposed National Committee for Quality Assurance (NCQA) adaptation of the MNCM Depression measure suite for the HEDIS measures for health plan accreditation. There was no contractual obligation for the recommended redesign and no determination has been made about potential inclusion in the Statewide Quality Reporting and Measurement System (SQRMS). Collette explained that the workgroup was charged with three tasks: 1. Consider the inclusion of adolescents (ages 12 to 17) • If yes, consider 4 to 8 month (or +/- 60 days) follow-up window 2. Consideration of PRO tools in addition to PHQ-9 3. Review appropriateness of current exclusion criteria **Task 1: Including Adolescents in Measures of Depression Outcomes** Prevalence statistics indicate that depression is a significant concern for adolescents. Discussion relevant to the consideration of measuring depression outcomes for adolescents included: • potential life-long impact of adolescent depression (school, work) • balance between potential stigma of diagnosis versus identifying and treating when functionally impacted • level of comfort of primary care providers treating depression in adolescents • challenges in screening, diagnosis and treatment of adolescents (adjustment disorder vs. depression) • systems in place for treatment and available treatment resources (schools and psychiatric assistance support) After thoughtful discussion, the workgroup reached consensus that it was important to include adolescents in the measurement of depression outcomes, stratifying the results by age (ages 12 to 17 and ages 18 and older).

Follow-up Window for Assessment
As part of NCQA's work adapting the measure to include adolescents, it was proposed that an increased window for follow-up was needed, in part due to the challenges in following up with adolescent patients. Workgroup members considered this, but felt that adult patients with depression presented an equal challenge for follow-up and that increasing the follow-up window should be considered for all patients.

Analysis was performed on data from ten medical groups (approx. 54,000 patients) to explore the impact of expanding the follow-up window from +/-30 days surrounding the follow-up date to +/- 60 days surrounding the follow-up date. Although the net impact of the change on the six month remission outcome rates was 5 percent (with 95 percent of the patients unchanged) the workgroup felt that it was reasonable to recommend this technical change for all patients in hopes that it would increase provider buy-in.

Collette then turned the discussion over to Michael Trangle, MD, Associate Medical Director of Behavioral Health and Psychiatrist at HealthPartners and chair of the workgroup, for his comments. He shared that providers are often tempted into making suggestions for measurement that may not be in the best interest for patients (e.g., credit for any low PHQ-9 even if it is at one week). He noted that the average duration of depression for adults is about eight months and that best practice treatment for adults is one year beyond remission. There is no "one and done" in the natural course of this condition and the patient needs continued monitoring in order to avoid relapse of symptoms. He also commented that the workgroup felt that expanding the follow-up window would help to engage providers without gaming the system.

Task 2: Consideration of Additional Patient Reported Outcome Tools
Collette explained that consideration of any depression patient reported outcome tool to be used for this measure, in addition to the PHQ-9, needed to meet several criteria to fit within the current measure construct:

- strong psychometric properties
- empirically defined cut points for remission and depression symptom severity
- have a basis in DSM diagnostic criteria for depression
- validation studies supporting the use of the tool to monitor progress and outcomes
- high implementation feasibility in a clinical setting

Twenty-one tools were selected for review. Information was compiled for the workgroup's review using standardized criteria. After the workgroup's review and discussion, dismissing those without reliable cut-points for remission, those that do not support the diagnosis of depression or measuring outcomes, those that do not have a level of use in the community and taking into consideration the feasibility of implementation in clinical practice, the workgroup reached consensus for no additional tools beyond the PHQ-9 and PHQ-9M. The workgroup had reservations on the impact of measure comparability between practices when different tools are used. This is of particular concern for the response measures (greater than or equal to 50 percent improved based on tool score).

The workgroup discussed the concept of administering the PHQ-9 to 12 year olds as studies in ages 13 through 17 did not explore individual ages and ages around the fringe. The workgroup decided to allow both tools, not restrict tool use by age, and leave the decision up to the medical groups in terms of which tool best fits their practice.

Michael noted the advantages of the PHQ-9 and PHQ-9M including the availability of the tool in the public domain, the lack of associated fees, and the tool is validated for multiple modes of administration.

Task 3: Review of Exclusions
Collette explained that depression, like many chronic or episodic conditions, does not often exist in isolation of other medical conditions. The National Quality Forum provides guidance for the use of exclusions and indicates that measures are to be patient-centered and as inclusive as possible without distortion of the measure.

She went on to explain that required exclusions are those that are critical to the measure and without the exclusion would cause distortion to the outcome rates. Allowable exclusions are considered optional, a group can decide to utilize them or not and in the case of this measure, are of such small volume as they would not serve to distort the rates. Many allowable exclusions are conditions or situations that may not be readily available (diagnosis codes) or in discreet fields in the medical record.

Exclusion Set #1

- Death (end of life issues or suicide)
- Permanent Nursing Home Resident
- Hospice/ Palliative Care Services (end of life issues)

These allowable exclusions are currently part of measure specifications and can occur any time during the measurement period. After thorough discussion the potential impacts of removing any of these lower volume exclusions to the measure, the workgroup decided to retain these allowable exclusions.

Exclusion Set #2 Bipolar Disorder
A disorder associated with episodes of mood swings ranging from depressive lows to manic highs is an appropriate clinical exclusion from depression outcome measures. The workgroup confirmed this exclusion is appropriate and recommended it be retained without change as a required exclusion.

Exclusion Set #3 Personality Disorder
The workgroup wanted the exclusions to remain focused on mental health conditions in which the patient could not reliably respond to a self-assessment due to emotional lability of the concomitant condition. The workgroup agreed that the current value set of diagnosis codes for this exclusion is too broad, historically including many conditions that can also occur with depression and the depression can be treated successfully.

Diagnosed personality disorders (versus personality traits) are rare and personality disorders are not indicated as mental health conditions that commonly occur with depression. For this reason, the workgroup changed this exclusion type from required to allowable. The remaining conditions, all of which exhibit emotional lability, in this exclusion value set are:

- Cyclothymic disorder
- Borderline personality disorder
- Histrionic personality disorder
- Factitious disorder

Exclusion Set #4 Pervasive Developmental Disorders
This value set proposed as an exclusion by NCQA includes autistic disorder and childhood disintegrative disorder. Due to the potential unreliability in completing the PHQ-9 accurately and the potential differences in therapy (increased socialization to improve depression symptoms), the workgroup would like to incorporate this as an allowable exclusion.

Collette noted that there are several types of conditions and patients who cannot complete a PHQ-9. Attempts to define them all would be incomplete and would significantly add burden to the measure. The guidance that MNCM has given to practices in the past is that if it is clinically inappropriate to administer a PHQ-9 to a patient, don't administer the tool. The patient does not come into the denominator without a PHQ-9 score.

Exclusion Set # 5 Schizophrenia or Psychotic Disorder
The most common mental health diagnoses that can occur with depression are anxiety disorders (GAD, panic, social, phobias, OCD, PTSD), eating disorders (anorexia, bulimia), substance abuse and schizophrenia.

Most patients with schizophrenia are treated in a psychiatry setting, and this diagnosis was one of the reasons for the technical specification that requires the depression diagnosis to be in the primary position in the psychiatry setting. The original intent of this criterion was to exclude patients with more serious psychiatric conditions with a secondary diagnosis of depression. The workgroup discussed the impact of adding this exclusion, deciding that it makes sense to exclude patients with schizophrenia from the depression measures.

With the exclusion of schizophrenia or psychotic disorder, there are no other concomitant mental health conditions that require this continued distinction between primary care and psychiatry settings. The workgroup reached consensus that this technical caveat can be removed (e.g., depression diagnosis in any position for both primary care and psychiatry).

Michael commented that, given the well balanced mix of representatives on the workgroup, they were able to identify the appropriate required and allowable exclusions for this recommendation.

Collette went on to say that in order to minimize disruption, allow time for medical groups to make changes, and permit future comparability of performance over time, the workgroup is seeking approval of their recommendations in its entirety for 2018 dates of index reported in 2020.

Recommendation:
For 2020 Report Year (dates of index event 1/1/2018 to 12/31/2018):

1. Incorporate adolescents into the depression measures.
    - Modify age range to include adolescents; age 12 and older

- Report measures as two separate stratifications by age (not combined); age 12 to17 and age 18 and older

2. Widen the follow-up assessment window to +/- 60 days for all populations and all response and remission measures.
    - Six month measures assessment window expands from 5 to 7 months to 4 to 8 months.
    - Twelve month measures assessment window expands from 11 to 13 months to 10 to 14 months.
3. Patient Reported Outcome Tools for index/denominator and measuring outcomes of remission and response are the PHQ-9 and PHQ-9M.
    - Add the PHQ-9M as an acceptable PRO tool for measurement
    - Providers may elect to use either tool; no measure construct restriction for age.
4. Modifications to exclusions include the following:
    - Personality disorders narrowed to emotionally labile conditions and moved to the allowable exclusion category
    - Add exclusion value set for schizophrenia or psychotic disorder as a required exclusion
    - Add exclusion value set for pervasive developmental disorder as an allowable exclusion
5. Remove denominator criteria for behavioral health settings that stipulates the diagnosis of major depression or dysthymia needs to be in the primary position.
    - Relates to new exclusion for schizophrenia or psychotic disorder; no longer necessary

Questions/Comments/Discussion

Bill Nersesian expressed concerns about the inclusion of a follow-up window as it is not the way most providers practice. The measure is attempting to quantify a fairly complex problem that has an undulating course. A provider may see patient four times over the course of the depression and receive a differing PHQ-9 result each time with none of the four visits falling into a follow-up window. Michael noted that the recommended expansion of the window is an attempt to capture more follow-up attempts than had been captured previously. He also commented that many medical groups were utilizing the internet and telephone outreach to follow-up with depression patients. Cara Broich noted that the workgroup liked the PHQ-9 because it was validated for phone administration, whereas the other tools considered did not accommodate multiple modes of administration.

Tim Hernandez inquired whether there was the ability to screen adolescents with tools similar to those available for adults for bipolar or personality disorder which may exclude them from the measure, noting that it is rare for adolescents to be diagnosed or labeled with these conditions. Michael shares that there are tools out there that screen broadly for mental health conditions but don't do a really great job of narrowing symptoms or evaluating intensity. For some mental health conditions like bipolar disorder, it takes time for the symptoms to develop to the point of being able to accurately identify and diagnose. Collette noted that for patients where a subsequent diagnosis appropriate for exclusions was determined after the depression diagnosis, the patient can be excluded from the measure by submitting the exclusion reason.

David Satin asked whether Post Traumatic Stress Disorder (PTSD) had been considered as an exclusion. Collette responded that PTSD is classified as an anxiety disorder where it is possible for depression to be treated.

David S. went on to inquire whether it was considered that including adolescents in the measure would have the unintended effect of increasing use of medications in this high risk group. Michael commented that there was good consensus in the workgroup that therapy is better for adolescents than medication. He went on to explain that the measure focus is to measure outcomes and not to direct clinical practice. Cara commented that the difference in treatment recommendations for adolescents and adults was one of the reasons the decision was made to recommend stratification of the results.

Sue Knudson asked how NCQA will approach the HEDIS Depression Remission or Response for Adolescents and Adults (DRR) measure since the data necessary to calculate the measure is clinical and not claims based. Cara shared that during pilot testing of the HEDIS DRR measure it was difficult for health plans to obtain the data necessary to calculate the HEDIS measure. Michael commented that as health systems move to EHRs, the future of measurement reporting is to have data submitted electronically, and he feels NCQA is receiving pressure to structure measures that align with that future. Cara noted that, currently, Minnesota has peer review and privacy laws that stand in the way of that electronic data submission.

Allan Ross expanded on David's concern about unintended consequences in the adolescent population particularly in rural areas where mental health resources are not readily available. He expressed his concern that inclusion of adolescents in the measure may lead rural providers to over-prescribe medications due to the lack of therapy options.

	Jeff Rank suggested that measurement of this population could help to shine a light on the lack of mental health resources in rural areas. Rahshana Price-Isuk commented that she would prefer a shift in focus to depression response and active patient involvement in treatment rather than depression remission. Peter Dehnel asked whether the 60-day follow-up window will be accepted by HEDIS. Collette explained that NCQA had requested the consideration of the expansion of the follow-up window. NCQA wants MNCM to remain the measure steward and alignment would follow suit. Peter followed-up by asking if stratification to adolescents and adults would create burden for pediatric groups. Collette noted that all patients, both adolescents and adults, would be included in one data submission and therefore stratification should not create additional reporting burden. Tim asked about phasing in the changes rather than implementing them all at once in the future. Collette noted that phasing in the changes would create loss of comparability for multiple reporting cycles. It is recommended to implement all changes at once in order to maintain comparability. **Jeff Rank made a motion to approve the recommendation as presented. Peter Dehnel seconded the motion. Motion passed.**
Recommended modifications to Colorectal Cancer Screening measure – for approval	Chris introduced the recommendation from MNCM to align with recently released guidelines and the NCQA HEDIS Colorectal Cancer Screening measure. Chris turned over the discussion to Anne Snowden, Director of Performance Measurement, Validation and Reporting at MNCM to present the recommendation. Anne explained that in June 2016, the United States Preventive Services Task Force (USPSTF) updated its recommendation statement on colorectal cancer screening. It continues to recommend screening for average-risk, asymptomatic adults aged 50-75, but expanded the recommended screening methods to include Computed Tomography (CT) Colonography and Fecal Immunochemical Test (FIT)-DNA. In October 2016, NCQA released final measure specifications for the 2017 report year which adds both newly recommended screening methods to their Colorectal Cancer Screening HEDIS measure. MNCM's Colorectal Cancer Screening measure is adapted from the NCQA HEDIS measure; therefore, the following changes are recommended to align MNCM's measure with the NCQA HEDIS measure. **Recommendation:** In addition to the current numerator screening options (colonoscopy every 10 years, flexible sigmoidoscopy every 5 years, or fecal occult blood test annually), MNCM recommends the following additions to achieve alignment with the USPSTF guidelines as well as NCQA's HEDIS *Colorectal Cancer Screening* measure for the 2017 report year: • CT Colonography during the measurement year or the four years prior to the measurement year • FIT-DNA test during the measurement year or the two years prior to the measurement year Additionally, it is recommended to remove CT Colonography as an allowable exclusion. **<u>Questions/Comments/Discussion</u>** Based on a question from the committee, Anne clarified that Cologuard is a FIT-DNA test. Currently, the FIT portion of the Cologuard test qualifies as an annual stool blood test for numerator compliance. With the recommended change, Cologuard will qualify as a FIT-DNA test if the screening occurred during the measurement period or two years prior. Janet asked whether the expansion of available screening tests would result in increased rates. Matt Flory commented that he feels it is less likely that there were tests being done that were not being counted in the past. He feels it is more likely that this alignment will underscore for patients and providers that colonoscopy is not the only screening choice, draw more attention to the other screening options, and hopefully engage more patients in being screened. Deb Krause noted that the American Cancer Society has done a lot of work with employers to encourage screening amongst their employees. Jeff commented that expanding screening is very important but added that the various screening test options are not comparable to one another and have different outcome results. **Matt Flory made a motion to approve the recommendation as presented. Cara Broich seconded the motion. Motion passed.**
Meeting Adjournment	Chris announced that the next meeting will be Wednesday, November 9, and adjourned the meeting.