QCDR Advisory Committee Meeting
Summary

Friday & Saturday, July 21-22, 2017

Attendance:

**Advisory Committee**: David Bard, Bruce Bobbitt, Zeeshan Butt (Friday only), Carol Goodheart (chair), Katy Lysell, Dean McKay, Kari Stephens

**Healthmonix**: Debbie Belczyk & Lauren Patrick (both Friday only)

**Staff**: Lynn Bufka, Elena Eisman, Chris Nettles, Katherine Nordal (Friday only), Diane Pedulla, Doug Tynan (Friday only), Vaile Wright (lead staff)

Friday

The meeting began with a welcome and introduction to the meeting by the chair and Executive Director of Professional Practice. Panel members and staff introduced themselves to the group and the lead staff member described the group’s charge, the overview of the goals of the project, and outlined the meeting agenda. The process and timeline to develop a Qualified Clinical Data Registry (QCDR) was discussed, including the necessary components for APA to self-nominate to CMS: (1) having a minimum of 25 participants in our registry, (2) an attestation statement verifying data results, (3) the ability to submit data via an approved and secure method, and (4) a data validation plan. The anticipated period for submitting the self-nomination for the 2018 performance year is September 1 – November 1st of the prior year. Committee members asked about whether there could be competition from independent companies proposing mental/behavioral health focused QCDRs, and if there could be a rush of self-nominations on November 1st. While it is impossible to know definitively, the committee and staff members agreed that it was unlikely there would be additional entities working on mental/behavioral health registries other than the American Psychiatric Association’s (ApA) QCDR. Committee members also wondered if there would be any possibility in collaborating with ApA.

Next an update on the Medicare Access and CHIP Reauthorization Act (MACRA) and the Quality Payment Program (QPP) was provided by government relations staff. In particular, the new proposed rule for year 2 of QPP was highlighted, which includes increasing the low volume threshold (LVT) exemption, which was created to ease burden on small practices. In 2017, the LVT exempts eligible clinicians (EC) if they treat fewer than 100 Medicare beneficiaries or have equal or fewer than $30,000 in allowed charges. However, in 2018, the proposed rule expands exemption to any EC who treats fewer than 200 beneficiaries or has equal or fewer than $90,000 in allowed charges. This expansion is likely to apply to the majority of psychologists who bill Medicare, particularly those in private or solo practices, making it unlikely that they will have to report MIPS under the QPP. Finally, the proposed rule would not allow EC’s who fall under the LVT to voluntarily participate under QPP in order to be eligible to receive bonuses or increased reimbursement. CMS has also proposed the possibility of allowing ECs to form
“virtual groups” which would enable them to bi-pass the LVT. CMS is also encouraging specialty societies to create their own QCDRs with metrics that are meaningful to their members, and is moving people away from claims-based reporting.

Following a mid-morning break, staff members from the Center for Psychology and Health discussed their interest in collaborating with the QCDR project to help meet needs related to their SAN 2.0 grant. Through the grant, they plan to enroll 6,000 psychologists and other mental health professionals who are interested in learning about- and transitioning into integrated care settings. In addition to workforce development, which includes a 6-hour on-demand educational video on integrated care basics, the goal is to move individuals toward value-based payment models. Enrollees are required to participate in a practice assessment interview, and the assessment score will be used to provide technical assistance to the practices to engage in more quality improvement activities. CMS is requiring that enrollees track two declared quality metrics: depression screening and a composite substance use measure. The QCDR will allow enrollees to report measures which can then be reported to the grant. There is no requirement that enrollees report directly to MIPS. The current enrollment is 62 individuals with 2 more years of recruitment left on the grant.

A brief presentation of APAPO registry participation from 2014-2016 revealed that the majority of participants were psychologists and/or solo practitioners. Clinical social workers and practitioners in skilled nursing facilities were also important participants in the registry up to this point. These data, coupled with the information presented by government relations and the Center of Psychology and Health, provided the foundation for the main discussion of the morning: to identify the target audience for the QCDR and registry going forward. The advisory committee agreed that it was important to keep the issue of value proposition for registry participants in the big picture throughout all discussions. As one example of this, many noted it would be beneficial if the registry and associated data could be used to negotiate reimbursement with 3rd party payers, and/or to collaborate with them in some way, such as by getting on insurance panels. Collaborations could also exist with individual state’s Departments of Labor (i.e., workman’s compensation) and Medicaid-based payers. Two barriers that committee members highlighted include that many 3rd party payers/managed care utilize their own proprietary measures and may not be interested in the measures in the registry. Further, many practitioners may be paneled with only one insurance company limiting their ability/need to negotiate.

The goal of the registry also needs to be to demonstrate/enhance psychotherapy effectiveness and may have the potential to differentiate psychologists from other providers (e.g., masters-level practitioners). Such data could be used in a practitioner’s marketing materials and efforts. One example could be the use of “badging” on websites and other forums (e.g., Psychologist Locator Service). Additional benefits noted include collaborating with ABPP to assist with board certification renewals, and ASPPB and their interest in a maintenance of competence (MOC) model for state licensing. Finally, the registry provides the opportunity to connect users to continuing education opportunities, and if these could be provided for free that might serve as a significant incentive for psychologists to participate. Following this robust discussion, six potential audiences were identified: (1) MIPS reporters including ACOs, (2) SAN 2.0 grant enrollees, (3) psychologists who do not need to report to CMS (includes both those in integrated care but also solo and group practices), (4) other health care providers (e.g., clinical social workers), (5) commercial/ government entities (i.e., National Council), and (6) consumers.
After a break for lunch, the Advisory Committee was joined by representatives from Healthmonix, the vendor with whom APAPO has contracted to develop the QCDR and the registry’s other potential uses and functions. The President and Founder of Healthmonix provided an introduction and orientation to the registry, reviewing the three components of MIPS (i.e., Quality, ACI, and Improvement Activities). A QCDR can include 30 custom measures and as many MIPS measures as appropriate. Individuals who use the registry will typically select 6-15 measures to report on over the course of the reporting period; one of those measures must be an outcome measure or at least one high priority measure if there is no appropriate outcome measure available. As the group begins to think about selecting measures for the APA QCDR, it’s important to keep in mind including at least some measures that are cross-cutting, high priority, and have available benchmarks, in addition to measure sets based on a specific diagnosis. This requires a balance of depth vs breadth when it comes to metrics. Further, if the group decides to create new measures, metric specifications will need to be determined which includes identifying the reporting frequency and period, the denominator and numerator, and the CPT and ICD codes associated with that measure.

A large amount of time during the afternoon was devoted to open discussion between the committee members and Healthmonix to better understand the requirements and the functionality of the registry. For example, committee members acknowledged that there is a lot of room for interpretation of the measures given how they are defined by the steward(s). The topic of risk adjusting measures to account for patient severity was also raised. Unfortunately, this is a common problem across all specialties when it comes to measurement and there currently is no agreed upon algorithm for risk-adjusting measures. A recent report by ASPE with their recommendations to CMS on risk adjustment was added to the committee Dropbox for further review. Another option would be to use strata within measure reporting to risk adjust outcome measures. It will also be important to educate providers that the goal of measuring outcomes is to enhance treatment effectiveness and not to identify “bad providers” or “bad therapists.” In addition to identifying measures, the group will also need to identify which Improvement Activities to include in the QCDR and what resources to provide within each activity.

The day concluded with a review of the progress of the day and previewing the agenda for Saturday. Of particular importance, the group noted that all options for measurement selection and registry functionality needed to be considered within the given timeline for self-nomination. As such, short-term, intermediate- and long-term goals for the registry will likely need to be set at the end of the 2-day meeting and going forward.

Saturday

The second day of the meeting started with a discussion of APA’s Conflict of Interest policies and procedures, and the forms were completed and signed. Next the group reviewed the report from the Expert Group convened in October 2015 to discuss the development of a QCDR. The Expert Group had identified four potential domains that were important to consider: (1) Measures, (2) Dissemination and Implementation, (3) Data management, and (4) Software platform. Specifically, measures need to be “free, elegant and brief” and include process, outcome and structural measures per recommendations made in the recent IOM report. They identified four domains of potential measures: role functioning, dropout (as a structural measure/proxy for alliance), symptom or disease management (including chronic health conditions), and patients’ perception of care. Within these domains, specific examples of measures were suggested including assessing adjustment disorders related to chronic medical
conditions; sleep; pain; and investigating the inclusion of PROMIS scales. The group also expressed interest in measuring attention to- or attainment of treatment goals in therapy. Measures need to be conceptually or empirically linked to the “need to know” aspects of care as opposed to the “nice to know” measures of care. And most critically, these measures need to capture change that is meaningful to the patients themselves, as well as to clinicians and to the health care system. Dissemination and Implementation was identified by the expert group as possibly the most important and challenging domain to address in the project. For example, training materials will need to be developed for: (1) how to use these metrics in order to make it beneficial to patient care; (2) how to improve care rather than punish providers; and (3) how to protect against cherry picking (i.e., only measuring care that makes provider look good). Data Management and software platform are also critical areas that will be addressed collaboratively with Healthmonix.

The committee agreed that the discussion from yesterday mirrored much of what was identified by the 2015 expert group. The remainder of the morning was spent reviewing available measures, identifying any gaps, and beginning to make selections on what additional measures to include in the QCDR, including any potential new measures that would need specification. The group proposed adding all MIPS measures included in the psychiatry registry that were not already in the APAPO registry but also had a couple of related questions to address to Healthmonix: (1) why is the data submission method for some items listed as “EHR only” and how does that impact our registry users, and (2) are there concerns about including measures that end up not being used by registry users? The committee also reviewed additional MIPS measures not included in either registry, a list of measures from PCPI, and a list of measures from the National Quality Forum (NQF). Measures from these lists were identified for further exploration and potential inclusion in the registry (NQF #0109, 1919, 0493, 0492, 1884, 1885, 0008, 0005).

The committee used a white board to facilitate brainstorming categories of measures that were important. The list included:

- Anxiety, sleep, pain (“low hanging fruit“)
- Functional measure, patient satisfaction, patient-reported outcomes, social determinants
- Child, teen, adult
- Diagnoses/common problems: depression, anxiety, PTSD, trauma, eating disorders, disruption behavior, physical disease
- Quality of life/coping in patients with significant disease
- Diversity/disparities
- Medical Screening (including transplant, bariatric)
- More nuanced substance use disorder items
- Violence screening/Adverse childhood experiences screening
- Developmental screening
- Sexuality disorders
- Gender identity

The committee also considered whether it was possible to create composites for medical disorders based on metrics, what role biometrics may play in outcome measurement, and whether a patient portal was an option in the future. The above list was then used to create a matrix/table of priority domains and gaps.
<table>
<thead>
<tr>
<th>Priority Domains</th>
<th>Do any quality metrics exist?</th>
<th>Do free, established scales exist?</th>
<th>What do we need?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>No</td>
<td>GAD-7</td>
<td>Need both process and outcome</td>
</tr>
<tr>
<td>Functional Outcome</td>
<td>Yes (process)</td>
<td>WHODAS (12 item; 36 item)</td>
<td>Need an outcome measure</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Yes – CAHPS &amp; ECHO</td>
<td></td>
<td>Might need better option</td>
</tr>
<tr>
<td>Trauma</td>
<td>No</td>
<td>PC-PTSD (screen)</td>
<td></td>
</tr>
<tr>
<td>Disruptive Behaviors (children)</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUD</td>
<td>Yes – process/screening</td>
<td></td>
<td>Need tx outcomes, closing referral loop</td>
</tr>
<tr>
<td>Sleep</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Determinants</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>No</td>
<td>PCL</td>
<td></td>
</tr>
</tbody>
</table>

Based on the priority matrix, it was agreed that the committee would attempt to specify the GAD-7 to add an anxiety outcome measure to be included in the QCDR before the self-nomination deadline. The second priority would be developing a functional outcome measure within the next year. A process measure for functioning currently exists and is being proposed to include in the current registry. Social determinants and sleep were the other two priority metrics identified to be investigated further within the next year.

After the lunch break, the afternoon was spent discussing issues related to dissemination and implementation. One proposal was to include different levels of resources in the registry based on a user’s level of familiarity and expertise with outcome measurement (i.e., basic, intermediate, advanced). The committee also suggested the following resources need to be available to users:

- How to use metrics in your practice
- Patient education materials about measures and why to use them
- Vulnerabilities of measurement
- De-mystifying measurement
- HIPAA
- Expectations regarding performance
- How the data will be used
- Definitions/FAQ
- Video/webinars on why this is beneficial (i.e., as a way to attract clients, badging)
- Linking to free CE’s
- How the measures were developed and used
- Providing a suite of scales
- Using metrics in healthcare more broadly
Next the committee discussed avenues to disseminate information to stakeholders/potential registry users, including:

- 2018 Practice Leadership Conference (PLC)
- 2018 APA Convention with CE credit
- APA divisional newsletters and listserves
- Interdivisional Health Committee
- Division leadership conferences/mid-winter meetings
- 2017 division meetings at convention
- Exhibitor booth
- APAPO Podcast
- Good Practice Magazine/Practice Update
- APAGS/Early Career Psychologists
- Training programs/CUDCUP
- State Psych Associations
- ASPPB/ABPP

The committee also suggested having an early adopter program/incentive, collaborating with the Trust, including user testimonials, and investigating whether CE’s can be offered for reporting outcomes. Engaging in market research to ascertain potential user feedback was also suggested. The committee also proposed expanding the workgroup to include other stakeholders – namely a consumer representative and a clinical social worker representative. Finally, the group agreed that a monthly recurring phone call would helpful to stay on track with project goals.