Measure ID: PP13

Measure Name/Title

Reduction In Suicidal Ideation Or Behavior Symptoms

1. Descriptive Information

1.1 Measure Type

Outcome: Patient-Reported Outcome-based Performance Measure (PRO-PM)

1.2 National Quality Strategy (NQS) domain

Effective Clinical Care

1.3 Meaningful Measure Area

Prevention, Treatment, and Management of Mental Health

1.4 Brief Description of Measure
The percentage of individuals aged 18 and older who demonstrated a reduction in suicidal ideation and/or behavior symptoms based on results from the Columbia-Suicide Severity Rating Scale 'Screen Version (CSSRS), within 120 days after an index assessment.

2. Measure Specifications

2.1 Data Dictionary, Code Table, or Value Sets
See Appendix A for data elements.

2.2 For an instrument-based measure
See Appendix B for copy of instrument.

2.3 Numerator Statement
Individuals who demonstrated a reduction in suicidal ideation and/or behavior symptoms as demonstrated by results of a follow-up assessment using the CSSRS within 120 days after the index assessment during the measurement period.

2.4 Numerator Details

- **Reduction:** Any decrease in score.

- **Follow-up Assessment:** Follow-up assessment using the CSSRS at a separate encounter from the baseline assessment. This assessment was administered within 90 days (+30 days) after the baseline assessment within the 16-month measurement period. If there are multiple assessments during the measurement period, the last assessment completed within 90 days (+30 days) after the baseline assessment was counted as the follow-up assessment.

- **Columbia-Suicide Severity Rating Scale 'Screen Version':** Suicidal ideation and behavior should be assessed using the Columbia-Suicide Severity Rating Scale 'Screen Version' or the 'Since Last Visit' version of the CSSRS. The CSSRS includes a 6-item patient self-reported tool that asked about wish for death, thoughts of suicide, suicidal thoughts with method without specific thoughts or intent, suicidal intent without and with specific plan, and suicide behavior along with the intensity of suicidal ideation subscale. The subscale is rated on a 5-point scale (1=least severe to 5=most severe).

- **Baseline Assessment:** Defined in denominator details.

- **Measurement Period:** A 16-month period, starting 4 months prior to the measurement year through the 12 months of the measurement year.

2.5 Denominator Statement

Individuals aged 18 and older with suicidal ideation and/or behavior symptoms OR deemed a suicide risk based on their clinician's evaluation using the CRPSR or similar tool and have an encounter with an index assessment completed using the CSSRS during the denominator identification period.

2.6 Denominator Details

- **Age Range:** Individuals aged 18 and older as of the date of the baseline encounter.

- **Suicidal Ideation and/or Behavior Symptoms:** Any non-zero score on the CSSRS or clinician determination of increased suicide risk.

- **Codes used to identify mental health and/or substance use disorder:** Mental, Behavioral, and Neurodevelopmental disorders, ICD-10 F01–F99
- **Codes used to identify outpatient encounters (Table 3):** 99205, 99211-99215, 90791, 90792, 99241-99245, 90832, 90834, 90837, 90839, 90847, 90853, 90845, 96110, 96127, 99441-99443, 90865, 90867, 90868, 90869, 90870, 90875, 90876, 90880, 96118, 90901, 90911

- **Baseline Assessment:** The encounter when the individual first completes the CSSRS was counted as the baseline assessment. If there are multiple assessments during the measurement period, the first assessment completed during the denominator identification period was counted as the baseline is.

- **Denominator Identification Period:** The period in which individuals can have an encounter with a baseline assessment using the CSSRS. The denominator encounter period is the 12-month window starting 4 months prior to the measurement year and ending 8 months into the measurement year.

2.7 Denominator Exclusions

Exclusion(s):

1. Patients were excluded from the denominator if the patient had a documented diagnosis of any mental health condition with a high likelihood of impaired functional capacity, motivation, and/or altered ability to use an assessment tool during denominator identification period.
2. Patient deceased during the measurement period.

Exception(s):
Not applicable

2.8 Denominator Exclusion Details

ICD-10 codes for exclusion included:

- F00-09: Mental disorders due to known physiological conditions
- F70-79: Intellectual disabilities
- F80-89: Pervasive and specific developmental disorders.

2.9 High Priority Status
Yes

2.10 Type of Score
rate/proportion

2.11 Telehealth
Yes

2.12 Number of performance rates
1

2.13 Traditional vs. inverse measure
Traditional

2.14 Interpretation of Score
Better quality = higher score

2.15 Stratification Details/Variables

The measure will be stratified by age, sex, and major mental health comorbidity.

2.16 Risk Adjustment Type

stratification by risk category/subgroup

2.17 Calculation Algorithm/Measure Logic

STEP 1: Initial denominator population. Identify all individuals aged 18 and older with suicidal ideation and/or behaviors and an encounter with an index assessment completed using the CSSRS during the denominator identification period as defined in sections 3.8 and 3.9.

STEP 2: Identify exclusions from denominator. For all individuals included in the denominator in Step 1 above, identify all individuals that meet the exclusion criteria as defined in sections 3.10 and 3.11. (Exclusion criteria will be determined during testing).

STEP 3: Identify final denominator population. For all individuals included in the denominator in Step 1 above, identify and remove all individuals that meet the exclusion criteria as defined in sections 3.10 and 3.11. (Exclusion criteria will be determined during measure testing).

STEP 4: Identify final numerator population. Identify all individuals who demonstrated a reduction in suicidal ideation and/or behavior symptoms as demonstrated by results of a follow-up assessment using the CSSRS within 120 days after the index assessment during the measurement period, as defined in sections 3.6 and 3.7.

STEP 5: Document exceptions. For all individuals who did not meet numerator criteria, check for documented exceptions as defined in criteria in sections 3.10 and 3.11.

STEP 6: Calculate the performance score for the given measurement period as follows:

Performance Score = Final Numerator Population (Step 4) ÷ Final Denominator Population (Step 3)

For the current measure, calculations were performed at the provider and site level. A given patient may see multiple providers in a single day, all of whom may utilize the patient-reported measure data in care. All providers associated with the index patient encounter are credited toward measure performance.

2.18 Survey/Patient-Reported Data
Patient-reported assessment results were uploaded to each patient's electronic medical record.

2.19 Data Source
- claims data
- patient medical records (i.e., paper-based or electronic)
- registries
- patient-reported data and surveys

2.20 Data Source or Collection Instrument

Electronic patient medical record data, which included results of patient-reported outcome assessments, from three sources were used in the testing of this process measure. All data elements requested consisted of structured data fields.

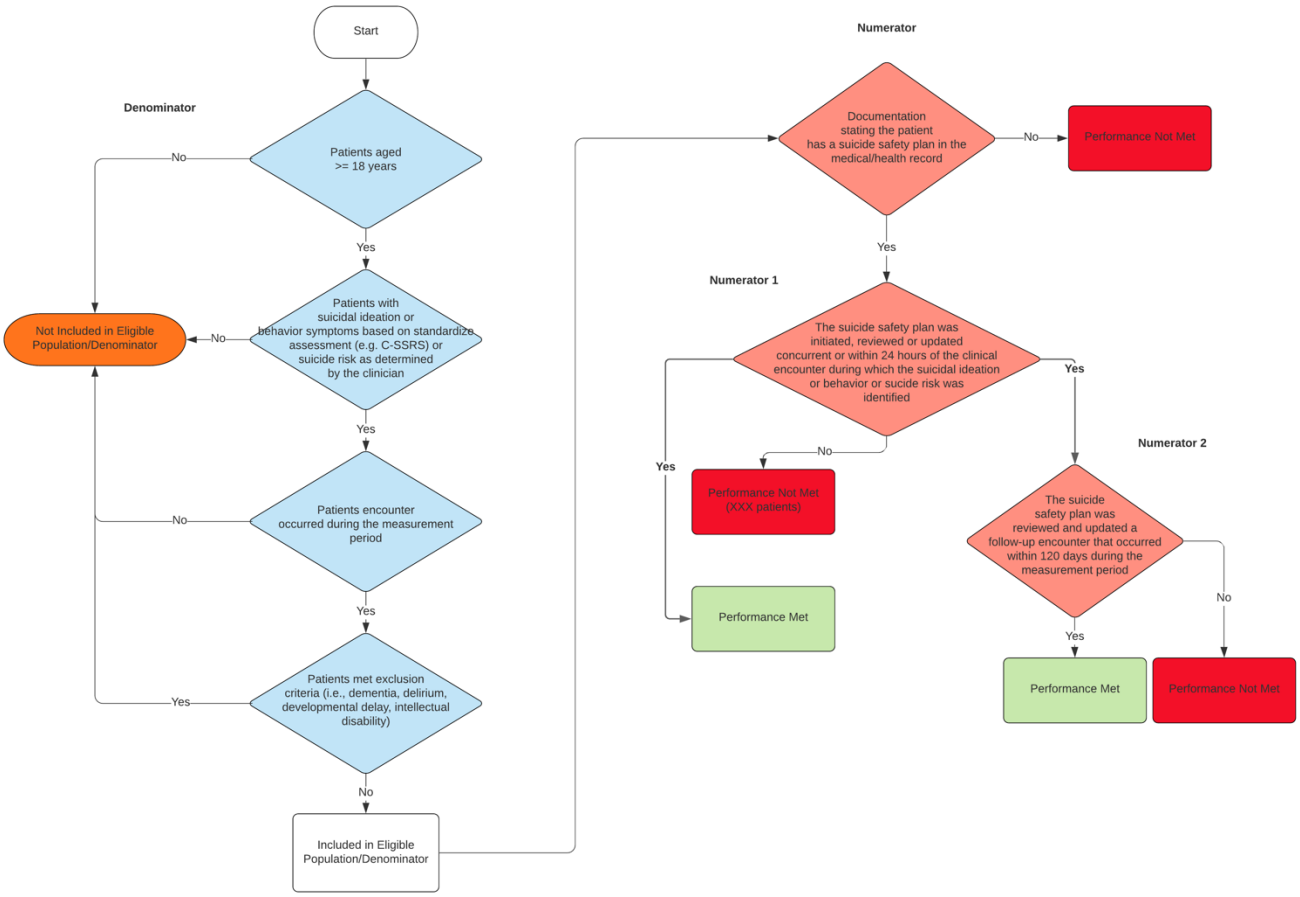
3.21 Data Source or Collection Instrument (Reference)
Columbia-Suicide Severity Rating Scale (CSSRS)

3.22 Level of Analysis
- individual clinician
- group/practice

3.23 Care Setting

- clinician office/clinic
- behavioral health: Outpatient

Figure 1. Measure specification logic



Appendix A: Data Elements

Data Element & Description	Validity Test Logic
gender Patient's sex	gender %in% c("MALE" "FEMALE")
signed_date Suicide safety plan date	signed_date >= "2019-09-01" & signed_date <= 2020-12-31
servicedate Encounter date	servicedate >= "2019-09-01" & servicedate <= 2020-12-31
ageatservice Age at encounter, derived from date of birth – encounter date	ageatservice >= 18 & ageatservice <= 120
cpt_code Encounter CPT code	cpt_code %in% cpt_codes [codes from denominator criteria]
phq_date PHQ-9 date	phq_date >= "2019-09-01" & phq_date <= 2020-12-31
phq9_9 PHQ-9 item 9 response	phq9_9 %in% c("Yes", "No)
completed_date PHQ-9 completion date	completed_date >= "2019-09-01" & completed_date <= 2020-12-31
user_decision Clinician's decision as to patient's suicide risk	user_decision %in% c("Enroll", "Do not enroll", "Unenroll", "Keep in pathway")
si_wish_dead_month CSSRS item 1	si_wish_dead_month %in% c("Yes, No)
si_wish_dead_visit CSSRS item 1	si_wish_dead_visit %in% c("Yes, No)
si_nonspec_active_month CSSRS item 2	si_nonspec_active_month %in% c("Yes, No)
si_nonspec_active_visit CSSRS item 2	si_nonspec_active_visit %in% c("Yes, No)
si_active_no_int_month CSSRS item 3	si_active_no_int_month %in% c("Yes, No)
si_active_no_int_visit CSSRS item 3	si_active_no_int_visit %in% c("Yes, No)
si_active_no_plan_month CSSRS item 4	si_active_no_plan_month %in% c("Yes, No)
si_active_no_plan_visit CSSRS item 4	si_active_no_plan_visit %in% c("Yes, No)
si_active_plan_month CSSRS item 5	si_active_plan_month %in% c("Yes, No)
si_active_plan_visit CSSRS item 5	si_active_plan_visit %in% c("Yes, No)
begin_date ICD-10 diagnosis date from problem list	begin_date >= "2019-09-01" & begin_date <= 2020-12-31
icd10_code ICD-10 diagnosis code	str_detect(icd10_code, "^F")
loc_type Encounter location type	loc_type == "Outpatient"

Appendix B. Instruments

Columbia-Suicide Severity Rating Scale 'Screen Version' plus the Intensity of Ideation Subscale of the 'Since Last Visit' version of the CSSRS (CSSRS+)

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it.*"		
4) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		

6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask: *Was this within the past three months?***	**YES**	**NO**

- Low Risk
- Moderate Risk
- High Risk

COLUMBIA-SUICIDE SEVERITY RATING SCALE 'SINCE LAST VISIT' VERSION (CSSRS): INTENSITY OF IDEATION SUBSCALE

Frequency

How many times have you had these thoughts?

(1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day

Duration

When you have the thoughts, how long do they last?

(1) Fleeting - few seconds or minutes
(2) Less than 1 hour/some of the time
(3) 1-4 hours/a lot of time
(4) 4-8 hours/most of day
(5) More than 8 hours/persistent or continuous

Controllability

Could/can you stop thinking about killing yourself or wanting to die if you want to?

(1) Easily able to control thoughts
(2) Can control thoughts with little difficulty
(3) Can control thoughts with some difficulty
(4) Can control thoughts with a lot of difficulty
(5) Unable to control thoughts
(0) Does not attempt to control thoughts

Deterrents

Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?

(1) Deterrents definitely stopped you from attempting suicide
(2) Deterrents probably stopped you
(3) Uncertain that deterrents stopped you
(4) Deterrents most likely did not stop you
(5) Deterrents definitely did not stop you
(0) Does not apply

Reasons for Ideation

What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?

(1) Completely to get attention, revenge or a reaction from others
(2) Mostly to get attention, revenge or a reaction from others
(3) Equally to get attention, revenge or a reaction from others and to end/stop the pain
(4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)
(0) Does not apply

Current Concern about Potential Suicide Behavior

Clinician Rating of Current Concern About Potential Suicide Behavior:

Note: The items below should serve as a guideline of minimum factors to be considered when determining your concern about the patient's potential risk for suicidal behaviors.

Is there evidence of:

L ONG-TERM FACTORS:		
1. Any history of suicide attempt?	❑ No	❑Yes
2. Any history of mental illness?	❑ No	❑Yes
3. Any history of physical or sexual abuse?	❑ No	❑Yes
4. Long-standing tendency to lose temper or become aggressive with little provocation?	❑ No	❑Yes
5. Chronic severe pain or disabling illness?	❑ No	❑Yes
6. Past suicidal behavior in family or associate?	❑ No	❑Yes
RECENT EVENTS (within the past 3 months)		
1. Recent significant loss?	❑ No	❑Yes
2. Recent psychiatric admission or discharge?	❑ No	❑Yes
3. Recent first diagnosis of any psychiatric disorder?	❑ No	❑Yes
4. Recent worsening of depressive symptoms or increase in alcohol abuse?	❑ No	❑Yes
CURRENT STATUS (within the last week)		
1. Current preoccupation and plans for suicide?	❑ No	❑Yes
2. Current psychomotor agitation or marked anxiety?	❑ No	❑Yes
3. Current prominent feelings of hopelessness?	❑ No	❑Yes
4. Currently living alone?	❑ No	❑Yes

VERY HIGH RISK might include:

- **Current abnormal mental state with agitation**
- **Current depression or other mood disorders with comorbid aggression, increased impulsivity, severe anxiety, or alcohol or benzodiazepine use**
- **Preoccupation and plans for suicide**
- **Current major loss or anticipated loss**
- **Recent discharge from the hospital after treatment for a suicidal state with residual ideation**
- **Availability of lethal means**

Clinician's Rating of the level of concern about potential suicidal behavior:

What is your level of concern about potential suicidal behavior for this patient?

- ❑ Lowest concern (no prior or current concern about suicidal behavior)
- ❑ Some concern (prior history of suicidal ideation or behavior, but preventing suicidal behavior is not a focus of the current clinical management)
- ❑ Moderate concern (preventing suicidal behavior is part of current clinical management of the patient)
- ❑ High concern (preventing suicidal behavior is one of the main goals in the current management of the patient)
- ❑ Imminent concern (preventing suicidal behavior is the most important goal in the current clinical management of the patient)