

New Behavioral Health Measures for Workgroup Consideration: September 30, 2015

| Information/Suggestion from: | Measure Name | NQF-Endorsed | NQF # | Measure Steward | Description | Data Required for Measure | Notes |
|-------------------------------------|---|--------------|-------|--|--|-------------------------------|---|
| Laura Pennington WAACP | Child and Adolescent Major Depressive Disorder: Diagnostic Evaluation | Yes | 1364 | AMA-convened Physician Consortium for Performance Improvement | Percentage of patients aged 6 through 17 years with a diagnosis of major depressive disorder with documented evidence that they met the DSM-IV criteria [at least 5 elements with symptom duration of two weeks or longer, including 1) depressed mood (can be irritable mood in children and adolescents) or 2) loss of interest or pleasure] during the visit in which the new diagnosis or recurrent episode was identified | Clinical | |
| Laura Pennington WAACP/ Robert Hilt | Depression: percent of clinically significant depression patients who, within one month of last New Episode Patient Health Questionnaire (PHQ), are on an antidepressant and/or in psychotherapy. | No | NA | HRSA Health Disparities Collaboratives : Depression Collaborative Federal Government Agency [U.S.] | Numerator: All clinically significant depression patients with a New Episode Patient Health Questionnaire (PHQ) in the last 12 months who were on an antidepressant or in psychotherapy within one month of last New Episode PHQ Denominator: All clinically significant depression* patients having a New Episode Patient Health Questionnaire (PHQ)** in the last 12 months. *Clinically significant depression = Patient with a diagnosis of depression and a New Episode PHQ of 10 or greater | Clinical | Used in primary care settings to assess the percent of clinically significant depression* patients who, within one month of last New Episode Patient Health Questionnaire (PHQ)**, are on an antidepressant*** and/or in psychotherapy. From Dr. Hilt: Although we do not have access to severity measures like the PHQ-9 in this state, insurers would have access to new claims with a diagnosis of depression and then could see whether there are subsequent claims for an antidepressant or psychotherapy visit in the next month. So I think this one is a fair consideration—it is an imperfect measure of receipt of treatment, but better than having no measure. |
| Jennifer Sabel, DOH | Hospital discharges attributable to alcohol | No | NA | DOH | Patients hospitalized for conditions due to alcohol | Hospital Discharge Data/CHARS | Detailed measure specifications/definitions would need to be developed. These could be available at state and county levels, and because they use ICD codes could be measured by most plans as well. |
| Jennifer Sabel, DOH | Hospital discharges attributable to drug use | No | NA | DOH | Patients hospitalized for conditions due to drug use | Hospital Discharge Data/CHARS | Detailed measure specifications/definitions would need to be developed. These could be available at state and county levels, and because they use ICD codes could be measured by most plans as well. |

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| Jennifer Sabel, DOH | Hospital discharges, depression and episodic mood disorders | No | NA | DOH | Patients hospitalized for Episodic Mood and Depressive Disorders | Hospital Discharge Data/CHARS | Detailed measure specifications/definitions would need to be developed. These could be available at state and county levels, and because they use ICD codes could be measured by most plans as well. |
| Kathy Bradley, GHC | Patient Experience: Screening and Brief Alcohol Intervention (BI) | No | NA | VA? | "In the past 12 months has a doctor or other health care provider advised you about your drinking (to drink less or not to drink alcohol)?" This question would be added to an existing CAHPS survey. The question is preceded by a brief alcohol screening question and only patients who drink answer the BI question. | Patient Survey/CAHPS | Requiring a few additional questions on a patient experience survey seems feasible given importance of global burden of alcohol-related disease. The VA has used this measure since 2004 and patients who report BI on the measure have higher satisfaction with their care generally and their provider specifically. Health plans field the CAHPS survey annually. The Alliance has been fielding the CG-CAHPS every other year. The current CG-CAHPS survey used by the Alliance includes the question: "In the last 12 months, did you and anyone in this provider's office talk about alcohol use or drug use?" This could easily be altered in future surveys. The real question will be funding for implementing the CG-CAHPS statewide in future years -- this is very expensive (estimated at \$600,000 per survey cycle). |

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| Robert Hilt | Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements | Yes | 649 | AMA- convened Physician Consortium for Performance Improvement | <p><u>Numerator Statement:</u> Patients or their caregiver(s) who received a transition record at the time of emergency department (ED) discharge including, at a minimum, all of the following elements:</p> <ul style="list-style-type: none"> •Summary of major procedures and tests performed during ED visit, AND •Principal clinical diagnosis at discharge which may include the presenting chief complaint, AND •Patient instructions, AND •Plan for follow-up care (OR statement that none required), including primary physician, other health care professional, or site designated for follow-up care, AND •List of new medications and changes to continued medications that patient should take after ED discharge, with quantity prescribed and/or dispensed (OR intended duration) and instructions for each. <p><u>Denominator Statement:</u> All patients, regardless of age, discharged from an emergency department (ED) to ambulatory care (home/self care) or home health care</p> | Clinical | This is follow-up to our last discussion re: NQF 2605 which is on the "Maybe List." Looked for but did not find a quality metric regarding how often <u>children</u> presenting to emergency rooms get follow up appointments specifically in mental health. This is NQF 0649, which is a measure about all sorts of follow up plans from an ED for all ages, but not specifically mental health. So we only have the NQF 2605 which we discussed together as addressing ED follow up for adults with mental health problems. |

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| Kara Panek | Mental Health Consumer Survey | No | NA | DSHS | The survey uses the Mental Health Statistical Improvement Program (MHSIP) questionnaire with versions for adult (18-21 years), youth (13-17), and child/caregiver (under 13). The Youth and Child/Caregiver questionnaires have additional questions pertaining to Child and Family Teams. The instrument has a telephone, paper, and Web-based version. Who Completes the Survey: A random sample of adult, youth, and child/caregiver consumers of publicly funded outpatient MH services in Washington State. | Patient Survey | Who Administers the Survey: The Social and Economic Sciences Research Center (SESRC) of Washington State University (WSU) is contracted to administer the survey annually through interviews conducted mainly by telephone with paper and Web options available. |

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| Laura Pennington | Screening, Brief Intervention or Referral to Treatment - Oregon SBIRT Measure | No | NA | Oregon Health Authority | Numerator: Unique counts of members age 12 years as of December 31 st of the measurement year who completed a full, standardized screening tool for alcohol/ substance use, or received screening and a brief intervention, as indicated by one of several CPT or HCPCS codes (see attached for detail). Denominator: Unique count of members age 12 years as of December 31 st of the measurement year, and having received an outpatient service as identified by one of several codes (see attached for detail). | Claims and Clinical | Feedback received from Oregon partners: The metric here is defined as: # of pts. 18+ seen within the last year who received a full screen and brief intervention/ total # of patients 18+ who have been seen for a visit in the last year. There are basically two main complaints –First, the brief annual screen is not a billable service, only full substance use assessments (AUDIT/DAST) are eligible for reimbursement. So there is no incentive for clinics to conduct universal annual brief screening and this increases the likelihood of targeted screening, where patients are profiled as being likely to suffer from a substance use issue and only screened when meeting the health system profile of a patient with risky substance use behaviors. Basically, the metric is built around a type of screen they can't bill for. Similarly, because brief interventions are considered a behavioral health visit, clinics can bill -- but they do not get reimbursed for this service because it occurs on the same day as a physical health visit. This strains clinics financially and requires clinics to add staff capacity without additional revenue to support additional positions. We heard these same complaints last year, when we were considering adding SBIRT then. There may be a disconnect between the metric and billing/reimbursement. In Washington Medicaid reimburses for screening and brief intervention, so this measure may be doable for the Medicaid population. |