



DATE: January 22, 2015  
TO: Performance Measures Coordinating Committee  
FROM: Behavioral Health Measures Selection Work Group  
RE: **FINAL Recommendations for 2016**

## INTRODUCTION AND BACKGROUND INFORMATION

In 2014, the Washington State Legislature passed ESHB 2572, which is a law relating to improving the effectiveness of health care purchasing and transforming the health care delivery system. A portion of this legislation (Section 6) relates to the development and use of a statewide common measure set on healthcare quality and cost. Governor Inslee appointed a Performance Measures Coordinating Committee (PMCC) in June 2014 to oversee this work. In December 2014, the PMCC approved the first Common Measure Set for Washington, including 52 measures. The first report from this initial measure set was co-released by the Washington Health Alliance and Healthier Washington on December 8, 2015.

Looking ahead, work is progressing to modify the measure set for 2016. During the process in 2014, several topics were identified for further consideration in future years. At their June 26, 2015 meeting, the PMCC considered these topics and selected behavioral health as the priority focus area for the selection of one or more additional measures to be added to the Common Measure Set in 2016.

Under the direction of the PMCC, an ad hoc work group was formed for the specific purpose of exploring potential behavioral health measures and recommending a limited number of new measures to be added to the Common Measure Set in 2016. The work group was instructed to formulate their recommendations taking into account: (1) the measure selection criteria used in 2014, and (2) what is feasible to implement in Washington State with currently available data sources. The PMCC indicated that both population and clinically-oriented measures could be considered. The Washington Health Alliance provided staff support for this ad hoc work group, providing both facilitation and technical expertise.

On October 22<sup>nd</sup>, the work group presented its preliminary recommendations to the PMCC. These recommendations are described in detail in a memorandum from the work group to the PMCC dated October 22, 2015.

Following deliberations and the opportunity for public comment at the October 22<sup>nd</sup> meeting, the PMCC decided the following:

1. The PMCC will seek public comment on including the following NCQA measure in the Common Measure Set for implementation in 2016: *Follow-up after Discharge from ER for Mental Health, Alcohol or Other Drug Dependence* (NQF-endorsed #2605).

2. The PMCC will seek public comment on whether to pilot the following four measures in 2016 prior to taking action on their inclusion in the Common Measure Set (for 2017 or beyond). It was made clear that piloting the measures in 2016 means generating results for each of the four measures and evaluating these results at the PMCC before a decision is made whether to include one or more of the measures in the Common Measure Set.
  - a. *Mental Health Service Penetration (Broad Version)*  
Measure Steward: WA State Department of Social and Health Services
  - b. *Substance Use Disorder Treatment Penetration*  
Measure Steward: WA State Department of Social and Health Services
  - c. *Hospital Discharges Attributable to Psychiatric Disorders*  
Measure Steward: WA State Department of Health
  - d. *Hospital Discharges Attributable to Alcohol and Drug Use*  
Measure Steward: WA State Department of Health
3. The PMCC tabled action on the recommendation related to the patient experience survey and asked that the work group revisit this recommendation with the concerns and questions of the PMCC in mind.

A public comment period, facilitated by the WA State Health Care Authority, was held for approximately three weeks during November 2015. Responses to the survey soliciting public comment were limited. There were a total of 26 responses, including 16 complete responses (i.e., all questions were answered). The details may be found in “Attachment 2A\_BH Measures Public Comment.”

The Behavioral Health Measures Selection Work Group re-convened on December 9 to finalize their recommendations to the PMCC. The work group was made aware of the PMCC’s October 22<sup>nd</sup> discussion and decisions. All of the detailed results from the public comment period were made available to the work group prior to the meeting and there was ample time during the meeting to take all of the information into account.

## FINAL WORK GROUP RECOMMENDATIONS FOR BEHAVIORAL HEALTH MEASURES

The following are the final recommendations of the Behavioral Health Measures Selection Work Group to the PMCC.

### Recommendation #1

**Include the following measure in the 2016 Common Measure Set: *Follow-up after Discharge from ER for Mental Health, Alcohol or Other Drug Dependence within 30 days***

- Measure Steward: NCQA (NQF-endorsed #2605)
- Produce four separate rates:
  1. The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge (ages 6-17)
  2. The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge (ages 18 and older)
  3. The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge (ages 6-17)
  4. The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge (ages 18 and older)
- Data Source: Commercial Health Plans and Medicaid Managed Care Organizations
- Units of Analysis for Public Reporting: Commercial Health Plans, Medicaid MCOs (and possibly County and Accountable Community of Health – TBD)

#### Rationale:

This measure is somewhat complementary to the measure already included in the Common Measure Set, *Follow-up after Hospitalization for Mental Illness* (NCQA, NQF #0576), and will provide additional information about transitions in care and community/outpatient follow-up for patients with behavioral health needs following an acute care episode.

This measure is a new measure developed by NCQA and endorsed by NQF in March 2015. It is currently not included in the HEDIS measure set required for health plan accreditation but is being considered for inclusion in the 2017 NCQA-HEDIS measure set (it will come out for public comment in February 2016 with a decision made during 2<sup>nd</sup> quarter 2016).

The NQF-endorsed version of this measure is for individuals ages 18 and older. The Work Group recommends also producing results (separately) for individuals ages 6-17.

Measure specifications are currently available through the NQF website. The measure specifications do not accompany this memo because they are NQF-endorsed.

*[Note: This will be a new measure for health plans and we will require their cooperation to implement the measure for the first time in Washington and share results for public reporting in 2016. Their formal commitment to do so is not in place at this time. We will also need to explore with the health plans whether they would be able to provide data at a county level in order to produce county/ACH results -- results at this level would increase action-ability.]*

---

## **Recommendation #2**

**Include the following two measures in the 2016 Common Measure Set:**

**(1) *Mental Health Service Penetration (Broad Version)***

**(2) *Substance Use Disorder Treatment Penetration***

- Measure Steward: Washington State Department of Social and Health Services
- Produce two separate rates for each measure: (1) Ages 6-17 and (2) Ages 18 and older
- Data Source: Commercial Health Plans and DSHS for Medicaid
- Units of Analysis for Public Reporting:
  - Mental Health Service Penetration: Commercial Health Plans, Medicaid Managed Care Organizations (possibly county and ACH – TBD)
  - Substance Use Disorder Treatment Penetration: Medicaid Managed Care Organizations (possibly county and ACH – TBD)

**Rationale:**

The work group understands that the PMCC was concerned that these measures were not ready for “prime time” and instead wanted to explore the possibility of piloting the measures. However, the work group respectfully disagrees and wishes to maintain its original recommendation to include these measures in the 2016 Common Measure Set.

The proposed mental health and substance use disorder treatment penetration measures are designed to measure access to services to treat or manage behavioral health conditions. Measure specifications can be found in “Attachment 2B\_Penetration Measures Specifications.” [Note: This attachment is very long but is included here for those who want access to the detail.] The proposed measures are analogous to the NCQA HEDIS “Adult Access to Preventive/ Ambulatory Health Services” (AAP) measure which measures access to “primary care” (the AAP measure is in the Common Measure Set). The measures use a two-year window to identify need for Mental Health and Substance Use Disorder treatment services, and then measure the proportion of those in need who used qualifying services in the measurement year. The two-year window to identify need is motivated by the tendency for behavioral health conditions to be under-identified in claims and encounter data. Given that there can be significant variation across health plans and other reporting units in the proportion of enrolled/attributed populations with behavioral health needs, using a need-based denominator provides a form of case-mix adjustment to achieve fairer comparisons of access across reporting entities or organizations.

These metrics were developed by the DSHS Research and Data Analysis Division (RDA), and have been shown in several studies over more than a decade to have a strong relationship to Medicaid client outcomes. That is, clients who meet numerator criteria have, in a variety of studies, better outcomes along many domains (e.g., health service utilization, cost, disease progression, mortality, criminal justice involvement, employment, and housing stability) relative to people who meet the denominator criteria but do not receive treatment as captured in the numerator. Below is a list of links to representative studies, including some in peer-reviewed

journals, using these approaches to define populations “in need,” and the associated “treated” and “untreated” comparison groups. David Mancuso is an excellent resource for questions.

1. Mental health services

- a. <https://www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-3-29.pdf>
- b. <https://www.dshs.wa.gov/sesa/rda/research-reports/outpatient-mental-health-services-and-medical-cost-offsets>

2. Substance use disorder treatment services

- a. <https://www.dshs.wa.gov/sesa/rda/research-reports/impact-substance-abuse-treatment-funding-reductions-health-care-costs-disabled-medicaid-adults-washington-state>
- b. <https://www.dshs.wa.gov/sesa/rda/research-reports/health-impact-substance-abuse-accelerating-disease-progression-and-death>
- c. <https://www.dshs.wa.gov/sesa/rda/research-reports/bending-health-care-cost-curve-expanding-alcohol-drug-treatment>
- d. <https://www.dshs.wa.gov/sesa/rda/research-reports/evaluation-washington-state-screening-brief-intervention-and-referral-treatment-project-cost-outcomes-medicaid-patients-screened-hospital-emergency-departments>
- e. <https://www.dshs.wa.gov/sesa/rda/research-reports/effect-substance-abuse-treatment-medicaid-expenditures-among-general-assistance-welfare-clients-washington-state>
- f. <https://www.dshs.wa.gov/sesa/rda/research-reports/chemical-dependency-treatment-public-safety>

These measures are currently being implemented in the Medicaid environment here in Washington State, where they are being deployed to help support the movement towards increasingly integrated delivery of physical and behavioral health care. These metrics are being adopted for use in 2016 in the Behavioral Health Organization delivery system administered by the DSHS Division of Behavioral Health and Recovery, and will be used statewide in Health Care Authority Apple Health contracting in 2016.

The work group understands the PMCC’s caution insofar as these are “home grown” measures. However, the Common Measure Set already includes other home grown measures, such as the 30-day psychiatric inpatient readmission measure, and doesn’t believe that this, in and of itself, should be a deterrent. In order to keep pace with a rapidly changing industry, the Common Measure Set will need to strike a careful balance between including a majority of tried-and-true, nationally vetted measures along with a small handful of more innovative measures that advance the work and help us target areas of particular interest here in Washington. We know that there are not many nationally vetted measures in behavioral health that we are able to use in Washington with currently available data sources, so this topic area is ripe for innovation.

These are important measures to include in the Common Measure Set. They focus on access to services to treat or manage behavioral health conditions – a major focus area of Healthier Washington. Behavioral health risk factors are a key driver of health care utilization across

physical and behavioral health settings. In addition, behavioral health conditions are key risk factors affecting patient experiences and quality of life across many functional domains. Because of this, the work group believes we need to take steps to increase the amount of information that we have *and share* about access to behavioral health treatment in order to inform the ongoing work of the state, accountable communities of health and health care providers. This is an important starting point for the state and will be foundational for moving us in the right direction.

And, as is the case with NCQA HEDIS measures, RDA expects to continue to revise these metrics over time based on input from plans, providers and other key stakeholders. In particular, there is an expectation that the metrics will continue to evolve to more comprehensively capture services provided to manage behavioral health conditions in a primary care setting.

*[Note: The Mental Health Service Penetration measure will be new for the commercial health plans and we will require their cooperation to implement the measure for the first time in Washington and share results for public reporting in 2016. Their formal commitment to do so is not in place at this time. We will also need to explore with the health plans whether they would be able to provide data at a county level in order to produce county/ACH results -- results at this level would increase action-ability.]*

---

### **Recommendation #3**

**Pilot the following two measures in 2016 and evaluate results at the PMCC before a decision is made about whether to include the measures in the Common Measure Set.**

***(1) Hospital Discharges Attributable to Psychiatric Disorders and (2) Hospital Discharges Attributable to Alcohol and Drug Use***

- Measure Steward: Washington State Department of Health
- Data Source: Washington State Department of Health (CHARS)
- Units of Analysis for Public Reporting: Counties, Accountable Communities of Health

**Rationale:**

The Behavioral Health Measures Selection Work Group agrees that these two measures are important to pilot because they have the potential to provide valuable information about prevalence and level of need. It's understood that the results may not be immediately actionable and there is some discomfort that we're not entirely clear whether more is better or worse. However, all things considered, the work group agreed that it is better to have fewer people hospitalized for behavioral health issues, believing that optimal care is primarily delivered on an outpatient basis in the communities where people live. The results may provide a directional indication about geographic variation within the state and level of need for additional outpatient services in different communities.

A pilot, led by the WA State Department of Health, will provide the opportunity to (1) develop and test detailed measure specifications and (2) facilitate broad agreement on those specifications prior to public reporting. A *preliminary* list of hospital discharge codes is included in "Attachment 2C\_Hospital Discharge Codes." The work group suggests that this list be refined

and that the pilot analysis examines three different denominators in producing rates to determine which one (or more) makes the most sense:

1. County population (per capita) - the work group recommends that the hospital discharge be attributed based on where the patient lives rather than where the hospital is located
2. Hospital discharges (acute medical care only)
3. Total hospital discharges (medical and psychiatric)

---

#### **Recommendation #4**

**Recommend that the CG-CAHPS patient experience survey implemented in Washington state by the Washington Health Alliance be modified to include the following four questions from the Veteran's Administration (VA) Survey of Health Experiences of Patients (SHEP) related to screening and brief alcohol intervention.**

Results would be publicly reported at a statewide level (not at a medical group level).

1. How often did you have a drink containing alcohol in the past 12 months? Consider a "drink" to be a can or bottle of beer, a glass of wine, a wine cooler, or one cocktail or a shot of hard liquor (like scotch, gin or vodka). (Please mark only one.)  
 Never (If never go to question #\_\_\_)  
 Monthly or less  
 2-4 times a month  
 2-3 times a week  
 4-5 times a week  
 6 or more times a week
2. How many drinks containing alcohol did you have on a typical day when you were drinking in the last year?  
 0 drinks (If 0, Go to question # \_\_)  
 1-2 drinks  
 3-4 drinks  
 5-6 drinks  
 7-9 drinks  
 10 or more
3. How often did you have 6 or more drinks on one occasion in the past 12 months?  
 Never  
 Less than monthly  
 Monthly  
 Weekly  
 Daily or almost daily

4. In the past 12 months has a [VA] doctor or other [VA] health care provider advised you about your drinking (to drink less or not to drink alcohol)?

\_\_\_\_\_ Yes

\_\_\_\_\_ No

*[Note: In the Washington Health Alliance’s current version of the CG-CAHPS survey, one question is asked related to alcohol/drug use: In the last 12 months, did you and anyone in this provider’s office talk about alcohol use or drug use? [Yes/No] The four questions listed above would replace this one question in future surveys.]*

Rationale:

This proposed set of questions indicate whether brief advice for unhealthy alcohol use – to drink less or not to drink alcohol - is taking place among patients who screen positive for unhealthy alcohol use on a confidential mailed survey. Measuring brief advice for unhealthy alcohol use is important for the following reasons:

- **High prevalence of unhealthy alcohol use.** The prevalence of unhealthy alcohol use ranges from 10 - 30% in primary care settings: 11 - 26% in three Washington State clinics that recently began screening.
- **High burden of disease.** Unhealthy alcohol use is a major contributor to the global burden of disease, including both disability and death.<sup>1-3</sup>
- **US Preventive Services Task Force (USPSTF) recommends brief alcohol counseling for unhealthy alcohol use in primary care.** Screening and brief alcohol counseling for unhealthy alcohol use has been recommended by USPSTF for primary care since 2004.<sup>4,5</sup>
- **Advice to drink below recommended limits or to abstain is a consistent element** of brief alcohol counseling interventions proven effective in randomized trials.<sup>4</sup>
- **Essential benefit.** Alcohol screening and brief alcohol counseling for patients with unhealthy alcohol use are essential benefits under health care reform based on USPSTF recommendation.
- **Ranked 3<sup>rd</sup> as a Prevention Priority.** When the U.S. Commission on Prevention Priorities ranked preventive interventions—based on the clinically preventable burden and the cost effectiveness of interventions—brief alcohol counseling for unhealthy alcohol use was ranked 3<sup>rd</sup> for adults (below aspirin and tobacco counseling, and *above* blood pressure, mammograms colon cancer screening etc.).<sup>6</sup>

Patient experience surveys, like CG-CAHPS, are an optimal way to measure brief alcohol advice. The Veteran’s Administration (VA) has included an alcohol screening questionnaire and a question about alcohol-related advice on a patient experience survey since 2004, yielding the following results and benefits:



- **The alcohol screening questions on surveys have been used to estimate the prevalence of unhealthy alcohol use in VA outpatients.**
  - ✓ Surveys showed that screening *at the time of outpatient visits* was markedly under-estimating the prevalence of unhealthy alcohol use.<sup>7</sup>
  - ✓ The survey was linked to chart reviews to show that 61% of patients who were screening positive on mailed surveys were missed when they were screened as part of clinical care.<sup>8</sup>
- **The measure of brief alcohol advice was sensitive to changes over time** in the proportion of patients with alcohol-related advice documented in their EHRs.
  - VA quality improvement efforts resulted in a 15% increase in rates of advice reported by patients who screened positive for surveys over 5 years.<sup>9</sup>
  - The measure will plateau if there are limitations in the quality of clinical alcohol screening (if patients with unhealthy alcohol use aren't identified, they won't be advised.)
- **Aligns with appropriate incentives.** Patient surveys get at what the patient experienced (i.e., were they screened and counseled if appropriate), rather than focusing on what was documented in the medical record. If you use chart review, V-codes or CPT codes to measure brief alcohol counseling, two things may happen: (1) fewer patients may be identified with screening<sup>10</sup>, i.e., fewer patients in the denominator may positively impact the score (Note: a regional study suggested that was operating in a VA department in 2013); or, (2) the incentive to the provider is to document rather than offer high quality counseling. It is also possible to arrange settings in an EHR to document that the patient was counseled any time a screen is positive.
- **Association with patient satisfaction.** VA patients with unhealthy alcohol use who report advice on the measure have higher satisfaction with VA care and their VA provider.<sup>11</sup>
- **Tobacco use is assessed similarly on the CAHPS.**<sup>10</sup> Such measures assess patient experience related to advice—which may be more important for predicting changes in behavior than EHR documentation. In the Washington Health Alliance's current version of the CG-CAHPS survey, two questions are asked related to tobacco use:
  1. Do you now smoke cigarettes or use tobacco products every day, some days or not at all?
    - \_\_\_\_\_ Every day
    - \_\_\_\_\_ Some days
    - \_\_\_\_\_ Not at all (If Not at all, Go to question # \_\_)
  2. In the last 12 months, how often were you advised to quit smoking or using tobacco products by this provider?
    - \_\_\_\_\_ Never
    - \_\_\_\_\_ Sometimes
    - \_\_\_\_\_ Usually
    - \_\_\_\_\_ Always

- **Why have we not recommended asking about drug screening and counseling?** Brief alcohol counseling is an essential benefit under the ACA because it is recommended by the US Preventive Services Task Force. The US Preventive Services Task Force does not recommend drug screening and brief counseling because trials have shown no benefit.
  - Agency for Healthcare Research and Quality (2008). Screening in Primary Care Settings for Illicit Drug Use: Staged Systematic Review for the United States Preventive Services Task Force. <http://www.ahrq.gov/clinic/uspstf08/druguse/drugsys.pdf>. Rockville, MD, U. S. Department of Health and Human Services.
  - Roy-Byrne, R., K. Bumgardner, et al. (2014). "Brief Intervention for Problem Drug Use in Safety-Net Primary Care Settings: A Randomized Clinical Trial." JAMA **312**(5): 492-501.
  - Saitz, R., T. P. A. Palfai, et al. (2014). "Screening and Brief Intervention for Drug Use in Primary Care: The ASPIRE Randomized Clinical Trial." JAMA **312**(5): 502-513.

## References

1. Murray CJ, Atkinson C, Bhalla K, et al. The state of US health, 1990-2010: burden of diseases, injuries, and risk factors. *JAMA*. Aug 14 2013;310(6):591-608.
2. Murray CJ, Lopez AD. Measuring the global burden of disease. *N Engl J Med*. Aug 1 2013;369(5):448-457.
3. Lim S, The Global Burden of Disease Collaborators. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet*. Dec 15 2012;380(9859):2224-2260.
4. Whitlock EP, Polen MR, Green CA, Orleans T, Klein J. Behavioral counseling interventions in primary care to reduce risky/harmful alcohol use by adults: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2004;140(7):557-568.
5. Jonas DE, Garbutt JC, Amick HR, et al. Behavioral counseling after screening for alcohol misuse in primary care: a systematic review and meta-analysis for the U.S. Preventive Services Task Force. *Ann Intern Med*. Nov 6 2012;157(9):645-654.
6. Solberg LI, Maciosek MV, Edwards NM. Primary care intervention to reduce alcohol misuse ranking its health impact and cost effectiveness. *Am J Prev Med*. Feb 2008;34(2):143-152.
7. Bradley KA, Williams EC, Achtmeyer CE, Volpp B, Collins BJ, Kivlahan DR. Implementation of evidence-based alcohol screening in the Veterans Health Administration. *Am J Manag Care*. Oct 2006;12(10):597-606.
8. Bradley KA, Lapham GT, Hawkins EJ, et al. Quality concerns with routine alcohol screening in VA clinical settings. *J Gen Intern Med*. Mar 2011;26(3):299-306.
9. Chavez L, Williams EC, Lapham G, Rubinsky A, Kivlahan D, K. B. Changes in patient-reported alcohol-related advice following Veterans Health Administration implementation of brief alcohol interventions. *J Stud Alcohol Drug*, in press. 2015.
10. Bradley KA, Johnson ML, Williams EC. Commentary on Nilsen et al.: The importance of asking patients-the potential value of patient report of brief interventions. *Addiction*. 2011;106(10):1757-1759.
11. Simonetti JA, Lapham GT, Williams EC. Association Between Receipt of Brief Alcohol Intervention and Quality of Care among Veteran Outpatients with Unhealthy Alcohol Use. *J Gen Intern Med*. Aug 2015;30(8):1097-1104.
12. Bush K, Kivlahan DR, McDonell MB, Fihn SD, Bradley KA. The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. *Arch Intern Med*. Sep 14 1998;158(16):1789-1795.
13. Bradley KA, Bush KR, Epler AJ, et al. Two brief alcohol-screening tests From the Alcohol Use Disorders Identification Test (AUDIT): validation in a female Veterans Affairs patient population. *Arch Intern Med*. Apr 14 2003;163(7):821-829.
14. Bradley KA, DeBenedetti AF, Volk RJ, Williams EC, Frank D, Kivlahan DR. AUDIT-C as a brief screen for alcohol misuse in primary care. *Alcohol Clin Exp Res*. Jul 2007;31(7):1208-1217.
15. Johnson JA, Lee A, Vinson D, Seale JP. Use of AUDIT-based measures to identify unhealthy alcohol use and alcohol dependence in primary care: a validation study. *Alcohol Clin Exp Res*. Jan 2013;37 Suppl 1:E253-259.