CONSIDERATION OF ADDITIONAL BEHAVIORAL HEALTH MEASURES FOR THE WASHINGTON STATE COMMON MEASURE SET – RESPONSE TO PUBLIC COMMENT PERIOD, NOVEMBER 2015

Question: Should the following measure be added to the Washington State Common Measure Set on Health Care Quality and Cost in 2016? Follow-up After Discharge from the ER for Mental Health, Alcohol or Other Drug Dependence

YES – 19
NO – 4
I DON'T KNOW – 2

Verbatim Comments

YES Responses

- YES - this may be worth measuring, but it is unclear what the ideal value of the measure would be.
- YES - This will help prevent relapse, ensure patients have appropriate meds and Rx's and get follow outpatient therapy.
- YES - WSHA supports following up with patients after emergency department visits to coordinate ongoing care in the outpatient setting that will help reduce future use of the emergency department.
- YES, as long as there is flexibility in how "follow up" is achieved. The measure should allow for follow-up to occur in both primary care and specialty settings. Also, follow-up should be allowed by face-to-face visits, phone, or electronically (through email, text, etc.). Typically patients have significant shame regarding a hospitalization that involves mental health or substance use disorders. Thus, patients are difficult to get ahold of and/or rarely agree to come into the clinic for a face-to-face visit.
- YES - Appropriate follow up after discharge from the ER could lead to a decline in future ER use, improved overall health, and improved overall outcome for the individual (sobriety, housing, education, etc.).
- YES - This measure should be revised to include space for a flexible follow-up visit definition that includes FU that occurs outside of the mental health specialty setting and face to face visits. A flexible follow-up definition will allow us to fully capture patients that are difficult to reach. An alternative would be to only capture measurements for those who are 18+ during 2016, and begin collecting data for those ages 6-17, after the difficulty in following-up, and its potential data inconsistencies, has been addressed.
- YES - Important to connect with patient at the time of critical health need.
- YES - Would like to clarify, that WCAAP endorsement of this measure is based on there being two data points generated--one for individuals age 18 and up, and another for individuals age 6-17 as proposed by the Washington Health Alliance workgroup. If this measure only looked at adults, then WCAAP would not have any grounds to support the measure as it would be ignoring the health care needs and access to care challenges faced by all children in our state.

- YES - First of all, a 6 year old should not be treated for alcohol or drug dependency!! Also, a 6 year old should not be treated in the ER for behavioral problems i e mental health. Secondly, you may have difficulty following up on these patrons as many are homeless.
- YES - This measurement appears simple enough - it'll verify % of individuals who had proper follow-up within 3o days of discharge.
- YES - They seem useful measures and a good place to begin.
- YES - NQF-Endorsed
- YES - Yes it should be followed/tracked, the issue is to have a plan to increase the availability of providers. It has been very difficult to find providers who are willing to move to our area.
- YES - This should be within 14 days vs 30 since it was an emergency visit and it should allow for a tele-health visit. We should also track near fatal suicides (over 480,000 visits a year) specifically in the ER itself.
- YES - The item seems reasonable to include.

NO and I DON'T KNOW Responses

NO - Two reasons. First, the criteria for follow-up are based on ICD9 which is now defunct. Needs to be updated to ICD10. Second, while it makes follow up for these patients required and reportable, it makes no attempt to provide adequate mental health follow up. I am a family doctor trained to take care of minor mental health issues but I do not feel equipped to deal with psychotic illness and I am not willing to deal with drug abusers.

NO - 30 days for a follow up visit is far too long. The current DSHS measure is 7 days, which is preferable.

NO - There are many factors that would contribute to non-follow-up. Would prefer a true access measure.

I DON'T KNOW - Depends on specific admit complaint and discharge status.

Question: Should Washington State pilot* the following measure in 2016 and evaluate results prior to taking action on its inclusion in the Common Measure Set (for 2017 or beyond)? Mental Health Service Penetration (Broad Version)

YES – 16
NO – 4
I DON'T KNOW – 2

Verbatim Comments

YES Responses

YES - we really won't know whether this measure is potentially valuable without piloting it.

YES - Pilot means the measure will not be used for payment or transparency efforts while underway. It is likely that the definition of this measure may need to evolve significantly. Currently, there is not a good measurement system in place to grasp the strains of limited access to mental health services. The pilot will help us create a system to be able track this better. The mental health penetration measure will help to shed light on access and follow up in outpatient care. One of the state's primary goals is to better integrate mental health and physical health care, access is a fundamental piece to integration. Beginning to track and measure mental health access across the system will increase our ability to make improvements and understand needed changes.

YES - Mental Health Service Penetration should be a measure with the following conditions: 1. Patients seen in the primary care setting by mental health professionals (psychologists, LMHC's, etc.) should count towards the numerator in this measure. Brief intervention treatment is included in the treatment modality for the numerator but the codes listed for primary care only include procedure codes (99201-99215) or 99241-99255. Mental health professionals in primary care utilize mental health codes (90801-90889) or Health and Behavior Codes (96150-96154). 2. As the measure currently reads, a patient receiving an intake evaluation would qualify as meeting the numerator for this "service penetration" measure. Just because a patient receives an intake does not guarantee that this individual will actually receive mental health services. Including "intake evaluation" could be misleading and inflate the service penetration rate.

YES - Useful to monitor overall effectiveness of interventions designed to increase the percentage of the population accessing mental health treatment.

YES - Measure should be revised to include a broader definition of "Mental Health Services". As is, services (including brief interventions) obtained in the primary care setting by mental health professionals are excluded. Additionally, the measure suggests that receiving an "intake evaluation" is equivalent to receiving mental health services. Measure should be revised to clarify that patients need to receive mental health services post-evaluation.

YES - Getting a comprehensive data set on # of lives receiving services is a good measure of resource efficiency.

YES - WCAAP endorses this measure, again if kids are specifically included as a part 2 data point.

YES - This appears to build on the first measure #2506 NQF endorsed measure. After member receives validation of mental health/substance use diagnosis, this measures verifies members continues to utilize available services.

YES - DSHS Research, Data and Analytics team offered to modify the measure specifications to: (1) define "mental health need" or "substance use disorder need" by primary, secondary or tertiary

diagnosis (rather than just primary), and (2) translate the required codes from ICD-9 to ICD-10 for use by health plans in producing results. These modifications address the initial concerns raised by the commercial health plans.

YES - Again is there help available and is it of the type that addresses the needs. We will need help designing programs for the community and they may need to have professionals that are not providers. The need will be to compare referred but no access compared to referred but did not show for the appointment and also a conversation of what the system should look like.

YES - The inclusion can provide valuable data.

NO and I DON'T KNOW Responses

NO - the construction of this measure, utilizing a calculated denominator, makes it impossible for implementing contractors to measure. Contractors should ALWAYS be able to independently measure their performance.

NO - I think it should just move forward without the pilot since it's needed and the pilot may provide barriers.

NO - I don't think more "bean counting" will solve the problems. You need to find a way to secure more outpatient providers.

I DON'T KNOW - Good luck getting all people to agree on a measure.

Question: Should Washington State pilot* the following measure in 2016 and evaluate results prior to taking action on its inclusion in the Common Measure Set (for 2017 or beyond)? Substance Use Disorder Service Penetration (Broad Version)

YES – 14
NO – 7
I DON'T KNOW – 1

Verbatim Comments

YES Responses

YES - we really won't know whether this measure is potentially valuable without piloting it.

YES - Access to substance use disorder treatment is currently strained often with long waits to get into treatment, especially for Medicaid patients. Similar to our comments on the mental health penetration measure, there is not a good measurement system in place to grasp these strains. Piloting the substance use disorder penetration measure will help to shed light on the access and follow up care in outpatient settings.

YES - Useful to monitor overall effectiveness of interventions designed to increase the percentage of the population accessing treatment for substance use disorders.

YES - WCAAP endorses this measure, again if kids age 6-17 are specifically included as a part two data point.

YES - this one is recommended for Medicaid only right now.

YES - We have limited availability to services in our area, we need to have assistance in obtaining the proper structure and function. Funding that flows in this direction will be needed.

YES - The inclusion can provide valuable data.

NO and I DON'T KNOW Responses

NO - I don't think more "bean counting" will solve the problems. You need to provide more outpatient treatment programs for low income citizens.

NO - SBIRT has not yet been implemented in a robust manner throughout Washington State. Thus, the coordination between primary care and outpatient SUD treatment has not been established well. In addition, the numerator for this measure does not include brief behavioral intervention received in primary care by mental health professionals (psychologists, LMHCs, etc.). Often times, patients diagnosed with a SUD are either unmotivated or unwilling to seek outpatient treatment. Thus, offering a behavioral treatment modality in primary care should be considered an option to count towards the numerator for this measure.

NO - Mental health parity in substance use disorder treatment has only recently come to full fruition, and as such, service delivery is very much in development. Coordination between primary care and outpatient SUD treatment has not been well established. Results of this measure would be unreliable. If measure does move forward, consider adding members who receive services in in primary care to the numerator.

NO - This should not include ED visits for 6 year olds for behavioral, drug or alcohol use. Raise the age to 10 or 12 at least. Children should be treated in clinic for counseling. If there is a drug situation it is a life threatening event due to the parent or guardian. The child is the victim not the abuser.

Question: Should Washington State pilot* the following measure in 2016 and evaluate results prior to taking action on its inclusion in the Common Measure Set (for 2017 or beyond)? Hospital Discharges Attributable to Psychiatric Disorders

YES – 14
NO – 5
I DON'T KNOW – 3

Verbatim Comments

YES Responses

YES - we really won't know whether this measure is potentially valuable without piloting it.

YES - This measure would provide good baseline data for the prevalence and financial impact of psychiatric disorders in hospital settings.

YES - Measure seems doable with claims data, and will provide good baseline data for the prevalence and financial impact of psychiatric disorders in hospital settings.

YES - Follows up on the above measures - if increase hospitalization %'s, community's resources and services should be reviewed and assessed as being beneficial and/or applicable to members.

YES - Important population measure and DOH will be data steward.

YES - Having accurate information on the types and frequency of mental illness across the state would be helpful and apply this next to resources available. Again what can be developed to treat the causes of the development of the problem (housing, safe living space, living wage) as well as treat those with the mental condition?

YES - This should also track ER visits so that measure 1 makes sense.

YES - The inclusion can provide valuable data.

NO and I DON'T KNOW Responses

NO - WSHA is unclear how this measure will inform and improve mental health treatment in our state. Washington State still faces a shortage of inpatient mental health services for people needing voluntary or involuntary services. The most significant crisis is occurring for people who meet the state's involuntary detention criteria and there is not a certified bed available for treatment. The state legislature has made adding inpatient capacity a priority and hospitals are working to bring new inpatient treatment beds online. Additionally, CHARS data provides only a subset of the discharges for inpatient mental health treatment in the state. Licensed residential evaluation and treatment facilities (E&Ts) that are non-hospital based also provide treatment for patients needing inpatient mental health services. More than 200 beds fall into the residential E&T category and these facilities do not report data to CHARS. By using CHARS data, the state will only have part of the picture on inpatient mental health and it is unclear how we are trying to influence these results given the historical shortages in capacity.

NO - I don't think more "bean counting" will solve the problems. We need more inpatient psychiatric beds.

I DON'T KNOW - Unsure what this will do other than maybe provide a more accurate measure of prevalence of conditions.

I DON'T KNOW - Access to inpatient psychiatric services is highly dependent on services being locally available, which they are not in this state. It would be important to somehow neutralize this measure for geographic bias.

Question: Should Washington State pilot* the following measure in 2016 and evaluate results prior to taking action on its inclusion in the Common Measure Set (for 2017 or beyond)? Hospital Discharges Attributable to Alcohol and Drug Use

YES – 14
NO – 5
I DON'T KNOW – 3

Verbatim Comments

YES Responses

YES - we really won't know whether this measure is potentially valuable without piloting it.

YES - This measure would provide good baseline data for the prevalence and financial impact of substance use disorders in hospital settings.

YES - Pilot would be good for those that are already collecting the data. Data on the prevalence and financial impact of SUD, as well as the prevalence and impact of substance abuse comorbidities, will be welcomed.

YES - Follows up on the above measures - if increase hospitalization %'s, community's resources and services should be reviewed and assessed as being beneficial and/or applicable to members.

YES - Important population measure and DOH will be data steward

YES - If the counts lead to no support for the development of the outpatient services or structures that prevent the development of mental illness or chemical dependency, then the information will go nowhere.

YES - As we shift from FFS to process based health care is it important to be aware that the "focus on collecting numerous process measures that may not reflect a patient-centered perspective on quality needs to be replaced by focusing on a more targeted number of important outcome measures." So I would also link in patient satisfaction scores to mental health measures. IE are patients being treated for a mental health illness receiving the same high quality patient centered care as those with a non-mental health one?

NO and I DON'T KNOW Responses

NO - Similar to our response for mental health CHARS data, WSHA does not support this measure because it is unclear how it will be used to improve substance abuse treatment. Hospitals provide a small subset of substance abuse treatment services with many services being delivered in non-hospital based licensed community facilities. This measure does not capture the array of services in non-hospital based treatment facilities.

NO - I don't think more "bean counting" will solve the problems. You need to provide more outpatient treatment programs for low income citizens.