DATE: October 22, 2015

TO: Performance Measures Coordinating Committee

FROM: Behavioral Health Measures Selection Workgroup, Susie Dade (Facilitator)

RE: RECOMMENDATIONS FOR ADDITIONAL BEHAVIORAL HEALTH MEASURES IN 2016

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 is due out in December 2015.

In the meantime, work is progressing to potentially 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 workgroup 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 measure set in 2016. The workgroup 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 workgroup, providing both facilitation and technical expertise.

In July 2015, a 16-member ad hoc workgroup was established (please see page 8 for a list of members). This workgroup met three times during the month of September to complete this phase of its work.

The workgroup reviewed a total of 69 potential measures. A complete list of measures is available upon request. For each potential measure, the workgroup considered:

1. a description of the measure (numerator, denominator),
2. measure steward (who developed the measure and maintains it over time),
3. whether or not the measure is currently NQF-endorsed,
4. the type of data required to complete measurement,
5. whether or not a reliable data source currently exists in Washington state, and
6. other available and relevant information related to the specific area addressed by the measure.

The workgroup used the measure selection criteria that were used during 2014, including:

1. Measures are based on *readily available data in WA (*identify data source during process).
2. Preference given to nationally-vetted measures (e.g., NQF-endorsed) and other measures currently used by public agencies within WA.
3. Each measure should be valid and reliable, and produce sufficient numerator and denominator size to support credible public reporting.
4. Measures target issues where we believe there is significant potential to improve health system performance in a way that will positively impact health outcomes and reduce costs.
5. If the unit of analysis includes health care providers, the measure should be amenable to the influence of providers.
6. The measure set is useable by multiple parties (e.g., payers, provider organizations, public health, communities, and/or policy-makers).

It is worthwhile noting that the 2015 Behavioral Health Measures Selection Workgroup encountered the same challenges and frustrations as the 2014 technical measures workgroups. It is difficult to identify well-vetted behavioral health measures that are either in use today or "doable" in the near future with currently available measure specifications, data sources in Washington, etc. As a consequence, as you review the workgroup's recommendations that follow, you'll note that we are "pushing the envelope" somewhat and careful consideration should be given to the practicalities of implementing the recommended measures in 2016. We are likely to receive push-back on some of the recommendations during the public comment period.

RECOMMENDATIONS: ADDITIONAL BEHAVIORAL HEALTH MEASURES IN 2016

Workgroup Recommendation #1:

Five measures are being tentatively recommended for consideration to include in the Common Measure Set, beginning in 2016. These draft recommendations are outlined on pages 3-6. The Workgroup welcomes guidance from the PMCC as well as public comment to help shape the final recommendations due to the PMCC in January 2016.

Measure Name	Measure Steward	NQF-Endorsed	Brief Description	Data Required	Source of Data	Recommended Unit(s) of Analysis
1. Mental Health Service Penetration (Broad Version)	DSHS	No	Percentage of health plan members with an identified mental health need who received mental health services during the reporting period. Report two rates, stratify by age groups: • Ages 6-17 • Ages 18 and older	Claims (including encounters)	Commercial Health Plans DSHS RDA for Medicaid/MCOs	• Medicaid Plans (MCOs) • Commercial Health Plans • County/ACH
2. Substance Use Disorder Treatment Penetration (Broad Version)	DSHS	No	Percentage of health plan members with an identified substance use disorder need who received substance use disorder services during the reporting period. Report two rates, stratify by age groups: • Ages 6-17 • Ages 18 and older	Claims (including encounters)	DSHS RDA for Medicaid/MCOs	• Medicaid Plans (MCOs) • County/ACH

Important Notes re: Measures #1 and #2:

- The Washington State Department of Social and Health Services originally developed measures #1 and #2 for the Medicaid population and contracting under 5732/1519 legislative requirements. David Mancuso (DSHS RDA) has 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.

- Measure #1 represents a new measure for the commercial health plans, so will require their cooperation to implement it and share results for public reporting in 2016. Their formal commitment to implement this measure is not in place at this time.

- Results for Measure #2 are being recommended only for the Medicaid population at this time.

- David Mancuso has indicated that the DSHS RDA is prepared to produce results for both Measures #1 and #2 for the Medicaid population, including results by MCO. MCOs don't have access to substance use disorder claims data, and only have limited access to mental health claims data.

- We will need to explore with DSHS RDA and commercial health plans whether they will be able to provide data at a zip code level in order to produce county/ACH results.

- The workgroup recommends that each measure be stratified by two age groups, to include results for children and adults separately.

Measure Name	Measure Steward	NQF-Endorsed	Brief Description	Data Required	Source of Data	Recommended Unit(s) of Analysis
3. Follow-up After Discharge from the ER for Mental Health, Alcohol or Other Drug Dependence	NCQA (Not in HEDIS)	Yes #2605	Percentage of discharges for patients who had a visit to the ER with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health, alcohol or other drug dependence within 7 days and 30 days of discharge (two rates). Stratify results to produce two rates: • Ages 6-17 (recommended add'l age group) • Ages 18 and older (NCQA HEDIS)	Claims (including encounters)	Health Plans	• Medicaid Plans (MCOs) • Commercial Plans

Important Notes re: Measures #3:

- 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, so we should assume that it is not currently in use by any health plans. NCQA reports that they are considering including it in the NCQA-HEDIS measure set for 2017 or beyond and, if so, it will come out for public comment in February 2016 with a decision made during 2nd quarter 2016. Detailed measure specifications are available through the NQF website. Therefore, this should be considered 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. We would 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. Their formal commitment to do so is not in place at this time.
- The workgroup recommends that the measure, which is constructed by NCQA to only include ages 18 and older, be modified to include a second rate for children ages 6-17. This second rate (for children) would be kept separate from results for adults so, to the extent that national benchmarks are available in the future, they may be used for comparison in the adult population.
- Consideration should be given before selecting this measure, whether we want to include two rates (7 days and 30 days) or just one. Given access to and the availability of community-based resources for follow-up, we may consider only including the 30-day rate to simplify initial efforts to publicly report results for this measure.

Measure Name	Measure Steward	NQF-Endorsed	Brief Description	Data Required	Source of Data	Recommended Unit(s) of Analysis
4. Hospital Discharges Attributable to Psychiatric Disorders	DOH	No	# of patients 18 years and older hospitalized for conditions due to or associated with psychiatric disorders (inclusive of psychotic, mood, anxiety and personality disorders).	Hospital Discharge Data/CHARS	DOH	• State • County/ACHs
5. Hospital Discharges Attributable to Alcohol and Drug Use	DOH	No	# of patients 18 years and older hospitalized for conditions due to or associated with alcohol and drug use.	Hospital Discharge Data/CHARS	DOH	• State • County/ACHs

Important Notes re: Measures #4 and #5:

- These measures were recommended by the Department of Health as important population measures. Treatment for mental illness and substance abuse disorder requires effective use of both community and clinical resources at the local level. A high rate of hospitalization in a geographic area may be an indicator of inadequate or unsuccessful interventions at the community and outpatient levels to support these populations.

- The Department of Health has volunteered to serve as measure steward and will have responsibility for finalizing the detailed measure specifications/definitions and producing results. The workgroup noted that psychiatric disorders and substance use disorder are likely to be under-reported as the primary diagnosis during hospitalization; therefore, the measure specifications should include all diagnoses associated with hospitalizations.

Workgroup Recommendation #2:

The workgroup is considering recommending that CAHPS patient experience surveys implemented in Washington state be modified to include three questions related to screening and brief alcohol intervention. The first question is a screening question.

1. During the past 12 months, did you have a drink containing alcohol?
   (Yes/No – If No, skip next two questions)
2. During the past 12 months, how often did you have 5 or more drinks on one occasion?
   (Never/ Less than Monthly/ Monthly/ Weekly or More Often)
3. During the last 12 months, how often were you advised about your drinking (to drink less or not to drink alcohol) by your doctor or other health provider? *(Never/Sometimes/Usually/Always)*

Important Notes re: Workgroup Recommendation #2:

- The Veteran's Administration has used questions similar to these since 2004 and patients who report brief intervention on the measure have higher satisfaction with their care generally and their provider specifically.
- Most health plans field the Health Plan CAHPS patient experience survey for adults every one to two years.
- The Washington Alliance has fielded the Clinician-Group CAHPS (CG-CAHPS) every other year – this is a patient experience survey that has the clinic/medical group as the unit of analysis (versus the health plan). The CG-CAHPS survey currently being 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?" If approved by the PMCC, this question could be altered in future surveys, starting in 2017. [Note: The challenge is to identify reliable funding to implement the CG-CAHPS statewide in future years. Fielding the survey for all primary care groups of four or more providers within WA state is approximately $600,000 per survey.]
- It is important to note that there was <u>not</u> unanimous support within the workgroup for this recommendation. Some workgroup members expressed concern:
  - One individual would like to see the wording of the question be broader, noting that "if we limit it to just the medical environment (which they may not have accessed, thus had no opportunity to receive provider advice) we will miss the likelihood that a spouse, parent, child or friend has confronted them." Another member countered that this is intended to measure brief alcohol interventions in a health care environment.

- A second individual expressed reservations about adding the alcohol screening questions to the Health Plan CAHPS survey noting that the CAHPS survey is intended to survey members about their satisfaction with the health plan. No one is looking closely at each individual survey response so there is no clinical follow-up on an individual basis. If members identify risky drinking behavior, there will either be zero follow-up with the member or health plans will have to build a process to get the information and follow-up individually with members. Likewise, there will be no opportunity to follow-up with patients that report risky drinking behavior in the Clinician-Group survey administered by the Alliance.
- A third individual noted a concern that patient experience survey questions pertaining to tobacco, alcohol and/or drug use may suppress survey response rates due to concerns about privacy.

BEHAVIORAL HEALTH MEASURES SELECTION WORKGROUP – MEMBERSHIP

1. Kathy Bradley, MD, Group Health Cooperative
2. Lydia Chwastiak, MD, UW Psychiatry and Behavioral Sciences
3. Stacey Devenney, Kitsap Mental Health Services
4. Charissa Fotinos, MD, Washington State Health Care Authority
5. Erin Hafer, Community Health Plan of Washington
6. Robert Hilt, MD, Seattle Childrens
7. Debbie Horowski, UnitedHealthcare/Optum
8. Julie Lindberg, Molina Healthcare of Washington
9. David Mancuso, Washington State Department of Social and Health Services
10. Eileen O'Connor, Regence Blue Shield
11. Kara Panek, Washington State Department of Social and Health Services
12. Terry Rogers, MD, Foundation for Healthcare Quality
13. Jennifer Sabel, PhD, Washington State Department of Health
14. Debra Srebnik, PhD, King County
15. Mary Tott, Navos
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