NQF

NATIONAL QUALITY FORUM

Integrating Behavioral Healthcare Performance Measures Throughout Healthcare

WORKSHOP PROCEEDINGS

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Editors

WORKSHOP PROCEEDINGS

Foreword

Millions of Americans suffer from behavioral health disorders such as depression, alcoholism, post-traumatic stress disorder, and schizophrenia. These conditions are frequently disabling and recurring or chronic. They also are extremely costly in both social and financial terms.

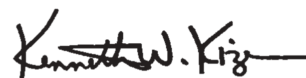
Cost-effective treatment is available for many behavioral health conditions, and treatment success for behavioral disorders is on par with that for chronic diseases such as diabetes, hypertension, and asthma. Regrettably, however, treatment is too often episodic, disjointed, incomplete, or otherwise deficient.

Widespread agreement has emerged about the need to improve the quality of care for behavioral health disorders, and that performance measures that can be used to monitor conformity with care guidelines and the public reporting of performance are important quality improvement tools in this regard. Although these tools are relatively underdeveloped for behavioral healthcare, noteworthy progress has been made in recent years.

On June 29, 2004, NQF convened a workshop to examine the state of behavioral healthcare performance measurement in general acute care and primary care settings. The workshop, "Integrating Behavioral Healthcare Performance Measures Throughout Healthcare," sought to identify promising areas for the application of performance measures in general healthcare settings. This report details the workshop findings and several specific recommendations made by the workshop's invited participants.

NQF would like to thank the Potomac Ridge Behavioral Health System, the Department of Veterans Affairs, and George Washington University for their support of the workshop. We also wish to thank workshop participants for their generous commitment of time and intellectual input.

NQF and its more than 250 Member organizations are committed to improving the quality of behavioral healthcare through the advancement of national voluntary consensus standards for performance measurement and public reporting.



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Integrating Behavioral Healthcare Performance Measures Throughout Healthcare

Executive Summary

Behavioral health conditions—mental illness and substance use disorders—are extremely common among patients in general acute and primary care. In recent years, the number of performance measures relating to the quality of identification and treatment of behavioral health problems has grown considerably. However, many of these measures have been developed and used only within the behavioral healthcare sector, with relatively few in use for general acute care, primary care, and other general care settings. A workshop convened by the National Quality Forum brought together experts from across stakeholder groups, and across general and specialty care areas, to examine the state of behavioral healthcare measurement and to recommend promising areas for the application of these measures in general healthcare settings.

Priorities for Immediate Action

Workshop participants identified three behavioral health areas as high priority for performance measurement in general care, due to the prevalence of the conditions, the availability of a pool of existing relevant measures, and the potential to achieve enormous improvements in care.

- Depression
  - General acute inpatient care: screening and initiation of treatment.
  - Primary care: screening and treatment (both children and adults).
- Substance use disorders
  - General acute inpatient care: screening and initiation of treatment for alcohol dependence.

  - Emergency department (ED) care: screening and initiation of treatment for substance use disorders (both drugs and alcohol).
  - Primary care: screening for alcohol dependence (adults); screening for substance abuse, including both drugs and alcohol (adolescents).

- Selected severe mental disorders
  - ED care: wait time to treatment for specified diagnoses (e.g., bipolar illness, schizophrenia).

Performance measures exist for all of these areas, although the extent of detailed development and testing varies considerably. In general, the availability and state of development of performance measures related to the screening and treatment of depression were considered somewhat ahead of those for the screening and treatment of substance use disorders. Measures of screening can permit the use of any of several specified screening tools, and participants agreed that a number of well-tested tools exist in both areas.

Participants also consistently identified two topics as crucial for quality improvement and as priorities for measure development in all age populations:

- Transitions between care providers and coordination of care (between care settings and among general/primary and specialty care providers).
- Medication assessment/management for patients on multiple medications (all age groups).

Care for patients with dual behavioral health diagnoses (in particular, patients having both mental and substance use disorders) is an especially important target for measurement. Additionally, pediatric and geriatric populations are especially vulnerable to being prescribed many medications without thorough and ongoing assessment of the benefits, interactions, and side effects of these drugs.

Other areas of measure development considered to be of high priority for improving behavioral healthcare for specific populations included:

- Children (screening for attention deficit hyperactivity disorder, bipolar disorder, and eating disorders), and
- Elderly adults in nursing homes (overuse/misuse of antidepressants/antipsychotics; misdiagnosis related to depression; and the use of physical and chemical restraints).

Screening for alcohol dependence in elderly home health care patients and people admitted to nursing homes also was noted as an important target for quality measurement and improvement.

Finally, workshop participants stressed the need for:

- standardization of performance measures across programs, purchasers, and plans;
- standardization of outcome measures (e.g., self-perceived health, absenteeism, productivity);
- greater emphasis on measures consistent with a chronic care model rather than a curative model; and
- greater attention to measurement of healthcare performance that illuminates population-based disparities in care (including the development of measures of family visits for children in treatment).

Integrating Behavioral Healthcare Performance Measures Throughout Healthcare

Introduction

Mental illness and substance use disorders afflict patients in all clinical care settings. Patients with illnesses such as heart disease and diabetes frequently have co-morbid behavioral health problems (e.g., depression or alcohol dependence). Primary care practitioners frequently treat patients with bipolar illness. Alcohol-related health problems and severe mental illness are common reasons for admission to acute care hospitals.

To date, efforts to develop and implement performance measures for behavioral healthcare have been separate from performance measurement efforts in general healthcare. Patients, however, cannot be neatly divided into separate healthcare worlds; good care for behavioral healthcare problems must involve both general and specialty behavioral healthcare providers.

The National Quality Forum (NQF) endorses voluntary consensus standards focusing on healthcare quality measurement and fosters their adoption and use through national, multistakeholder consensus. Although mental illness is a designated priority topic for NQF, few performance measures endorsed to date by NQF specifically address care for behavioral health problems. To lay the foundation and provide direction for future efforts, NQF convened a workshop to examine behavioral healthcare quality measurement.

Workshop Overview

On June 29, 2004, NQF convened a workshop of stakeholders familiar with and interested in performance measurement and the care of people with mental illness and substance use disorders. Participants included representatives from both the public and private sectors; academia and consumer organizations; and provider, health professional, policy, and purchaser groups (appendix A).

The principal purpose of the workshop was to identify areas of behavioral healthcare performance measurement that offer the most immediate promise for improving provider-level performance measurement in primary and general acute care. Participants addressed three overarching questions:

- Given the state of performance measurement in behavioral healthcare, to what extent do provider-level measures exist that are potentially applicable to primary and general acute care?
- What are the areas (e.g., care settings, diagnoses, specific measures) most "ripe" for undertaking NQF consensus on behavioral healthcare measures, either as part of existing NQF-endorsed measure sets or as new consensus initiatives?
- Where are appropriate provider-level performance measures that are the most noticeably lacking? What are the critical needs?

The workshop discussion was supported by a background paper (appendix B) that summarized the relationship between general and behavioral healthcare diagnoses; the treatment of patients with behavioral healthcare problems in general (non-specialty) care settings; and the development of behavioral healthcare performance measures.

Performance Measures for Behavioral Healthcare

As summarized in the background paper and presented at the workshop, inventories and reviews of performance measures specific to the care of patients with mental illness

and substance use disorders have found that there are a substantial number of measures related to behavioral health. For example:

- An effort to establish a comprehensive inventory of process measures for mental healthcare yielded 317 single-item measures (based on a survey of 348 organizations) that met the inclusion criteria for the inventory.[1]
- A 2001 meeting sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) identified more than 140 performance indicators that had been used in child and adolescent behavioral healthcare service systems[2]; another recent review focused on performance measures for children's healthcare generally that identified 43 measures of mental health-care for children and adolescents.[3]

Currently, many of these measures do not appear to be widely used even within the behavioral healthcare sector. Of the more than 300 measures in a national mental health quality measures inventory, researchers were able to identify measurement results from prior use for only 56 of the measures.[4] In addition, there is great variation among existing measures in the degree of testing and documentation they have undergone. Some appear to be supported by evidence on their performance that is reported in the literature. Data on other measures are more elusive; the measures may have undergone some testing, but the results are not published.

Behavioral healthcare performance measures that target program- or health plan-level services and outcomes appear to be more common than those focused on individual providers or settings of care. These program and plan measures tend to be based either on administrative data or on patient surveys. Measures that draw from medication and medical record data also are represented, however, particularly in depression and other specific clinical diagnostic areas. Depression is notable as a particularly active area of performance measure development.

Although there are a large number of performance measures pertaining to behavioral healthcare conditions, there is also a trend toward more between-group consensus and consolidation. In addition, SAMHSA has supported an effort to develop core measures that apply across a variety of conditions and contexts.

Workshop Discussion

Although the workshop discussion was structured around behavioral healthcare performance measurement as it applies in specific settings of care, several cross-cutting

[1] Hermann RC, Leff HS, Lagodmos G. *Selecting Process Measures for Quality Improvement in Mental Healthcare;* July 2002. Available at www.hsri.org/index.asp?id=pubs.

[2] Doucette A. *Summary of Findings: Outcome Roundtable for Children and Families Performance Measurement Survey*. Unpublished manuscript; July 2003.

[3] Simpson L, Dougherty D, Krause D, et al. *Measures of Children's Health Care Quality: Building Towards Consensus.* Paper prepared for National Quality Forum workshop, January 8, 2004.

[4] Hermann RC, Palmer RH, Leff HS, et al. Achieving Consensus Across Diverse Stakeholders on Quality Measures for Mental Healthcare. *Medical Care.* 2004;42(12):1246-1253.

themes were woven throughout these setting-specific discussions. These included the following:

- **Conditions versus care settings.** Behavioral healthcare problems that are prevalent and considered important in one setting were often considered important in others as well. In considering priorities for behavioral healthcare performance measurement in general care, participants frequently weighed the benefits of focusing on a few conditions across care settings versus focusing on many conditions in one or two care settings.
- **Perceived relevance by individual patients or purchasers versus importance in stimulating overall improvements in care.** Participants noted that some measures that are likely to be important to improving care overall (e.g., measures of how well providers screen for and diagnose alcohol use disorders) are not the measures that patients themselves might seek (e.g., rates of use of patient restraints) or that might most immediately interest purchasers (e.g., care that improves outcomes in patients with a disabling mental illness and enables them to return to work). A performance measure set may need to address a mix of measures to draw support from all stakeholders.
- **Adequacy of the evidence underlying measures.** Participants noted that although a robust body of available performance measures related to behavioral healthcare appears to exist, the rigor of evidence supporting each measure varies considerably. Throughout the discussion, participants spoke from their own expert knowledge about whether relevant and credible measures might exist in an area of interest. Although they also used their knowledge of the general scientific grounding of the measures during the discussion, participants frequently commented that even in measurement areas with a considerable research base, not all measures are ready for widespread use without further testing. One participant noted, for example, that only about one-third of existing measures in one well-known database are evidence based; furthermore, these measures tend to be used less than others because they often require detailed clinical or survey data.
- **Need to address behavioral health conditions under a chronic care model rather than a curative model.** The workshop discussion repeatedly emphasized that for most people with mental illness and substance use disorders, the goal is not a one-time cure but long-term management: Outcome and care performance measures must focus on whether effective chronic care is being provided.
- **Use of performance measures in assessing population-based disparities in care.** Participants were concerned that opportunities are being missed to develop and apply performance measures to examine age- and race/ethnicity-related disparities in behavioral healthcare and to stimulate resulting quality improvements. They noted that improving the use of measures for this purpose may require devoting greater attention to how measures are specified (e.g., to ensure that they apply across age groups); developing more measures that apply to conditions that are prevalent in minority, elderly, and pediatric populations; and developing more measures that apply to settings of care where many disparities in care may exist (e.g., residential settings).

Behavioral Healthcare in General Acute Care Hospitals

Workshop participants identified the following areas of care in general acute care hospitals as those for which there were both substantial existing measure activity and great interest in and potential impact for improving care.

- **Inpatient care**
  - Depression (screening and initiation of treatment), and
  - Alcohol dependence (screening and initiation of treatment).
- **Emergency Department care**
  - Substance use disorders (screening and initiation of treatment for both drugs and/or alcohol), and
  - Wait time to treatment for selected diagnoses (e.g., bipolar illness, schizophrenia).

Participants also identified "transitions between care providers" and "coordination of care" (within a hospital, across hospitals, and between hospitals and other care settings) as crucial areas for healthcare quality improvement and as priorities for performance measure development.

Inpatient Care

Participants debated the benefits and drawbacks of performance measures that are focused on the use of restraints and other safety topics. Although there was considerable emphasis by consumer and purchaser representatives on the importance of reporting such measures, participants agreed that safety measures alone are inadequate and will not stimulate changes in the broader processes of care for people with mental illness and substance use disorders.

Participants believed that depression and alcohol dependence are underdiagnosed, prevalent among patients hospitalized for other conditions, and treatable. One person estimated that 80 percent of alcohol use disorders go undiagnosed. Furthermore, alcohol abuse and depression often co-exist.[5] Although participants recognized the limitations of inpatient treatment alone, they asserted that hospitalized patients

[5] Participants also noted the relevance of the cognitive behavioral therapy test in emergency department and inpatient settings. This test can detect long-term alcohol abuse even when no signs of intoxication are apparent.

should be screened for these conditions; that patients who are diagnosed with these conditions should start treatment; and that performance measures for these care processes exist.

Emergency Department Care

A substantial set of literature supports linkage between screening and brief interventions in the ED or trauma center and the effectiveness of such interventions in achieving, at minimum, short-term positive outcomes. Given the prevalence of substance use as a factor in ED visits, workshop participants emphasized that screening and treatment initiation for substance use disorders is a clear target for performance measurement and quality improvement.

Psychosis is likewise a condition seen frequently in EDs. For both psychosis- and substance use-related visits, participants felt that wait time to be seen and treated is a major issue for patients and an important target for quality improvement efforts. It was noted that there is a perception that patients with behavioral health diagnoses receive low priority for attention and that this delay in treatment contributes to the subsequent use of physical and chemical restraints. Although measuring wait time for all patients with behavioral health diagnoses may not be feasible, participants felt that focusing attention on the wait time to treatment for patients with selected major mental illnesses (e.g., bipolar illness and schizophrenia) would greatly improve care for these patients.

Participants also felt strongly about the need for clear, evidence-based performance measures aimed at ED care. It was widely believed that the emergency care setting offers some of the greatest opportunities for immediately improving the quality of care for behavioral healthcare.

Care Transitions and Coordination of Care

The need for measures that relate to the quality of care transitions and the quality of coordination of care within and across care settings has become a widely discussed topic for healthcare quality, generally. In a series of listening sessions hosted by the Centers for Medicare and Medicaid Services in 2003, for example, this topic was raised repeatedly.

Separately, discussions of performance measures relevant to small or rural hospitals have similarly emphasized the importance of measures that deal with patient transfers and care "hand-offs." Participants at the NQF workshop noted that such measures are similarly important for patients with behavioral health problems. In particular, participants felt that if behavioral-relevant care transition performance measures were developed, it would be a major stimulus to move the behavioral healthcare field forward and aid the continuity of patient care across general and specialty behavioral healthcare settings. Additionally, measures of care concepts such as discharge readiness and predischarge links to posthospital care were identified as promising areas for research.

Sources of Potential Measures

Workshop participants identified the following starting points for more specific discussion and development of relevant measures:

- Health Plan Employer Data and Information Set (HEDIS) measures (used by the National Committee for Quality Assurance), in particular the measure relating to follow-up after hospitalization for a mental health problem. This measure relates to the linkage between hospital and post-hospital care (and general and specialty care). The limitation of the HEDIS measure, however, is that it is not provider specific (e.g., it does not separate the hospital and outpatient components of this process or follow-up by specialty versus primary care providers).
- The framework for developing measures of hospital psychiatric care being used in a joint measure development effort of the National Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors, the NAPHS Research Institute, and the Joint Commission on Accreditation of Healthcare Organizations. This framework defines four measurement domains:
    - transitional care (discharge planning, case management and assessment criteria);
    - processes of care (family involvement with treatment);
    - clinical outcomes (symptom reduction, functional improvement, patient perception of recovery); and
    - safety (seclusion and restraint, medication use, suicide risk assessment).

Behavioral Healthcare in Primary Care

Workshop participants agreed that the areas of greatest priority and existing measurement activity in inpatient care were similarly of the greatest priority in primary care:

- Depression (screening and treatment), and
- Alcohol abuse (screening).

Performance measures exist for these conditions, and these conditions are highly prevalent among patients in primary care and are underdiagnosed and undertreated. In addition, performance measurement in these areas would provide important continuity across settings of care and provide leverage for quality improvement.

Workshop participants noted that coordinated management between primary care and specialty care providers for patients with dual diagnoses is a crucial area for performance measurement in which the development of good measures is needed. The co-occurrence of multiple conditions (e.g., mental illness and substance abuse, psychiatric illness and non-psychiatric illnesses) is extremely common, but care of patients with co-occurring conditions is highly fragmented.

A lack of appropriate medication assessment and management also was noted as a major source of unnecessary, ineffective, and inefficient care that is particularly a problem for those with behavioral health conditions. Drug interactions and side effects are often perceived as relating to the health condition rather than to the treatment, leading to even greater overmedication. Participants considered the problem to be especially great in children and the elderly, who are often prescribed medications without appropriate assessment or monitoring of the overall medication regimen and its effects.

Participants also noted that it would be of great benefit to standardize outcome measures for behavioral healthcare. Many measures, such as patient well-being, work productivity, and absenteeism, exist; standardizing them would improve the ability of employers and other purchasers to assess the benefits of covering effective treatments.

- ***Depression.*** Participants agreed that the healthcare system has made great strides toward raising primary care physicians' awareness of depression and of the existence of tools to screen for this condition. The adequacy of screening and treatment, however, was considered to be an area in which substantial improvement in the quality of care is both needed and possible.

  Measuring performance simply as initiation of treatment, however, was noted as inadequate in outpatient settings. Although drug treatment for depression may be prescribed, there may be inadequate patient education, monitoring, and intervention provided, leading to underdosing and overdosing. Workshop participants emphasized that performance measures should be implemented in ways that address the full spectrum of care for depression.

- ***Alcohol use disorder.*** Workshop participants considered alcohol abuse to be a public health problem that is common among primary care patients—hence, screening all primary care patients for alcohol use disorder should be a fundamental part of preventive care. Measures for alcohol use disorder screening were believed to exist, although these measures may need to be carefully scrutinized to ensure that they accommodate needs for patient confidentiality, informed consent, and patient refusal of screening. Linking screening with initiation and continuity of treatment was considered extremely important by participants, but it was unclear whether adequate alcohol-specific treatment performance measures exist for primary care.

Behavioral Healthcare for Specific Populations

Children and Adolescents

Participants agreed that tools for screening children and adolescents for depression and substance use disorder exist, as do some measures for assessing whether children are screened. In general, these measures would be similar to those used for adults, but the screening tools would probably differ.

Participants agreed that depression in children is an extremely important problem that needs to be addressed. (Some participants noted that logistical concerns and technical complications, including the need for parental consent, can complicate screening in children.) Screening for substance use disorder in children likewise was considered to be a critical need, particularly in light of the frequency with which substance abuse is associated with other health problems. One person noted that research shows that young teens (12 to 15 years old) with substance use disorders are 2.5 times more likely to have ED visits than other adolescents; for older teens, trauma related to alcohol use is common. Experience in screening students in school-based settings exists and has shown success.

There was also considerable discussion and agreement around four areas of performance measurement that were identified as particularly important for the pediatric population. In some of these areas, performance measures exist; in others, some additional development and testing of measures may be necessary, and well-tested performance measures are badly needed.

- **Care coordination (e.g., between schools and medical providers of care, between primary care and specialty mental healthcare providers).** Participants noted there are numerous studies of coordination between mental health specialists and primary care practitioners. The elements for coordination performance measures exist, but the measures themselves are still underdeveloped.
- **Screening for attention deficit hyperactivity disorder (ADHD), bipolar disorder, eating disorders.** Participants stressed that ADHD, bipolar disorder, and eating disorders

are also important behavioral health disorders in children, and performance in screening for these disorders can be greatly improved. However, performance measures, and even standardized screening tools and diagnostic criteria, do not exist for all of these disorders. ADHD is especially controversial, because there is great variation in detection and treatment for this disease; both overdiagnosis/treatment and underdiagnosis probably exist. Misdiagnosis is also believed to be a problem; some children diagnosed with ADHD actually may have bipolar disorder.

- **Medication management.** The paradoxical situation of undertreatment, overtreatment, and mistreatment for the same condition (ADHD) illustrates the need for improved medication assessment and management for children. Although there has been hesitancy to develop performance measures for appropriate medication management because of concerns about burden (the need to extract data from medical record), the potential yield is high because the problem is so great. Measures in this area for children should apply across conditions, not just to medication management for a few individual disorders.
- **Family visits for children in treatment.** Family visits are an important component of care for children undergoing inpatient and residential treatment for behavioral health disorders. Such visits seem to be far less common than is consistent with good treatment practice. Some of the problem may be a lack of coding to document that a visit took place, because family visits are often not reimbursed. It is likely, however, that family visits are also sometimes discouraged, despite their importance in good care. Evidence suggesting that there may be racial and ethnic differences in family visitation rates underscores the importance of good performance measures for this care component.

Geriatrics and Long-term Care

Participants identified the following areas of behavioral healthcare performance measurement as of concern for this population:

- **Overuse/misuse of antidepressants/antipsychotics in nursing home patients.** Participants noted a need for assessment of medication interactions and appropriate use of medications in nursing homes. Data suggest that

approximately one-third of nursing home patients may be on antidepressant medications, indicating that overuse and undermanagement of medications are extensive. It is widely believed that antipsychotic drugs, which are frequently prescribed to treat agitated and confused behavior, also are overused. One participant asserted that Haldol,™ an antipsychotic drug, is more widely prescribed in nursing homes than in almost any other setting of care, possibly because prescribers give insufficient weight to side effects (e.g., tardive dyskinesia) in geriatric nursing home residents. It also was noted that antipsychotics are susceptible to misuse, which may occur in response to agitated behavior caused by environmental problems or poor care for other conditions (e.g., urinary tract infections).

Participants stressed that developing valid and reliable measures to address these problems will be difficult, but it is a task that needs to be undertaken. They noted that it is helpful that there are many data elements in the dataset that is already required by Medicare for nursing home patients. Processes and protocols for routine assessment of patients on antipsychotic and antidepressant medications also exist.

- **Use of physical and chemical restraints.** The use of restraints, and especially chemical restraints, is closely related to the issue of overuse and misuse of antipsychotic drugs. Nursing homes differ in what they consider a restraint, and how they use chemical restraints. Participants agreed that standardizing definitions and measures (beyond physical restraints) is critical to improving treatment quality for nursing home patients with behavioral health problems.

- **Misdiagnosis related to depression.** "Pseudodementia" is believed to be a common problem in nursing home patients, particularly among those who are physically disabled. These patients are treated as though they have dementia, when instead they may have very treatable depression. Although no performance measures apparently exist to address this problem, the data that would allow them to be developed probably do exist in the Minimum Data Set.

  Some concern was expressed that performance measures focus on screening only for depression, when ideally screening would address mental status more generally (while ensuring that the screening tools addressed by a measure were rigorous enough to identify depression).

- **Alcohol use disorder in home health.** Participants agreed that alcohol use disorders are a major problem among elderly persons residing in their homes. In addition to the health problem such use poses in itself, these patients may have unrecognized (or misdiagnosed) withdrawal symptoms upon being admitted to nursing homes, with concomitant inadequate or inappropriate treatment.

  Other areas considered important for further development of standard tools and measures include assessment of nursing home patients who cannot provide adequate cognitive responses. In such cases, cognitive assessments may be relying on the use of informal tools and staff observations, which often are poorly documented.

Acknowledgments

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Simpson L, Dougherty D, Krause D, et al. *Measures of Children's Health Care Quality: Building Towards Consensus.* Paper prepared for National Quality Forum meeting, January 8, 2004.

Appendix A

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Appendix B

Agenda—Workshop on Integrating Behavioral Healthcare Performance Measures Throughout Healthcare

WASHINGTON, DC
TUESDAY, JUNE 29, 2004

9:00 a.m.	**Overview and purpose** Introductions Overview of NQF Context and purpose of the workshop
9:30 a.m.	**Performance measurement landscape** Standardized performance measure sets for general healthcare Behavioral healthcare performance measures: status and use Emerging areas of overlap
10:15 a.m.	**Break**
10:30 a.m.	**Behavioral measures for general acute hospital care measure sets: relevance, issues, gaps**
12:00 noon	**Open comment**
12:15 p.m.	**Lunch**
1:15 p.m.	**Behavioral measures for primary care/other general healthcare measure sets: relevance, issues, gaps**
2:30 p.m.	**Action priorities and research needs**
3:15 p.m.	**Open comment**
3:45 p.m.	**Next steps**
4:00 p.m.	**Adjourn**

Appendix C

Background Paper: Considering Behavioral Healthcare Performance Measures for General Healthcare Settings

Behavioral healthcare is "a general term for services aimed at diagnosis and treatment of mental illness and chemical dependency," including alcohol and other drugs.[1] Historically, behavioral healthcare services have been characterized by different insurance coverage rules, different payment sources, and frequently different organizational systems of care than other healthcare services. It is thus not surprising that the development of performance measures for behavioral health and the development of performance measures for general healthcare have often occurred isolated from each other. Nonetheless, many performance measures developed for behavioral healthcare might be applicable to primary and general acute care providers who diagnose and treat those with mental illness and substance use disorders as part of the spectrum of general healthcare services.

The purpose of this background paper is to provide a shared basis for workshop discussions of the applicability of behavioral healthcare measures to general healthcare at the healthcare provider level. Specifically, the paper will briefly summarize:

- the scope of mental illness and substance use disorders, including their diagnosis and treatment by non-specialty providers;
- the state of national consensus on performance measures for general healthcare in areas where measures for behavioral healthcare services may be relevant; and
- the state of the field of performance measurement in behavioral healthcare.

Behavioral Healthcare in General Care Settings

An estimated 44 million U.S. adults (22 percent) have a "mental disorder" (i.e., a disorder as defined in the DSM-IV [American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* 4th ed.] list of diagnoses, which includes substance use disorders), as do an estimated 21 percent of children ages 9 to 17.[2,3] Seven percent of all adults have a medical diagnosis of alcohol abuse or dependence (many of them also with a co-occurring mental illness); 8 percent of people over age 12 report recent illegal drug use.[4]

Collectively, the burden of disease from these problems is enormous. Behavioral health disorders account for more than 15 percent of the overall burden of disease from all causes—more than cancer.[3] Approximately 30,000 people die every year due to suicide (which is strongly associated with mental illness and substance abuse), while 500,000 more receive emergency treatment after attempting suicide. More than 100,000 deaths and 415,000 hospital stays per year are attributed to alcohol-related injuries and illnesses; 193,000 emergency department (ED) visits occur as a result of cocaine use.[4,5]

Improving the diagnosis and treatment rates for those with behavioral health disorders requires the engagement of general as well as specialty behavioral healthcare providers. An estimated 5.5 million people with mental illness, for example, are admitted to specialty (inpatient, residential, or less than 24-hour) treatment programs,[6] with the remaining 38 million adults with mental disorders either remaining untreated or receiving treatment in other settings. According to the National Center for Health Statistics:

- About 44.8 million visits were made to office-based physicians for mental health disorders (the data do not distinguish primary from specialty care physicians);
- Two million visits to hospital EDs were for mental disorders; and
- More than 445,000 nursing home residents (about one-fourth of the nursing home population) have mental disorders as a primary diagnosis; more than half of these have a disorder other than dementia.[7]

Depressive and anxiety disorders account for more than half (52 percent) of ambulatory care visits for mental and substance use disorders (including emergency, hospital outpatient, and physician office visits). Another 7 percent of ambulatory visits are for alcohol or drug dependence, with attention deficit, schizophrenic, and stress disorders the next most common primary diagnoses (together accounting for 18 percent of ambulatory visits for behavioral health disorders).[7] The role of primary care physicians in diagnosing and treating mental illness and substance abuse is especially notable. Most elderly people with depression, for example, are treated by primary care physicians.[8]

Recently, the prevalence of depression and other mental health problems in patients with other health conditions has been gaining attention. Research suggests that the prevalence of depression among older adults may be as high as 25 percent.[9] People with activity limitations, particularly functional limitations due to arthritis and heart disease, are especially at risk.[9,10] Among elderly persons with chronic illness, those who also have a depressive syndrome are twice as likely to have ED visits and medical inpatient stays.[11] Hence, many patients with mental disorders may be treated—both as inpatients and outpatients—principally by physicians with specialties other than behavioral health.

The dissociation between general and mental healthcare services has disadvantages not only for those who have both chronic diseases and mental disorders, but also for those whose primary diagnosis is a behavioral health disorder. A recent study of patients who had recently undergone treatment in a residential detoxification program for substance addiction found that nearly 40 percent of them had no link to primary care. Furthermore, health status and a history of recent mental health service usage were not associated with such linkage.[12]

Although mental illness and substance use disorders are prevalent among patients in primary and general acute care settings, diagnosis and treatment of these conditions are inadequate. Substance use disorders in their patients are under-recognized by physicians, even for patients who have been in recovery programs.[13] Most patients with depression are seen initially by primary care professionals, but the existence and severity of depression is consistently under-recognized.[14] Most patients who die by suicide had a physician visit within their last month of life.[15] Collectively, this suggests that the potential for performance improvement in the treatment of behavioral health disorders in primary and general acute care settings is enormous. The availability of credible and well-developed behavioral healthcare performance measures and their potential applicability to general healthcare settings is thus of considerable interest.

Performance Measures for General Care Providers: Status of Voluntary Consensus Standards Relating to Behavioral Healthcare

Since the inception of its first consensus project in December 2000, the National Quality Forum (NQF) has endorsed as voluntary consensus standards four sets of performance measures that apply to general care providers (as of June 2004)*:

- acute hospital care measures,
- adult diabetes measures,
- nursing home measures, and
- performance measures for nursing-sensitive care in hospitals.

Four other consensus development projects around performance measures for general care providers are ongoing:

- home health care measures,
- ambulatory care measures,
- cardiac surgery measures, and
- cancer care measures.

As summarized in table 1, several of the performance measures endorsed by NQF to date are relevant to the care provided to those with mental illness or substance use disorders. Few, however, specifically target this population.** All of the clearly relevant endorsed measures are in setting-specific measure sets, rather than disease-specific measure sets (e.g., diabetes).

Of ongoing performance measure consensus projects, only the ambulatory care set includes measures that have been formally recommended for consensus and that specifically address healthcare for behavioral disorders (table 2).***

In addition to its work endorsing performance measures as voluntary consensus standards, NQF has endorsed two sets of voluntary consensus standards for patient safety that are not performance measures, but that include items relevant to behavioral healthcare:

- The NQF-endorsed *Safe Practices for Better Healthcare* presents a set of 30 voluntary consensus standards to improve patient safety through specific healthcare practices. Endorsed practices relevant to patient safety for patients with mental illness or substance use disorder are listed in table 3. Many of the patient safety practices relevant to behavioral healthcare relate to communication and safe medication use.

*Since the original publication of this paper, NQF has completed endorsement of voluntary consensus standards for home healthcare and cardiac surgery.

**Mental health was specified by the Steering Committee for the hospital performance measures project as being a priority condition of interest, but no suitable existing performance measures could be identified at that time for inclusion in the set undergoing consensus.

***No home health or cardiac surgery measures that were endorsed shortly after this workshop directly relate to behavioral health disorders.

- *Serious Reportable Events in Healthcare* includes 27 serious adverse events that have been endorsed by NQF in part as a way to begin the standardization of state adverse event reporting systems so that data on rare but serious events can be combined and analyzed across states. Relevant events are listed in table 4.

Behavioral Healthcare Performance Measures

The availability of fully developed performance measures specific to the care of patients with mental illness and substance use disorders is substantial:

- An effort to establish a comprehensive inventory of process measures for mental healthcare yielded 317 separate single-item measures (based on a survey of 348 organizations) that met the inclusion criteria for the inventory.[16]
- A 2001 summit sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) yielded more than 140 performance indicators that had been identified for use in child and adolescent behavioral healthcare service systems.[17] Another recent review focused on performance measures for children's healthcare generally and identified 43 measures of mental healthcare for children and adolescents.[18]

The fact that developed, identifiable behavioral healthcare performance measures exist does not necessarily mean that they have undergone testing or extensive use. For example, the authors were able to easily identify studies of reliability and validity for only 13 of the 43 measures identified by Simpson et al.[18] Of the more than 300 measures in the national mental health quality measures inventory, researchers were able to identify measurement results from prior use for only 56 of them.[19] The National Quality Measures Clearinghouse (www.qualitymeasures.ahrq.gov) currently includes 49 "mental disorder" quality measures that have been submitted and that meet its strict standards of testing and documentation. (Several of these are items from a single instrument.)

Existing measures developed for behavioral healthcare vary greatly in their data source, health delivery system level, and purpose. Many are based on program- or plan-based administrative data and patient surveys. Measures that draw from medication and medical record data also are represented, however, particularly in depression and other specific clinical diagnostic areas.

Among behavioral healthcare conditions, depression has been a particularly extensive area of performance measure development. A recent review of performance measures for ambulatory care identified 67 performance measures for patients with depression alone.[20] A number of the behavioral health measures in the National Committee for Quality Assurance's (NCQA's) Health Plan Employer Data and Information Set (HEDIS) measures pertain specifically to depression, as do all of the 11 mental health measures in the "DOQ" measure set (recently approved for NQF consensus, as discussed above). Three of the four mental health measures in the Agency for Healthcare Research and Quality's 2003 *National Healthcare Quality Report* similarly pertain to only depression; the fourth (national suicide rate) is relevant to mental health more generally.[21]

One notable trend among behavioral healthcare measure developers has been a movement toward more between-group consensus and consolidation and an effort to develop core measures that are applicable across a wide variety of conditions and contexts:

- The set of performance measures developed by the American Managed Behavioral Healthcare Organization ("PERMS") was adopted in part by NCQA as part of its HEDIS performance measure set for behavioral health plans. HEDIS continues to add behavioral healthcare performance measures in other areas.[22]
- In 2002, three major mental healthcare groups—the National Association of State Mental Health Program directors (NASMHPD), the National Association of Psychiatric Health Systems, and the NASMHPD Research Institute—announced an effort to seek congruence among measures in their separate measure development projects. More recently, these groups collaborated with the Joint Commission on Accreditation of Healthcare Organizations to convene a meeting with the intent of identifying a core set of performance measures to assess the psychiatric care provided to hospital patients.
- In April 2004, SAMHSA sponsored the Second Forum on Performance Measures in Behavioral Health and Related Service Systems, part of a multiyear effort to establish core performance measures applicable to persons with mental illness and substance use disorders (with particular interest in persons served by publicly funded mental health and substance abuse treatment programs). Three performance measures developed and tested by the Washington Circle group for substance abuse care[23] were discussed in this forum for their broader applicability to mental healthcare. (The same three measures, in combined form, are being adopted by NCQA in HEDIS.) In addition, the forum discussed efforts to create a core patient survey measure (derived from several existing surveys) that could be used, with additional population-specific modules, by both adults and children with behavioral health disorders.

A comprehensive list of existing and in-development performance measures that potentially relate to primary and general acute care is beyond the scope of this paper. Table 5 presents some illustrative examples of existing behavioral healthcare performance measures and the variety of settings and conditions they address.

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TABLE 1. NQF-ENDORSED PERFORMANCE MEASURES RELEVANT TO BEHAVIORAL HEALTHCARE*

Acute Hospital Care

- Falls prevalence (falls per 1,000 patient days)

Nursing-Sensitive Care in Hospitals

- Falls prevalence (same as above)
- Falls with injury
- **Vest/limb restraint prevalence (percentage of inpatients)**
- Nursing skill mix (based on percentages of registered nursing (RN), licensed vocational/practical nursing (LVN/LPN), unlicensed assistive personnel (UAP) care, and contract hours (RN, LVN/LPN, and UAP) as percentage of total nursing hours)
- Nursing care hours per patient day (separate components for RN and all nursing staff [RN, LVN/LPN, UAP])
- Practice Environment Scale – Nursing Work Index (composite + five subscales)
- Voluntary nursing staff turnover

Nursing Homes

Chronic care

- Residents whose need for more help with daily activities has increased
- Residents who lost too much weight
- **Residents who were physically restrained daily during the 7-day assessment period**
- **Residents with worsening of a depressed or anxious mood**
- Residents who have a catheter in the bladder at any time during the 14-day assessment period (paired with above)
- Residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period
- Residents with a decline in their ability to move about in their room and the adjacent corridor

Post-acute care

- **Recently hospitalized residents with symptoms of delirium**

All nursing home residents and facilities

- Nursing care hours per patient day (separate components for RN, LVN/LPN, certified nurse's assistant, and total nursing staff hours)

*Does not include general surgical, infection-related, pain or pressure ulcer patient safety performance measures or smoking cessation measures. Measures that are especially specific to behavioral health disorders are in bold.

TABLE 2. MENTAL HEALTHCARE MEASURES UNDER CONSIDERATION IN THE NQF AMBULATORY CARE CONSENSUS PROJECT

Depression

Screening for Depression and Follow-up

- Percentage of patients who were screened annually for depression in primary settings.

Follow-up After Screening

- Percentage of patients with a positive screen for depression with a follow-up assessment or referral.

Diagnostic Evaluation

- Percentage of patients with depressive symptoms who were adequately assessed for major depressive disorder (MDD) during the initial visit.

Effective Acute Phase Treatment

- Percentage of patients with new-episode depression and treated with an antidepressant medication who remained on an antidepressant drug for at least 12 weeks.

Optimal Practitioner Contacts for Medication Management

- Percentage of patients with new-episode depression and treated with an antidepressant medication who had at least 3 follow-up contacts in 12 weeks.

Effective Continuation Phase Treatment

- Percentage of patients with new-episode depression and treated with an antidepressant medication who remained on an antidepressant drug for at least 6 months.

Continuation of Antidepressant Medication After Remission

- Percentage of patients prescribed an antidepressant medication who continued on medication for a minimum of 16 weeks following remission of symptoms.

Severity Classification

- Percentage of patients with MDD whose severity of MDD was classified at the initial visit.

Suicide Risk Assessment

- Percentage of patients with MDD who had a suicide risk assessment completed at each visit.

Treatment: Psychotherapy, Medication Management, and/or Electroconvulsive Therapy

- Percentage of patients with MDD who received therapy appropriate to their classification.

Mental Disorders

Follow-up After Hospitalization for Mental Illness

- Percentage of discharges for patients >age 6 who were hospitalized for treatment of selected mental disorders, who were seen on an ambulatory basis or were in day/night treatment with a mental health provider, 1) within 7 days, and 2) within 30 days.

TABLE 3. NQF-ENDORSED SAFE PRACTICES RELEVANT TO BEHAVIORAL HEALTHCARE

- Create a healthcare culture of safety.
- Specify an explicit protocol to be used to ensure an adequate level of nursing care based on the institution's usual patient mix and the experience and training of its nursing staff.
- Pharmacists should actively participate in the medication-use process, including, at a minimum, being available for consultation with prescribers on medication ordering, interpretation and review of medication orders, preparation of medications, dispensing of medications, and administration and monitoring of medications.
- Verbal orders should be recorded whenever possible and immediately read back to the prescriber – that is, a healthcare provider receiving a verbal order should read back the information that the prescriber conveys in order to verify the accuracy of what was heard.
- Use only standardized abbreviations and dose designations.
- Patient care summaries or other similar records should not be prepared from memory.
- Ensure that care information, especially changes in orders and new diagnostic information, is transmitted in a timely and clearly understandable form to all of the patient's current healthcare providers/professionals who need that information to provide care.
- Ask each patient or legal surrogate to recount what he or she has been told during the informed consent discussion.
- Implement a computerized prescriber order entry system.
- Implement standardized protocols to prevent the occurrence of wrong-site or wrong-patient procedures.
- Evaluate each patient upon admission, and periodically thereafter, for risk of malnutrition. Employ clinically appropriate strategies to prevent malnutrition.
- Decontaminate hands with either a hygienic hand rub or by washing with disinfectant soap prior to and after direct contact with the patient or objects immediately around the patient.
- Keep workspaces where medications are prepared clean, orderly, well lit, and free of clutter, distraction, and noise.
- Standardize the methods for labeling, packaging, and storing medications.
- Identify all "high-alert" drugs (e.g., intravenous adrenergic agonists and antagonists, chemotherapy agents, anticoagulants and anti-thrombotics, concentrated parenteral electrolytes, general anesthetics, neuromuscular blockers, insulin and oral hypoglycemics, narcotics and opiates).
- Dispense medications in unit-dose or, when appropriate, unit-of-use form, whenever possible.

TABLE 4. NQF-ENDORSED SERIOUS REPORTABLE EVENTS RELEVANT TO BEHAVIORAL HEALTHCARE*

- Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the healthcare facility.
- Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than intended.
- Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a healthcare facility.
- **Patient death or serious disability associated with patient elopement (disappearance) for more than four hours.**
- **Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility.**
- Patient death or serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration).
- Patient death or serious disability associated with an electric shock while being cared for in a healthcare facility.
- Any incident in which a line designated for oxygen or other gas to be delivered to the patient contains the wrong gas or is contaminated by toxic substances.
- Patient death or serious disability associated with a burn incurred from any source while being cared for in a healthcare facility.
- Patient death associated with a fall while being cared for in a healthcare facility.
- **Patient death or serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility.**
- Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider.
- Abduction of patient of any age.
- Sexual assault on a patient within or on the grounds of a healthcare facility.
- Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

*Practices highly relevant to behavioral health disorders are in bold.

TABLE 5. BEHAVIORAL HEALTHCARE PERFORMANCE MEASURES—ILLUSTRATIVE EXAMPLES

Health Plan/Program/System—General

- Percent of members receiving inpatient and outpatient services for mental health
- Ambulatory follow-up within 7 and 30 days of discharge for mental health
- Readmission rates for mental health
- Percent of psychiatrists who are board certified
- Availability of providers with bilingual language skills (English plus another)
- Percentage of consumers living independently
- Percentage of consumers arrested
- Average number of days of incarceration per consumer in past 30 days
- Percent of adult enrollees with a claim for alcohol/other drug (AOD) disorder
- Percent of adults with an index AOD claim who have an additional AOD claim w/in 14 days
- Percent of adults with an index AOD claim who have 2+ AOD services w/in 30 days
- MHSIP (Mental Health Statistics Improvement Project) consumer survey
- ECHO® (Experience of Care and Health Outcome) consumer survey

Health Plan/Program/System—Condition Specific

- Average change in self-reported score of severity of depressive symptoms between baseline and follow-up for patients w/depression
- Average change in self-reported score of social functioning between baseline and follow-up for patients w/depression
- Average change in self-reported number of disability days between baseline and follow-up for patients w/depression
- Antipsychotic drug dose within the guideline-recommended range for patients w/schizophrenia
- Assessment at least once in the past year for antipsychotic medication side effects for patients w/schizophrenia

Inpatient Care—General

- Injurious behaviors (adult and adolescent units)
  - Physical assault events by discharges and patient days
  - Self-injury events by discharges and patient days
  - Patient days with one or more self-injury events
  - Patient days with one or more physical assault events
- Use of seclusion in psychiatric inpatient units
- Use of restraints in psychiatric inpatient settings

Inpatient Care—Condition Specific

- Suicide status on admission for depressed elderly patients
- Cognitive status on admission for depressed elderly patients
- Psychosis assessment on admission for depressed elderly patients
- Psychiatric history on admission for depressed elderly patients
- Assessment of prior medications on admission for depressed elderly patients
- Completeness of neurological examination on admission for depressed elderly patients
- Inpatient complications for depressed elderly patients

Ambulatory Care—Condition Specific

- Diagnostic evaluation for patients with suspected major depressive disorder (MDD)
- Suicide risk assessment for patients with MDD
- Severity classification for patients with MDD
- Treatment: psychotherapy, medication management, and/or electroconvulsive therapy in patients with MDD
- Continuation of antidepressant medication in patients with MDD

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