SIM Behavioral Health design group

Recommendations for Quality Measures for Primary Care Regarding Behavioral Health 1.30.15

Background: The SIM Behavioral Health design group has been meeting several times since late October 2014 with the charge of making recommendations to SIM (both the Practice Transformation Task Force and the Quality Council) regarding behavioral health quality measures for the primary care setting.

After numerous discussions (both during in-person and phone meetings and via email), this group decided to submit an initial list of five behavioral health quality measures for the primary care setting to the SIM Quality Council (QC), based on the deadline currently in place via the SIM QC (to submit recommendations by the end of January 2015). This list of measures is submitted with the acknowledgment that this is *only the first phase* of identifying measures and knowing that there will need to be several phases of identifying measures and implementation processes, and an iterations of this process, in order to get to a health care system that operationalizes the full vision of integrated health care and accomplishing the Triple Aim of improving individual experience of care, improving population health, and reducing per capita health care costs.

Group members feel strongly about each of the actual measures (listed in progressive order), and also want to provide flexibility for implementation and thus have offered guidance on specific tools for implementation that have been standardized and/or found to work well already.

1. **<u>Universal Screenings</u> – as evidenced by documentation in medical chart/EHR**
    a. **Frequency**
        i. As part of health maintenance visits (using guidelines of U.S. Preventive Services Task Force www.uspreventiveservicestaskforce.org) – frequency depends on age group AND
        ii. When a person sees a primary care provider for specific issues and screens have not been conducted within the last 12 months

    b. **Screen domains**
        i. Mental health
            1. The Survey of Wellbeing of Young Children (SWYC) – for birth through age 3 www.theswyc.org

2. Pediatric Symptom Checklist – for age 4 through age 17 https://brightfutures.aap.org/pdfs/Other%203/PSC_35%20parent.pdf using the Pediatric Symptom Checklist (PSC) to be filled out by parents/caregivers until age 12 and using PSC ***and*** Pediatric Symptom Checklist-Youth Report (Y- PSC) starting at age 13
3. Patient Health Questionnaire (PHQ 9) or for shorter version PHQ 4, for depression screening for adults and older adolescents (*Note:* can also be used for maternal mental health screening in the pediatric setting) www.agencymeddirectors.wa.gov/Files/depressoverview.pdf
4. Patient Stress Questionnaire, a more general adult behavioral health screen that was adapted from PHQ 9 and other measures to create broader based tool to encompass multiple issues, not just depression (includes alcohol use) www.integration.samhsa.gov/Patient_Stress_Questionnaire.pdf

ii. Substance use
1. SBIRT (Screening, Brief Intervention and Referral to Treatment) (more involved screens and best practice) www.integration.samhsa.gov/clinical-practice/SBIRT
2. CAGE-AID (- Adapted to Include Drug use) for alcohol and other drugs (four questions, with any yes response requiring further assessment) www.integration.samhsa.gov/images/res/CAGEAID.pdf

iii. Trauma
1. LEC (Life Events Checklist) www.integration.samhsa.gov/clinical-practice/life-event-checklist-lec.pdf
2. PCL-C (shortened version of PTSD Check List – Civilian version) http://www.integration.samhsa.gov/clinical-practice/Abbreviated_PCL.pdf

iv. Wellbeing – Global functioning
1. PROMIS® (Patient Reported Outcomes Measurement Information System) - a system of highly reliable, precise measures of patient–reported health status for physical, mental, and social well–being. Specifically the 10-item Global Health Short Form. www.nihpromis.org

2. **<u>Follow-up Assessment and Care</u> – as evidenced by documentation in medical chart/EHR**
    a. **Population**
    Follow-up care is expected after a person has been screened and if the screen was positive
    b. **Follow-up care – appropriate action was taken**
        i. Follow-up to include full behavioral health assessment and determination of need for specialty behavioral health care
        ii. Actions could include (but are not limited to) follow-up within the practice, either by primary care provider or co-located behavioral health provider; or making referrals to behavioral health care providers
        iii. Best practices include shared practice guidelines and protocols (such as agreed upon expectations/guidelines for documentation, communications, information-sharing, and coding and billing), which should include having Memorandum of Agreement (MOA) between primary care practices and behavioral health providers, when providers are not part of the same practice/co-located.
        iv. Best practices include utilizing Access MH – a free and timely consultation services for pediatric providers on behavioral health questions that require more expertise than pediatric practice has available. Telephonic consultation includes education on assessment, treatment, and access to community resources for youth with mental health needs. (www.accessmhct.com)
        v. Evidence that the primary care practice itself, and/or the non-co-located behavioral health care providers, when they are involved, are documenting the use of measures of outcomes/recovery for the conditions in these domains which have been diagnosed and are under treatment.

3. **<u>Access to Care</u> – Referral to specialty behavioral health care and other services and supports: as evidenced by documentation in medical chart/EHR and Billing data**
    a. **Co-located or integrated** with the primary care practice;
    b. **Memorandums of Agreement (MOA)** with community behavioral health providers;
    c. If follow-up care was indicated based on a screen, and follow-up was expected to be done with a behavioral health provider, a **referral should be made, and communication loop closed** after referral has been completed with such provider. This should be done whether providers are co-located or whether behavioral health provider(s) are outside the primary care practice.
        i. Goal would be for the individual to have choices between several behavioral health providers (to allow for personal choice/good match between person and provider and to allow for different levels of severity/condition, provider specializes in)

ii. Primary care practices can also utilize carriers' information to identify potential behavioral health providers/support individuals in accessing this information and supporting their health literacy

d. Other services and supports that can be included in accessing relevant care, may include peer services (e.g., peer supports, support groups), school-based services (for school-age children/youth) and other social determinants, e.g., housing issues.

4. <u>Coordination of Care</u> – as evidenced by documentation in medical chart/EHR and Billing data

a. Population: Primary care patients with identified behavioral health condition and one or more chronic medical conditions, as determined by the measured need of the particular practice's patient panel/population (e.g., asthma, diabetes, COPD, cardiac, etc.)

b. Intensive case management services should be offered to persons who have been identified as having a behavioral health condition and a (chronic) medical condition (e.g., diabetes, asthma, cardiac condition; and/or conditions identified by the practice as relevant issues for the people they serve)

5. Hospital Readmission – as evidenced by Billing data

a. 30 day readmission (Custom measure endorsed by and stewarded by Medicaid Medical Directors Learning Network (MMDLN)

As an **overall recommendation**, this group recommends further discussion and development of educational opportunities **for 1) the community at large** (to increase health literacy among persons and become better-informed health care actors (v simply being 'consumers' of health care services) and **2) health care providers**, both in their professional education and continuing education/in-services.

This group offers its resources to be part of these crucial educational efforts in regards to behavioral health.