What Counts in Mental Health and What We Are Counting?
Our “Performance Measures” and Other Metrics

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For the Work Group at VHA OMHS METRICS
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  – “We are from Central Office and we are here to help you”

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  – National Institute on Alcohol Abuse and Alcoholism
  – National Institute on Drug Abuse
  – VA Health Services Research & Development
  – VA Quality Enhancement Research Initiative

• DK participation in National Quality Forum panels
Overview

- Very brief history of Performance Measurement in VHA
- Key dimensions of performance in health care - IOM
- Measure evaluation criteria – NQF
- VHA Mental Health Access Composite – NDPP
- Findings from DRAFT report by Office of Inspector General
- T-21 Operating Plan Metrics
- Getting to Effectiveness
- Measurement-based Care
A Brief History

EDITORIALS

The Double Edged Sword of Performance Measurement

Kerrioth W. Kizor, MD, MPH1,2 and Susan R. Kirsh, MD, MPH3

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ORIGINAL RESEARCH

Unintended Consequences of Implementing a National Performance Measurement System into Local Practice

Adam A. Powell, PhD1,2, Katie M. White, EdD3, Melissa R. Partin, PhD1,2, Krysten Halek, MA1, Jon B. Christianson, PhD3, Brian Neil, MD4, Sylvia J. Hysong, PhD5,6, Edwin J. Zarling, MD7, and Hanna E. Bloomfield, MD1,2

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Powell et al 2012
Unintended Consequences

• 59 semi-structured interviews in Primary Care at 4 VAMCs

• Inappropriate clinical care
• Decrease provider focus on patient concerns
• Compromise patient education and autonomy
• Consequences for clinical team dynamics

• Largely due to local implementation strategies
“Quality problems occur typically not because of failure of goodwill, knowledge, effort or resources devoted to health care, but because of fundamental shortcomings in the ways care is organized”

The American health care delivery system is in need of fundamental change. The current care systems cannot do the job.

*Trying harder* will not work: Changing systems of care will!

Institute of Medicine, 2001
IOM Six Aims For Improvement

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable
Quality Measure Evaluation Criteria

- Impact, Opportunity, Evidence—Importance to Measure and Report
  - important to making significant gains in healthcare quality improving health outcomes
- Reliability and Validity—Scientific Acceptability
- Usability
  - Extent to which intended audiences can understand the results and find them useful for decisionmaking
- Feasibility
  - Extent to which the required data are readily available or could be captured without undue burden and can be implemented for performance measurement

National Quality Forum, January 2011
Accountability Measures — to Promote Quality Improvement

• based on a strong foundation of research showing that the process addressed by the measure, when performed correctly, leads to improved clinical outcomes
  – Process “tightly linked” to outcome
• must accurately capture whether the evidence-based care has been delivered
• address a process quite proximate to the desired outcome, with relatively few intervening processes
• should have minimal or no unintended adverse consequences

Chassin et al., NEJM 2010
Mental Health Access Composite of Network Directors Performance Plan

- Based on 5 measures (elements)
- Each VISN must pass at least 4 of the 5 measures in Q4.
- The VISN score for each element is the total numerator divided by the total denominator for all the eligible cases within a VISN.
- The VISN composite score is defined as the number of measures that meet or exceed the target.
- VISN will need to provide an action plan by September 1 for each element not passed based on 3rd quarter cumulative score.
5 Elements of the Mental Health Access Composite

- New Mental Health patients receiving a full evaluation in less than 15 days of referral
- Veterans discharged from an inpatient Mental Health unit who are seen in outpatient care within 7 days.
- Veterans identified at high risk for suicide who have clinical contact with a mental health provider at least 4 times in the 4 weeks after identified risk.
- OEF/OIF Veterans with PTSD who get a course of psychotherapy that could be consistent with evidence-based psychotherapy.
- Patients new to PTSD specialty care who complete an appointment within 14 days of “desired date”
Review of Veterans’ Access to Mental Health Care – March 2012
DRAFT OIG Summary
OIG: Measuring Access to Mental Health Care in the Private Sector

- Timeliness of Care – “create date”
- Continuity of Care and Follow-Up Appointments
  - e.g., at least 4 visits within 45-60 days
- Treatment Engagement
  - e.g., percent completing 2\textsuperscript{nd} appointment $\geq60\%$
- Capacity
  - availability of future appointment slots
- Patient Satisfaction
  - surveys and patient-initiated feedback
Process of Measuring Access

- Veteran/Provider requests a MH Evaluation and is scheduled

  T-0  
  Must occur within 24 hours

- Patient triaged (this may also happen at T0)

  T-1  
  Must occur within 14 days

- Veteran completes full evaluation

  T-2

- Treatment needed? (If yes... continue on to T3)

  T-3

- If Patient has a new problem or exacerbation of the old problem - complete a focused exam.

  T-5

- Ongoing Treatment

  T-4
Post OIG - Elements of the Mental Health Access Composite

• New Mental Health patients receiving a full evaluation in less than 15 days of referral?
• Veterans discharged from an inpatient Mental Health unit who are seen in outpatient care within 7 days.
• Veterans identified at high risk for suicide who have clinical contact with a mental health provider at least 4 times in the month after identified risk.
• OEF/OIF Veterans with PTSD who get a course of psychotherapy that could be consistent with evidence-based psychotherapy.
• Patients new to PTSD specialty care who complete an appointment within 14 days of “desired date”?
T-21 Initiative for Mental Health

Department of Veterans Affairs

Improving Veterans Mental Health Initiative Operating Plan FY 12+

Providing excellence in mental health care through innovation, public health outreach, and seamless transition from active duty for our Nation’s Veterans

Veterans Health Administration
UNIFORM MENTAL HEALTH SERVICES IN VA MEDICAL CENTERS AND CLINICS

1. REASON FOR ISSUE. This revised Veterans Health Administration (VHA) Handbook defines minimum clinical requirements for VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally, to ensure that all veterans, wherever they obtain care in VHA, have access to needed mental health services.
Other T-21 Metrics Proposed for FY13

• 5 Elements of the NDPP
• Demonstrate capability to deliver psychotherapy for PTSD via telemental health
• VISNs with at least 75% of eligible Veterans assigned to a Mental Health Treatment Coordinator
• “Regular” assessment with PTSD Checklist for OEF/OIF Veterans with PTSD
• Clinical symptom monitoring for Depression and Substance Use Disorder
Most Veterans Reported Treatment Was Helpful, But Fewer Reported Improvement in Key Recovery Dimensions

- 74% of veterans reported being helped “a lot” or “somewhat” by their counseling or treatment in the last 12 months

![Bar chart showing improvement in various recovery dimensions: Dealing with daily problems (40%), Dealing with social situations (30%), Problems or symptoms (20%), Ability to accomplish things (20%) with a range of 0% to 60% improvement.](chart)
Current Considerations on Symptom Monitoring

• Evidence-based psychotherapy protocols for PTSD and depression now incorporate routine symptom monitoring

• Aspirational goal is “routine” measurement-based care with clinically feasible methods (i.e., informatics tools)

• Incremental proposal:
  – at intake for all new episodes of SUD or PTSD specialty care
    • targeting depression involves multiple settings?
  – Reassessment at least once soon after from intake (30-90 days?)
  – Expected for those who remain active in treatment
  – Data in Mental Health Assistant data base
  – Available for clinical review and aggregate analyses

• Actual measure specifications still in development
Many Unresolved Issues

• Measurement-based care is culture change for many patients and providers
• Alternative data entry
  – Computer kiosks in waiting room; Limited demo for FY12
  – Remote, non-visit based entry
• Co-occurring conditions (e.g., PTSD&SUD)
• Inpatient and residential admissions
Measurement-Based Care

“Enhanced precision and consistency in disease assessment, tracking, and treatment to achieve optimal outcomes”

Measurement-Based Care in Psychiatric Practice: A Policy Framework for Implementation

Kelli Jane K. Harding, MD; A. John Rush, MD; Melissa Arbuckle, MD, PhD; Madhukar H. Trivedi, MD; and Harold Alan Pincus, MD

VETERANS HEALTH ADMINISTRATION

### Measurement-Based Care: Key Elements

<table>
<thead>
<tr>
<th>Assessments that are</th>
<th>Specific</th>
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<tbody>
<tr>
<td></td>
<td>Targeted to a specific issue (Is X working?)</td>
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<tr>
<td></td>
<td>Tailored to the individual</td>
</tr>
<tr>
<td></td>
<td>Psychometrically and conceptually sound</td>
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<tr>
<td></td>
<td>Brief</td>
</tr>
<tr>
<td></td>
<td>Inexpensive</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Action plans that are</th>
<th>Specific</th>
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<tbody>
<tr>
<td></td>
<td>Evidence based (whenever possible)</td>
</tr>
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<td></td>
<td>Flexible—provide an array of reasonable options</td>
</tr>
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<td></td>
<td>Evaluable</td>
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</tbody>
</table>
Measurement-Based Care: Limitations

- Efficacy has not been established in larger numbers of comparative trials
- Excessive assessments are burdensome
- Risk of oversystematizing and depersonalizing
- Replaying a clinical question with a lengthy scale is not useful
- Without an action plan, measurement is unhelpful
- Many action plans are not evidence based
“We have several good treatment options to choose from. On average, they have about the same chance of success. But you are not an average; you are an individual. At this time, there is no scientific way to predict which treatment will work best for you. Together, we will look at your options and decide what treatment to start with. But it is important to remember that there are other options. If the first treatment we pick does not work out for you, some other treatment might work well. Regular follow-up over the next several weeks will tell us whether to stay with our first choice or try something else.”

Questions?
Back-up Slides
Who Would be Eligible Patients?

• Any PTSD diagnosis?
• Any outpatient PTSD diagnosis?
• Any active PTSD outpatient specialty care
• New episode of PTSD outpatient specialty care
  – Which stop codes (540, 561, 516, 562)?
  – How many days of visits in what period?
  – What constitutes “new” (e.g., 90 day hiatus)?
• New episode of PTSD specialty care and remain in treatment during follow-up window
What Gets Reported?

• Fact of monitoring
  – % of eligible at intake
  – % of eligible at reassessment
• Clinically significant improvement
  – % with minimum change of X on PCL total score
  – Problems with change scores
Potential Frequency/Timing

- Each encounter
- Fixed frequency (e.g., quarterly)
- At intake to new episode of PTSD specialty care
  - Within +/- XX days of qualifying visit?
- Reassessed at least once during follow-up window:
  - Baseline + 30-60 days
  - Baseline + 30-90 days
  - Baseline + 30-120 days
DSS identifiers (stop codes)

- 540 (PTSD CLINICAL TEAM (PCT) IND),
- 561 (PCT-GROUP),
- 516 (PTSD Group)
- 562 (PTSD Individual)
<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Measure Type</th>
<th>Key Goal</th>
<th>Status</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Improvement</td>
<td>Outcome or Output</td>
<td>Enhance VA’s capacity to deliver evidence-based interventions</td>
<td>Instrument and Administration strategies being piloted in SUD Intensive Outpatient Programs (IOPs). Will require national reminder.</td>
<td>National Implementation targeted for FY 2011</td>
</tr>
<tr>
<td>Percent of VA facilities reporting BAM (Brief Addiction Measure)</td>
<td>Outcome or Output</td>
<td>Enhance VA’s capacity to deliver evidence-based interventions</td>
<td>Instrument and Administration strategies being piloted in SUD Intensive Outpatient Programs (IOPs). Will require national reminder.</td>
<td>National Implementation targeted for FY 2011</td>
</tr>
<tr>
<td>Depression Improvement</td>
<td>Outcome or Output</td>
<td>Enhance VA’s capacity to deliver evidence-based interventions</td>
<td>Instrument and Administration strategies being piloted in Mental Health / Primary Care Integration clinics. Will require national reminder.</td>
<td>National Implementation targeted for FY 2011</td>
</tr>
<tr>
<td>Percent of VA facilities reporting PHQ9 change scores from repeated administrations of the PHQ9 instrument for individual patients under treatment for depression</td>
<td>Outcome or Output</td>
<td>Enhance VA’s capacity to deliver evidence-based interventions</td>
<td>Instrument and Administration strategies being piloted in Mental Health / Primary Care Integration clinics. Will require national reminder.</td>
<td>National Implementation targeted for FY 2011</td>
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</table>
Mental Disorders\(^1\) among OEF/OIF/OND Veterans\(^2\)
Cumulative from 1st Quarter FY 2002 through 3rd Quarter FY 2011

<table>
<thead>
<tr>
<th>Disease Category (ICD 290-319 code)</th>
<th>Total Number of OEF/OIF/OND Veterans(^3)</th>
<th>Change since Q3FY10</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD (ICD-9CM 309.81)</td>
<td>197,074</td>
<td>25.6%</td>
</tr>
<tr>
<td>Depressive Disorders (311)</td>
<td>147,659</td>
<td>29.9%</td>
</tr>
<tr>
<td>Neurotic Disorders (300)</td>
<td>126,673</td>
<td>33.7%</td>
</tr>
<tr>
<td><strong>Tobacco Use Disorder (305.1)</strong></td>
<td><strong>119,248</strong></td>
<td>***</td>
</tr>
<tr>
<td>Affective Psychoses (296)</td>
<td>89,001</td>
<td>31.8%</td>
</tr>
<tr>
<td><strong>Alcohol Abuse (305.0)</strong></td>
<td><strong>44,611</strong></td>
<td>***</td>
</tr>
<tr>
<td>Alcohol Dependence Syndrome (303)</td>
<td>41,409</td>
<td>33.1%</td>
</tr>
<tr>
<td><strong>Non-Alcohol Abuse of Drugs (ICD 305.2-9)</strong></td>
<td><strong>28,776</strong></td>
<td>***</td>
</tr>
<tr>
<td>Specific Nonpsychotic Mental Disorder due to Organic Brain Damage (310)</td>
<td>25,038</td>
<td>24.9%</td>
</tr>
<tr>
<td>Special Symptoms, Not Elsewhere Classified (307)</td>
<td>24,936</td>
<td>34.8%</td>
</tr>
<tr>
<td><strong>Drug Dependence (304)</strong></td>
<td><strong>21,309</strong></td>
<td><strong>38.3%</strong></td>
</tr>
</tbody>
</table>

\(^1\) Includes both provisional and confirmed diagnoses.
\(^2\) These are cumulative administrative data since FY 2002.
\(^3\) A total of 367,749 unique patients received one or more diagnoses of a possible mental disorder.
Most Veterans Reported Treatment Was Helpful, But Fewer Reported Symptom Improvement

- 74% of veterans reported being helped “a lot” or “somewhat” by their counseling or treatment in the last 12 months.
Satisfaction with VA Treatment Varied by Diagnostic Cohort

VHA National Average (42.3%)

** denotes p < .01; *** denotes p < .001
## Emerging Metric from FY11 IVMH Operating Plan

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>Measure Type Outcome or Output</th>
<th>Key Goal</th>
<th>Status (include resources/support required to implement)</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD Improvement-Percent of VA facilities reporting PCL-S change scores from repeated administrations of the PCL-S instrument for individual patients under treatment for PTSD</td>
<td>Outcome Final</td>
<td>Enhance VA’s capacity to deliver evidence-based interventions</td>
<td>Instrument and Administration strategies being piloted in Mental Health / Primary Care Integration clinics Will require national clinical reminder.</td>
<td>National Implementation targeted for FY11</td>
</tr>
</tbody>
</table>
Systematic outcome evaluation by OMHO

- Outcome Evaluation is complementary to clinical symptom monitoring
- Centralized follow-up assessment regardless of treatment retention
- Re-assessment of broader set of dimensions
  - Patient experience of care
  - Recovery oriented measures
- Re-assessment not by treating clinician
- Achievable more efficiently by appropriate sampling
NDPP Element 1: 14 Day Mental Health Follow Up

- The percent of new veterans receiving an evaluation in less than 15 days of referral.

- *Denominator:* Veterans with encounter in any mental health stop code except C&P, neuropsychological testing and smoking cessation for a MH dx/problem and no prior encounters in mental health in the previous 24 months.

- *Numerator:* Veterans with a full evaluation based on the CPT code by a valid provider.

- Benchmark- FY12 target is set at 96%.
NDPP Element 2: 7 Day Discharge Visit

- The proportion of veterans being discharged from an inpatient Mental Health unit who are seen in outpatient care within 7 days.

- Denominator: VA inpatient discharges from acute mental health service.
- Numerator: Veterans with an encounter in a mental health stop code by within 7 days after the discharge date (not same day as discharge).
- If initial follow-up contact is by telephone within 7 days, a face to face or telemental health follow up must occur within 14 days of the patient’s discharge.
- Exclusions: Patients discharged or transferred from inpatient mental health to another VHA bed section.
- Benchmark- FY12 target is set at 75%.
NDPP Element 3: High Risk Suicide Monitor

- The percentage of veterans identified at high risk for suicide attempt who have clinical contact with a mental health provider at least 4 times in the month after identification risk.

- Denominator: Veterans with the health factor “Suicide High Risk PRF Placed on Chart” activated.

- Numerator: Total number of patients that received a qualifying follow-up mental health encounter (telephone or face to face) in each of four weeks following discharge from inpatient or the date of the flag. Two of the visits need to occur in the first 14 days and 2 in the second 14 days.

- Benchmark- FY12 target is set at 85%.
NDPP Element 4: OEF/OIF Psychotherapy

- The proportion of OEF/OIF Veterans with PTSD who get a course of psychotherapy that could be consistent with evidence-based psychotherapy.

- Denominator- OEF/OIF Veterans who have 2 outpatient encounters with a primary diagnosis of PTSD (309.81) within a 90 day period.

- Numerator- Those patients are then required to have 8 psychotherapy sessions (using the CPT codes 90801, 90806, 90807, 90808, 90809, 90818, 90819, 90821, 90822, 90847, 90853) within 14 weeks sometime during the next 12 months.

- Exclusions- Patients who have had 8 psychotherapy sessions in 14 weeks (as defined by the codes above) in the previous 5 years

- Benchmark- FY12 target is set at 20%.
NDPP Element 5: Timely access to specialty PTSD Care

- Patients new to PTSD specialty care over prior 2 years who complete an appointment with 14 days of desired date as shown in the scheduling package software

- Denominator: Veterans with a primary PTSD diagnosis and completed appointment in one of the PTSD specialty clinics: 516 PTSD GRP, 519 PTSD SUD, 540 PCT-PTSD IND, 561 PCT-PTSD GRP, 562 PTSD-IND.

- Denominator Exclusions: Veterans with an encounter having a C&P credit stop of 450 or 542 TELEPHONE/PTSD and 580 PTSD DAY HOSPITAL

- Numerator: Veteran with completed appointment to the PTSD specialty clinic within 14 days of desired date.

- Benchmark- FY12 target is 92%.