Draft Measures for Task Force's Consideration
December 15, 2014

We've organized a proposed set of measures based on the key ideas included within the draft vision statement. We've attempted to include measures that would help policymakers to assess the state's performance towards each of these goals. Typical performance measures are largely unable to inform policymakers of the goals included below.

As a first step we should determine whether each of the items in red below should be measured, or whether some should continue to be measured in other ways, such as parity, and health outcomes. After determining which areas should be measured, we will then discuss potential measures to be included.

Draft Vision for the Massachusetts Behavioral Health System (Key Topics in Red)

A high-performing behavioral health system will be integrated with the medical health system to deliver appropriate access to the right care, at the right time and in the right place across the full continuum of care (starting with prevention). The system should be patient-centered. Behavioral health needs and treatments are diverse, so there should be 'no wrong door' to access appropriate care.

A high performing health system will treat behavioral health no differently than physical health care (parity). An educated workforce of both behavioral health specialists and other medical professionals should deliver evidence-based care, coordinated and supported by tools such as an interoperable electronic health record. Patient's families should be involved in care decisions and information sharing where appropriate (e.g. with the patient's informed consent).

The system should be of sufficient capacity to ensure that there is no emergency-room boarding, and that individuals are able to flow through the system and access different levels of care as needed, without undue waits. Payment for these services should be fair and reasonable to allow for sustained capacity, and should include incentives for providers to work together to provide effective care towards maximizing patient outcomes and experience.

Proposed Measures for Task Force Consideration

Domain	Measure	Notes
Person-centered	***Experience of care measures*** • How much improvement they perceived in themselves as a result of care provided. • Percent of patients that agree they had a team of providers working to meet the patient's needs	Ideally these are collected through surveys of individuals and families. If that is cost prohibitive may want to consider using proxy measures.
	Ability to access care when needed	Ideally this would be collected through a survey of individuals and families; could potentially get at this through a provider survey of who is accepting new patients or wait lists.
	Consumer and family participant in treatment planning, as desired, and agreement with plan of care	This could potentially be collected via survey of individuals and families or through a record review.
Workforce and Infrastructure	Number of providers in specialty, including: • Hours worked • Work setting • Types of insurance accepted • Specialty training • Languages spoken • Types of services provided	Compared to prevalence of behavioral health issues for MA population
	Numbers and types of behavioral health providers with interoperable Electronic Health Records (EHRs) and protocols in place to share information with physical health and behavioral health providers	MeHI or the HIT Council may collect some of this data.
	Number of prescribing providers with ability to review up-to-date behavioral and physical health medication lists prior to issuing new prescriptions[1]	

[1] This is a meaningful use measure.

Access	Number of patients in the emergency department that are ready to be discharged or admitted but unable to leave ED because they are waiting for available care in either the community or hospital.	This measure should: • Be stratified by age; payer; geography; and reason why the patient cannot be placed; • include both the average length of stay and should look at those who remain in the ED for 3, 6, 12, 24, or more hours; • be conducted daily, if possible, to see differences in ability to discharge by day of week and time of year, and • be trended over time
	Number of individuals with more than six ED visits within a 12 month period with a behavioral health diagnosis	This measure would look at the number of frequent ED users
	Number of patients in inpatient psychiatric care that are ready to be discharged to step-down care but unable to leave inpatient care because they are waiting for available step-down care.	This measure should: • be stratified by age; payer; geography; and reason why cannot be placed; • include both the average length of stay, and the amount of time individuals remain post-readiness for discharge as they are waiting for care; • be conducted daily, if possible, to see differences in ability to discharge by day of week and time of year, and • trended over time
	Number of patients in DMH Continuing Care Facilities that are	This measure should:

	ready to be discharged to community but are unable to leave because they are waiting for community-based supports	• be stratified by age, payer, geography, service or support waiting for and why cannot be placed; • include both the average length of stay, and the amount of time individuals remain in CCF post-readiness for discharge as they are waiting for care/supports, and • be trended over time
	Unduplicated count of individuals receiving behavioral health services in the state as compared to those expected to need behavioral health services (based on prevalence data)	• Stratified by age, payer, geography and service type
	Number of licensed beds and occupancy rates for: o Inpatient psychiatric beds o Free-standing psychiatric facility o DMH Continuing Care Facilities	
	Number of licensed inpatient psychiatric beds compared to number of staffed beds, by region	May also want to consider access to nearby out-of-state facilities.
	Average time to appointment for outpatient behavioral health care, by service type	• Stratified by age, payer, and geography, new vs. current patient
Care Delivery; Health and Well-being Outcomes	***Measures of Behavioral Health Integration*** • Number of patients with behavioral health issues that are being screened for medical issues (e.g., LDL, BP, BMI, A1C, as appropriate) • Number of patients with medical health issues that are being screened for behavioral health issues in the primary care setting (e.g., depression, substance use, suicidal ideation) • Number of primary care practices that offer integrated behavioral health services	

	• Number of behavioral health practices that offered integrated primary care services	
	Provider performance against evidence-based standards of care	This would need to be refined.
	Re-admissions to any care setting within 30 days of discharge from inpatient psychiatric care	
	Follow-up after hospitalization for mental illness or substance use disorder within 7 days and within 30 days	
	Follow-up referral and adequate connection to care after discharge	
	Number of arrests for individuals who have received behavioral health care and for individuals who have received treatment within the past 30 days Percent of individuals with behavioral health needs who have stable housing	
Fair and Reasonable Payment Rates and Financial Alignment	Variation in payment rate across providers types	By insurer
	Total cost of care for individuals receiving behavioral health services	By diagnosis By insurer
	Number of providers that receive payment and/or performance incentives for integration and/or coordination work	E.g., incentives for integrated care or payment for phone calls necessary to coordinate care with primary care providers.
	Cost of care for individuals receiving behavioral health services in a hospital setting, including emergency department care	By diagnosis By insurer
	Inclusion of behavioral health services within global budgets	By insurer
Parity		