



**Department  
of Health**

Medicaid  
Redesign Team

# Behavioral Health (Depression & Anxiety, Trauma & Stressor)

Clinical Advisory Group #4

Meeting Date: April 28, 2016

# Tentative Meeting Schedule & Agenda

Depending on the number of issues address during each meeting, the meeting agenda for each CAG meeting will consist of the following:

## Meeting 1

- Clinical Advisory Group - Roles and Responsibilities
- Introduction to Value Based Payment
- HARP Population Definition and Analysis
- Introduction to Outcome Measures

## Meeting 2

- Recap First Meeting
- HARP Population Quality Measures

## Meeting 3

- Episodes - Understanding the Approach
  - Depression Episode
  - Bipolar Disorder Episode
- Introduction to Bipolar Disorder Outcome Measures

## Meeting 4

- Behavioral Health CAG – Status Recap and Scope Refinement
- CVG Behavioral Health Episode Restructuring Process
- Behavioral Health Episodes and the Big Picture
- Understanding the Approach – Introduction to HCI3
- Depression & Anxiety (D&A) – Trauma & Stressor (T&S) Episode Definition
- Introduction to D&A – T&S Outcome Measures

## Meeting 5

- SUD Episode Definition
- Introduction to SUD Outcome Measures
- Wrap-up

# Content

## Introductions & Tentative Meeting Schedule and Agenda:

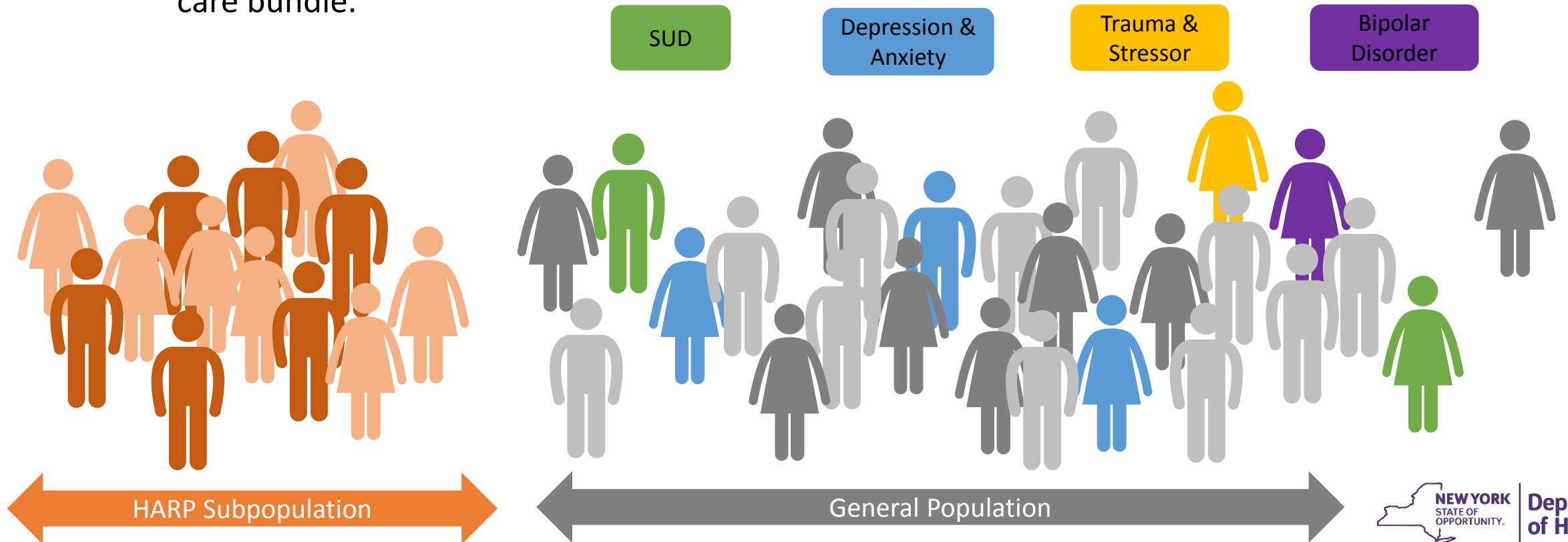
- A. Behavioral Health CAG – Status Recap and Scope Refinement
- B. CVG Behavioral Health Episode Restructuring Process
- C. Behavioral Health Episodes and the Big Picture - Contracting and the Chronic Care Bundle
- D. Understanding the Approach – Introduction to HCI3
- E. Depression & Anxiety Episode
- F. Trauma & Stressor Episode
- G. Quality Measures – Depression & Anxiety – Trauma & Stressor

## A. Behavioral Health CAG

Status Recap and Scope Refinement

# Behavioral Health CAG Scope

- The BH CAG comprises:
  - The HARP subpopulation which is contracted separately in a Total Cost For Subpopulation arrangement.
  - It also includes episodes which are contracted in the general population through the chronic care bundle.



# Behavioral Health CAG Recap

## Past

### Recap of work completed in Fall 2015

- HARP Population
- Bipolar Disorder Episode

### Winter 2015-2016 work

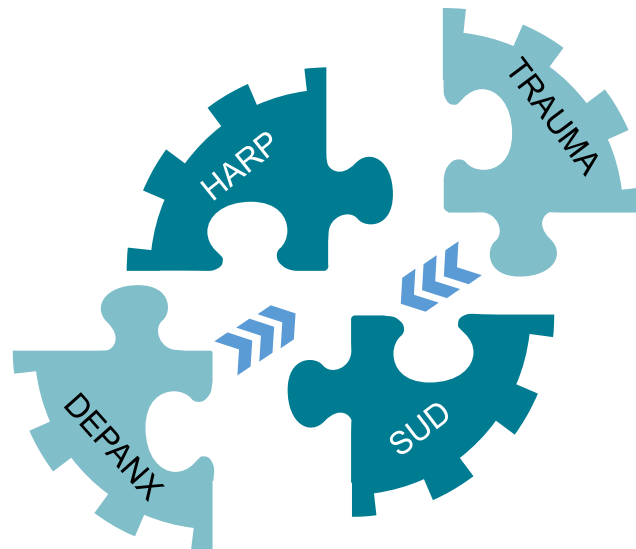
- Development and convening of Clinical Validation Group (CVG) to refine and create BH episodes



## Present

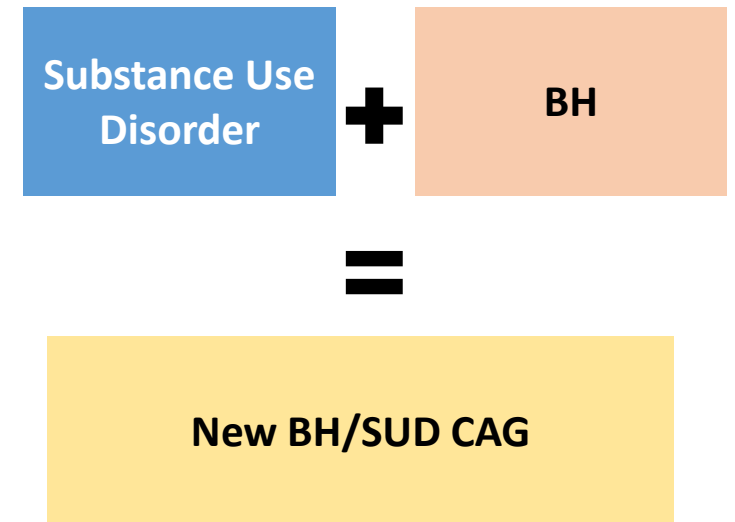
### Definition to Depression & Anxiety – Trauma & Stressor Episodes

- Episode definition
- Discussion of quality measures



## Future

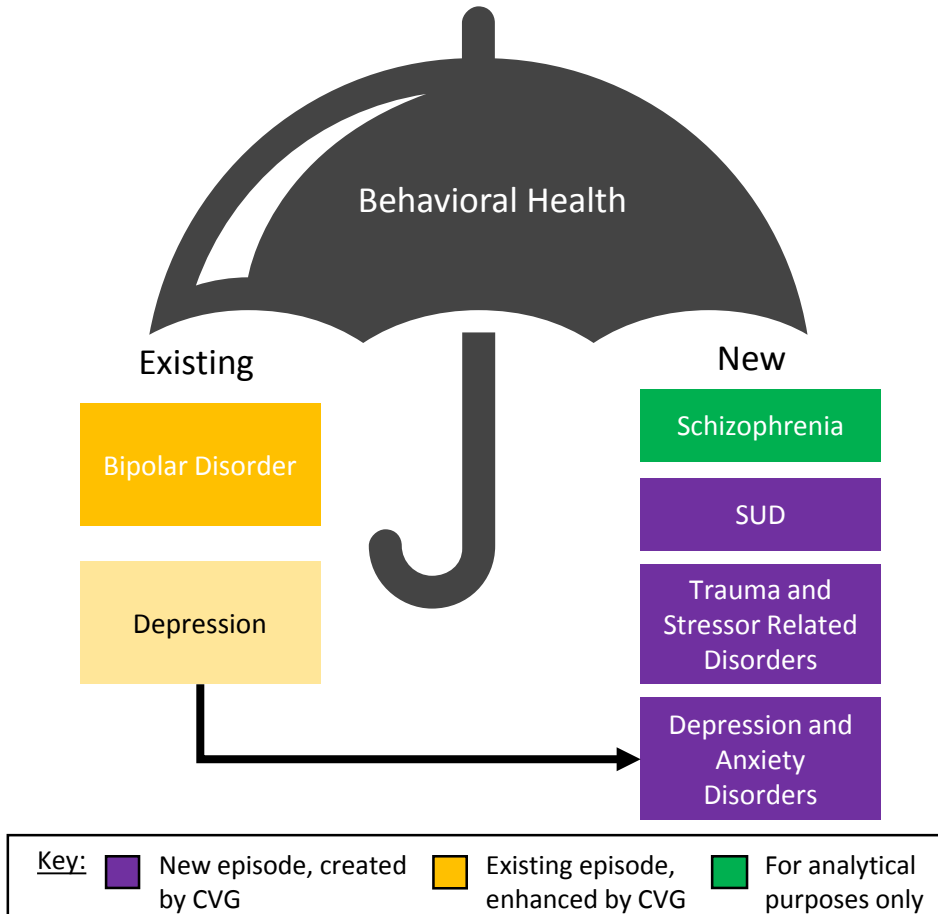
### Incorporation of the SUD members into future CAG meetings



## B. Clinical Validation Group

Behavioral Health Episode Restructuring Process

# Clinical Validation Group (CVG)



- NYC and NYS are forerunners in leading the way for progressive Behavioral Health initiatives
  - NYC - Mayor De Blasio’s ThriveNYC Initiative (\$850 million)
  - NYS - Behavioral Health integration
    - Strong emphasis on incentivizing the integration of behavioral and physical health in DSRIP
    - HARP SNP and now HARP VBP arrangement is nationally leading concept
    - *Putting visibility, quality and the need for integrated care for (combinations of) individual chronic BH conditions on the map is next*
- **Thank you to the participants of the CVG for their tremendous effort to enhance/create five episodes!**
  - Dr. Tom Smith, Dr. Sharon Stancliff, Dr. Bruce Maslack, Pat Lincourt, Dawn Lambert-Wacey, Dr. Charles Morgan, Belinda Greenfield and Stephan Brown
- The CVG, led by Dr. Amita Rastogi (HCI3), met over six times from September-November 2016 and reviewed 4,000+ lines of ICD-9 Codes to develop and enhance five separate episodes



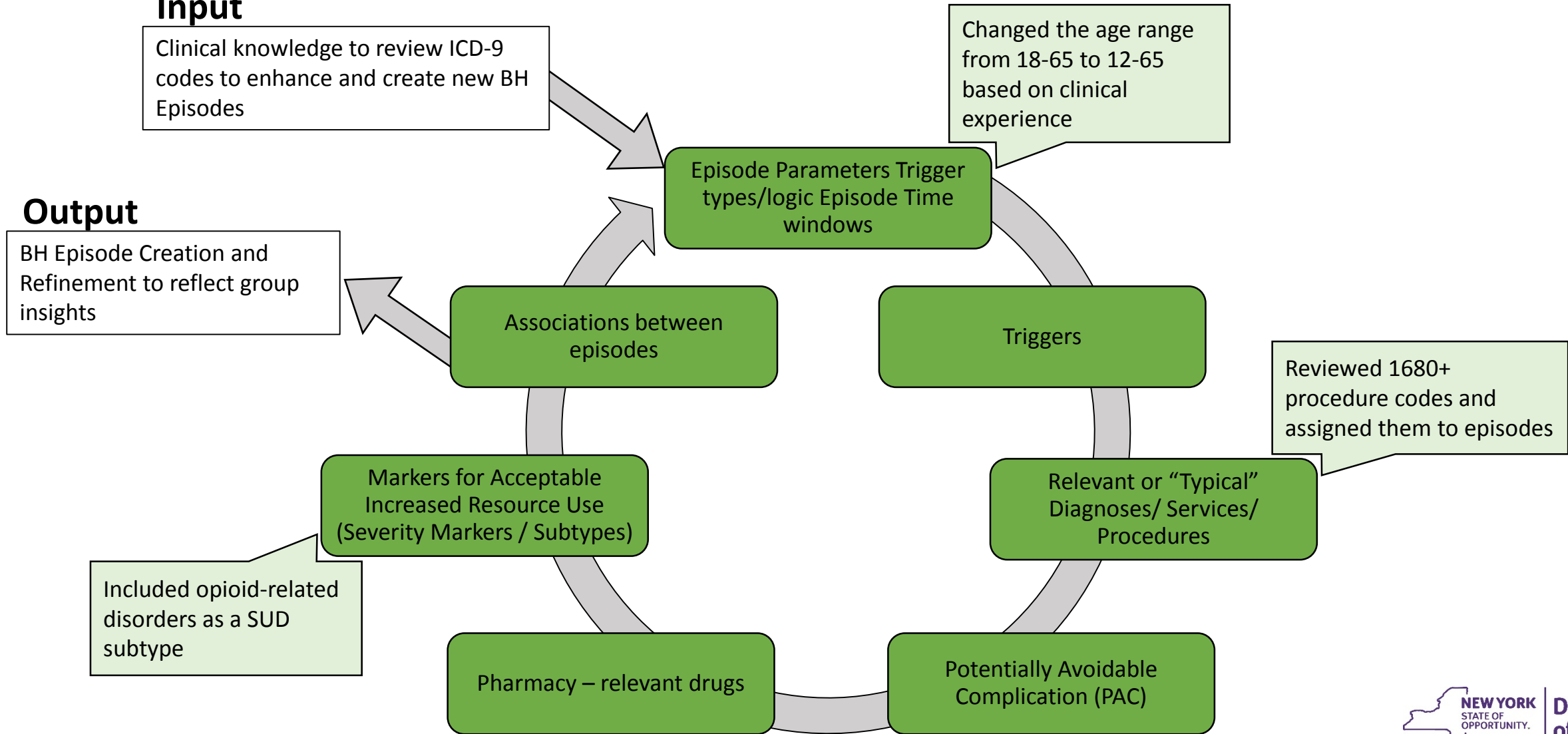
# Clinical Validation Group (CVG) – Process & Example Changes

## Input

Clinical knowledge to review ICD-9 codes to enhance and create new BH Episodes

## Output

BH Episode Creation and Refinement to reflect group insights



# Newly Developed/Changed/Enhanced Episodes

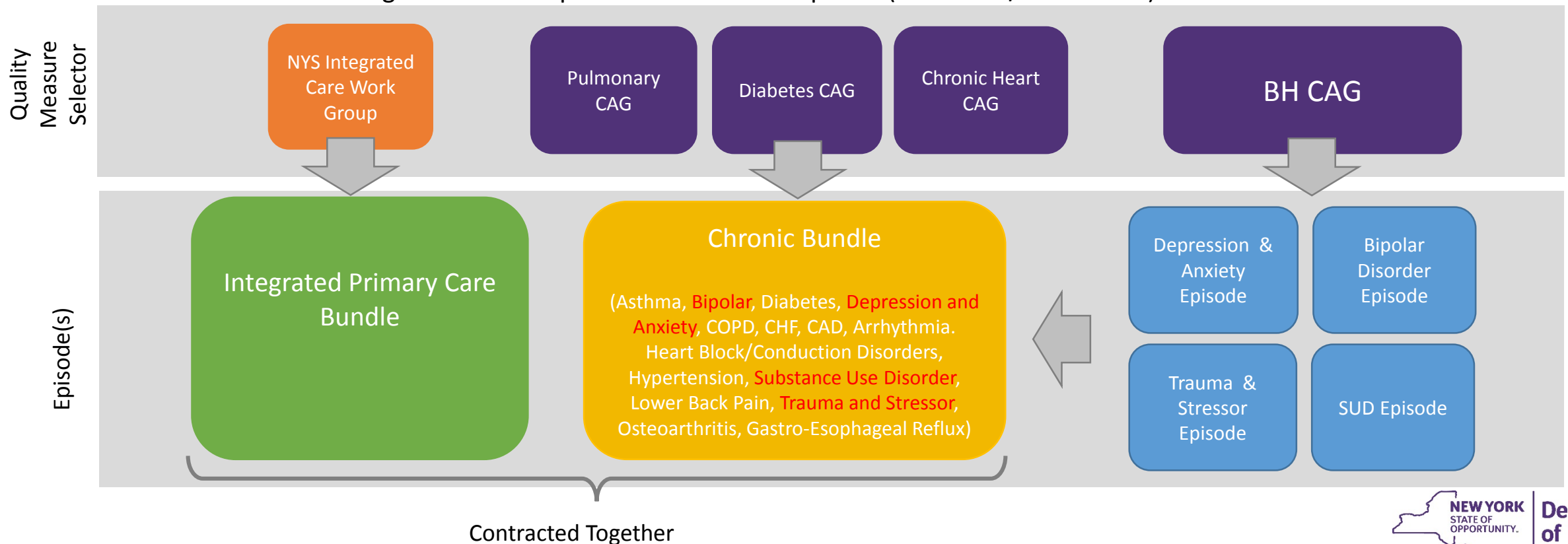
Episode	Change	Reason/Logic
Depression and Anxiety	<ul style="list-style-type: none"> <li>• Depression and Anxiety disorders combined, including Panic Disorders and OCD</li> <li>• Subtype of mild/moderate/severe for both Depression and Anxiety disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Episode triggers, treatment protocols and complications for depression and anxiety are similar</li> <li>• Anxiety disorders cause high costs for physical healthcare</li> </ul>
Trauma and Stressor	<ul style="list-style-type: none"> <li>• <b>New episode</b>, including PTSD, acute stress disorders, adjustment disorders and mood disorders</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical logic exercised that this form of depression warranted a slightly different emphasis and treatment protocol</li> </ul>
Substance Use Disorder	<ul style="list-style-type: none"> <li>• <b>New episode</b>, including alcohol abuse and tobacco use</li> </ul>	<ul style="list-style-type: none"> <li>• Very high costs for substance use disorder itself and also large impact on general healthcare costs</li> </ul>

## C. Behavioral Health Episodes and the Big Picture

Contracting and the Chronic Care Bundle

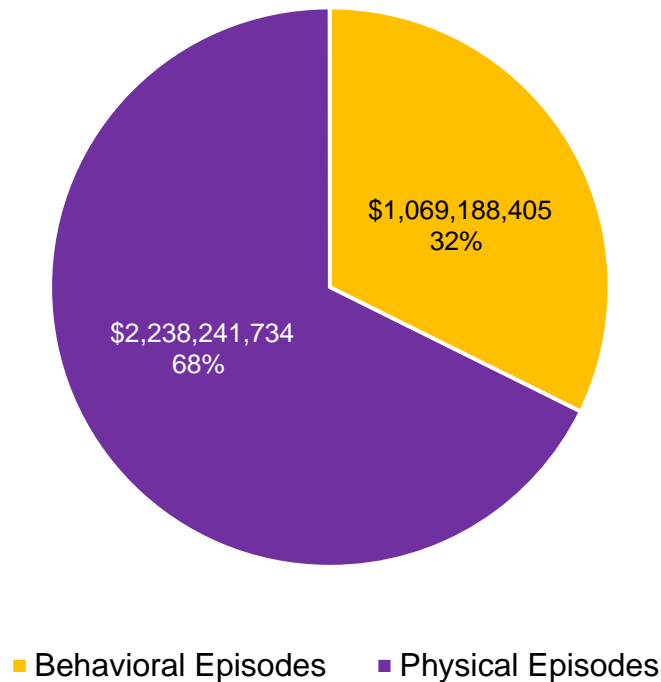
# Behavioral Health and the Bigger Picture

- The BH CAG will review the BH episodes and develop a set of quality measures which will be part of the broader Chronic Bundle
  - In addition, the Chronic Bundle will be contracted with the Integrated Primary Care (IPC) bundle for which currently 3 BH measures are selected by the NYS Integrated Care Work Group (APC) as part of the SHIP program. Two of these are condition specific; only one is truly BH prevention-focused:
    - Screening for Clinical Depression and Follow-up Plan (NQF 0418/CMS CQMs)

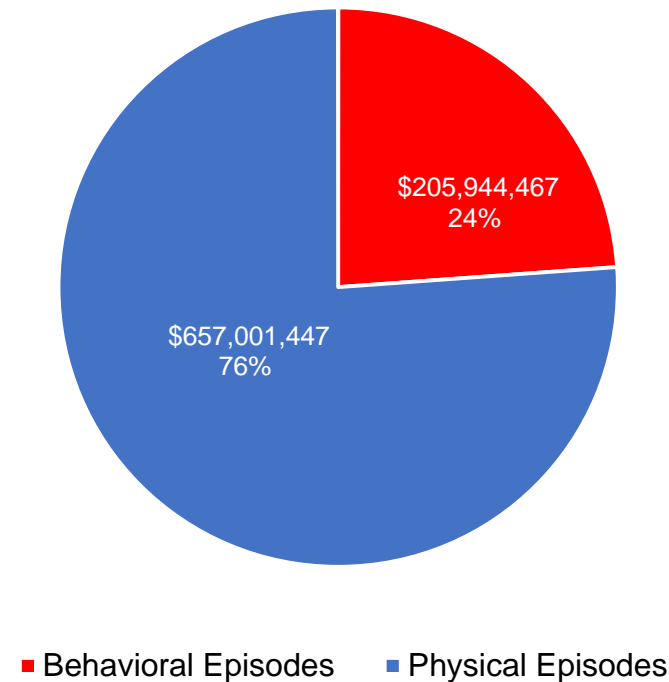


# Chronic Care Bundle – Incentivizing Behavioral and Physical Health Integration

### Chronic Care Bundle – Behavioral vs. Physical Total Spend (CY 2014)



### Chronic Care Bundle – Behavioral vs. Physical Episode PAC Cost (CY 2014)



**Costs Included:**

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

## D. Understanding the Approach

Introduction to HCI3

## Why HCI3? – Recap

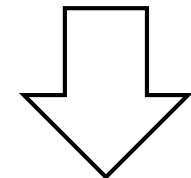
- One of two nationally used bundled payment programs
- Specifically built for use in value based payment
- Not-for-profit and independent
- Open source
- Clinically validated
- National standard which evolves based on new guidelines as well as lessons learned

## Evidence Informed Case Rates (ECRs) – Recap

- Evidence Informed Case Rates (ECRs) are the HCI3 episode definitions
- ECRs are patient centered, time-limited, episodes of treatment
- Include all covered services related to the specific condition
  - E.g.: surgery, procedures, management, ancillary, lab, pharmacy services
- Distinguish between “typical” services from “potentially avoidable” complications
- Are based on clinical logic: Clinically vetted and developed based on evidence-informed practice guidelines or expert opinions



All patient services related to a single condition



Sum of services (based on encounter data the State receives from MCOs).



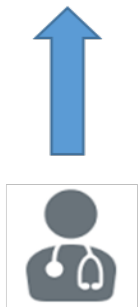
# Clinical Logic – Recap

- The CVG changed the depression episode to include anxiety since the co-occurrence of depression with anxiety is one of the most common co-morbidities seen in patients

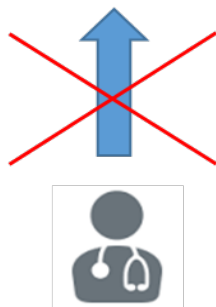
## Depression & Anxiety as an Example

### Depression & Anxiety (DEPANX)

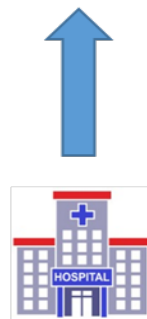
Look Back



Initial doctor visit, during which a diagnosis of depression is given.



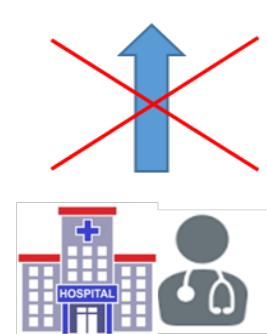
Doctor visit for a broken bone (e.g. a sports injury) unrelated to depression



ER Visits and inpatient admissions related to depression



Prescription medicine to manage depression

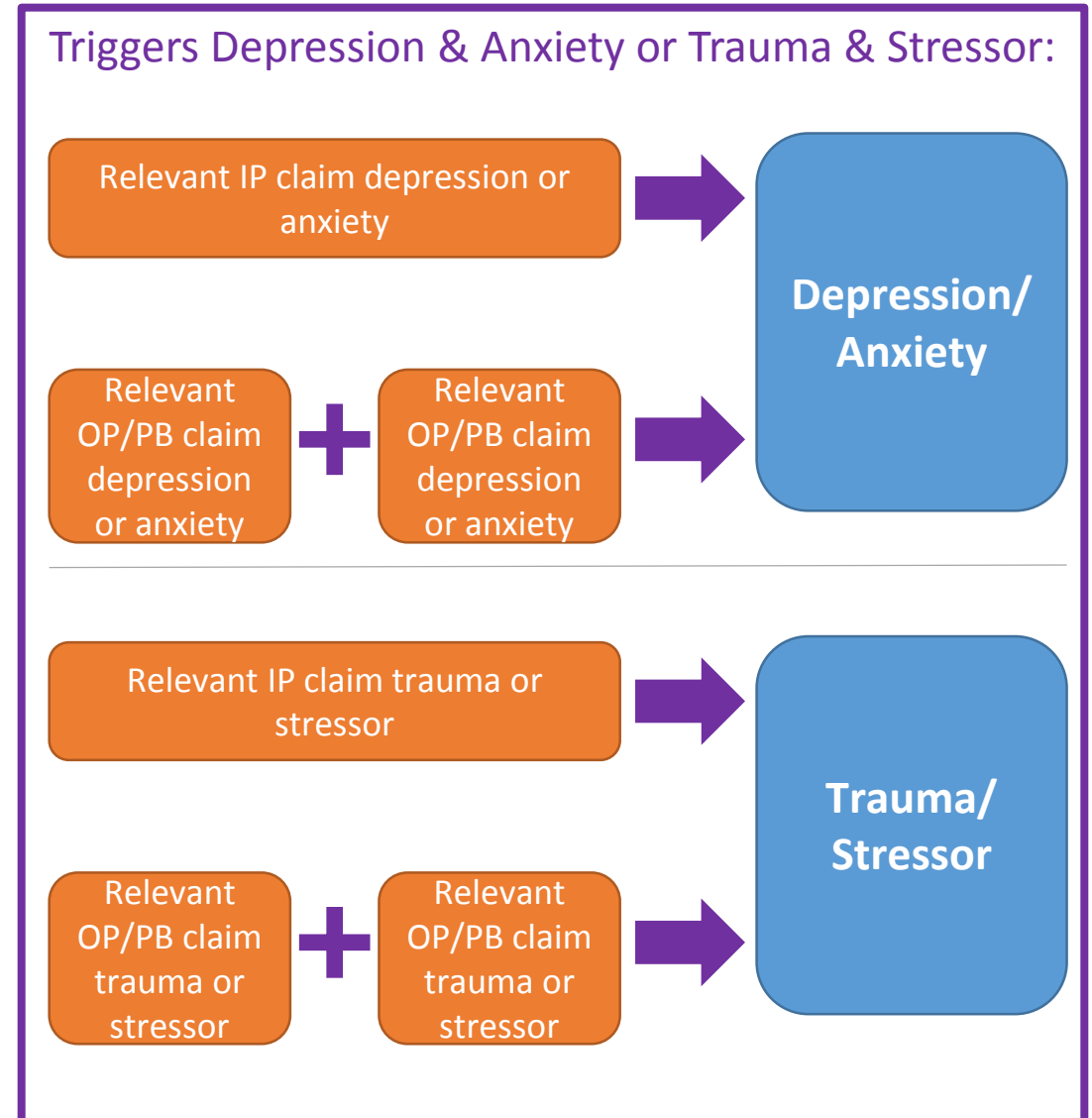


Inpatient admission caused by diabetes

# Episode Component: Triggers

## – Recap

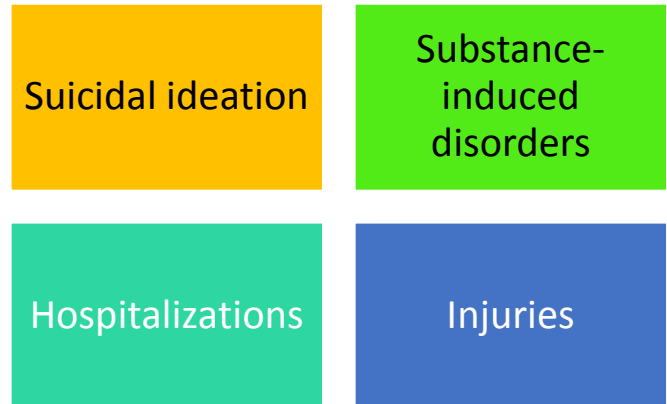
- The CVG reviewed 250+ trigger codes and uniquely assigned the codes to each of the 5 episodes they were working on
- A trigger signals the opening of an episode, e.g.:
  - Inpatient Facility Claim
  - Outpatient Facility Claim
  - Professional Claim
- More than one trigger can be used for an episode
  - Often a confirming claim is used to reduce false positives



## Episode Components: PACs – Recap

- Costs are separated for “typical” care, from costs associated with care for Potentially Avoidable Complications (PACs)
- PACs can stem from care avoidance, poor coordination, failure to implement evidence-based practices or from medical error
- As all aspects of the episode definitions, PACs are established as a national standard by clinical expert groups, and constantly evolve on the basis of feedback and validation work
- Risk-adjusted expected costs of PACs are built in as an incentive towards a shared savings
- Only events that are generally considered to be (potentially) avoidable by the caregivers that manage and co-manage the patient are labeled as ‘PACs’ by clinical expert groups
- Examples of PACs: exacerbations, ambulatory-care sensitive admissions, and inpatient-based patient safety features

### Example Behavioral Health PACs

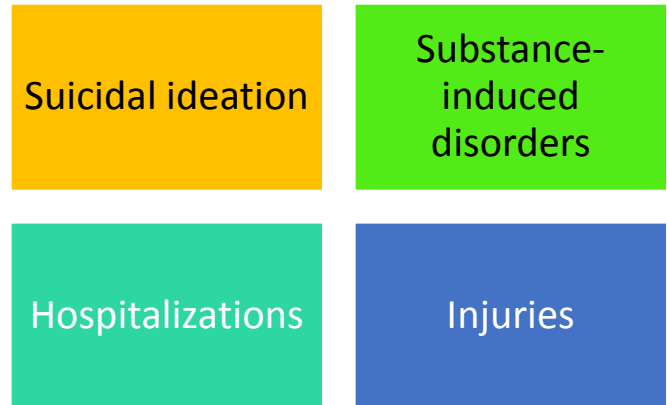


## Episode Components: PACs – Recap

Two uses of PACs:

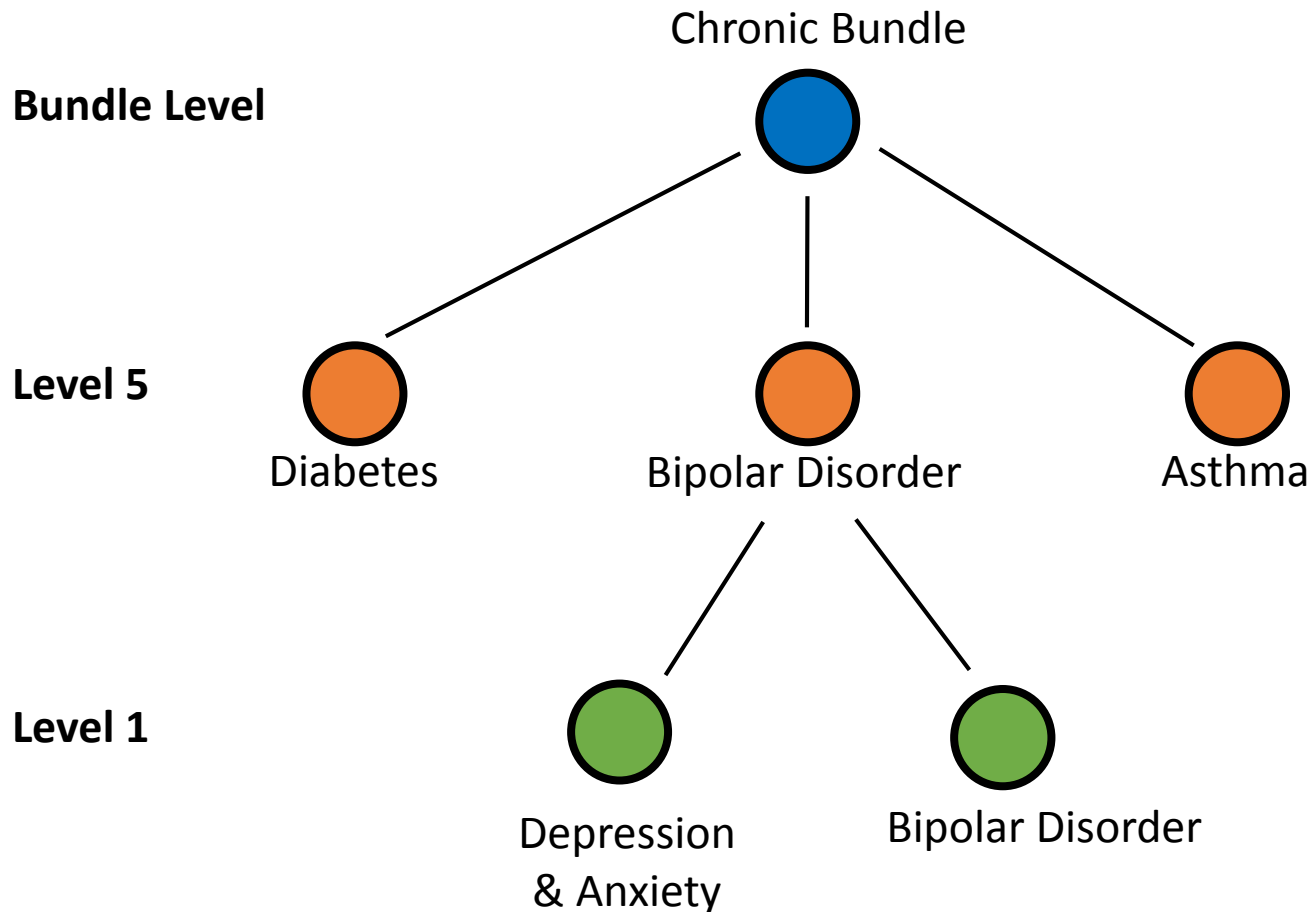
- **% of episode costs that are PACs:** indication for improvement opportunity
- **% of episodes without a PAC:** endorsed by NQF for several physical chronic episodes. Validation of use as *overall* outcome measure for chronic episodes and the Chronic Bundle is ongoing
- *All risk-adjusted measures*

### Example Behavioral Health PACs



# Episode Components: PACs – Recap

The grouper uses the concept of leveling (1-5 and Bundle Level), in which individual associated episodes may get grouped together to reflect a primary diagnosis as you move higher in the levels.

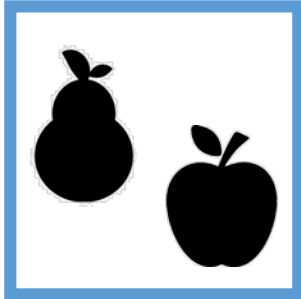


As you move higher up in levels, associated episodes get grouped together to reflect a primary diagnosis, in our example, depression & anxiety rolls up under bipolar disorder; bipolar, asthma and diabetes roll up under Chronic Care bundle.



In Level 1, claims are grouped into defined episodes, for example depression & anxiety and bipolar disorders exist as separate episodes at level 1.

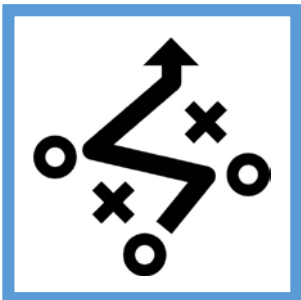
## Risk Adjustment for Episodes – Recap



Make “apples-to-apples” comparisons between providers by accounting for differences in their patient populations



Takes the patient factors (co-morbidity, severity of condition at outset, etc.) out of the equation



Separate risk adjustment models are created for ‘typical’ services and for ‘potentially avoidable complications’

# Inclusion and Identification of Risk Factors – Recap

The CVG helped re-define the parameters of age and developed sub-types for Depression (mild, moderate, severe)

- **Risk Factors**

- Patient demographics – Age, gender, etc.
  - Risk factors - Co-morbidities
  - Subtypes - Markers of clinical severity within an episode
- } Patient related risk factors
- } Episode related risk factors



**Examples of Sub Types**

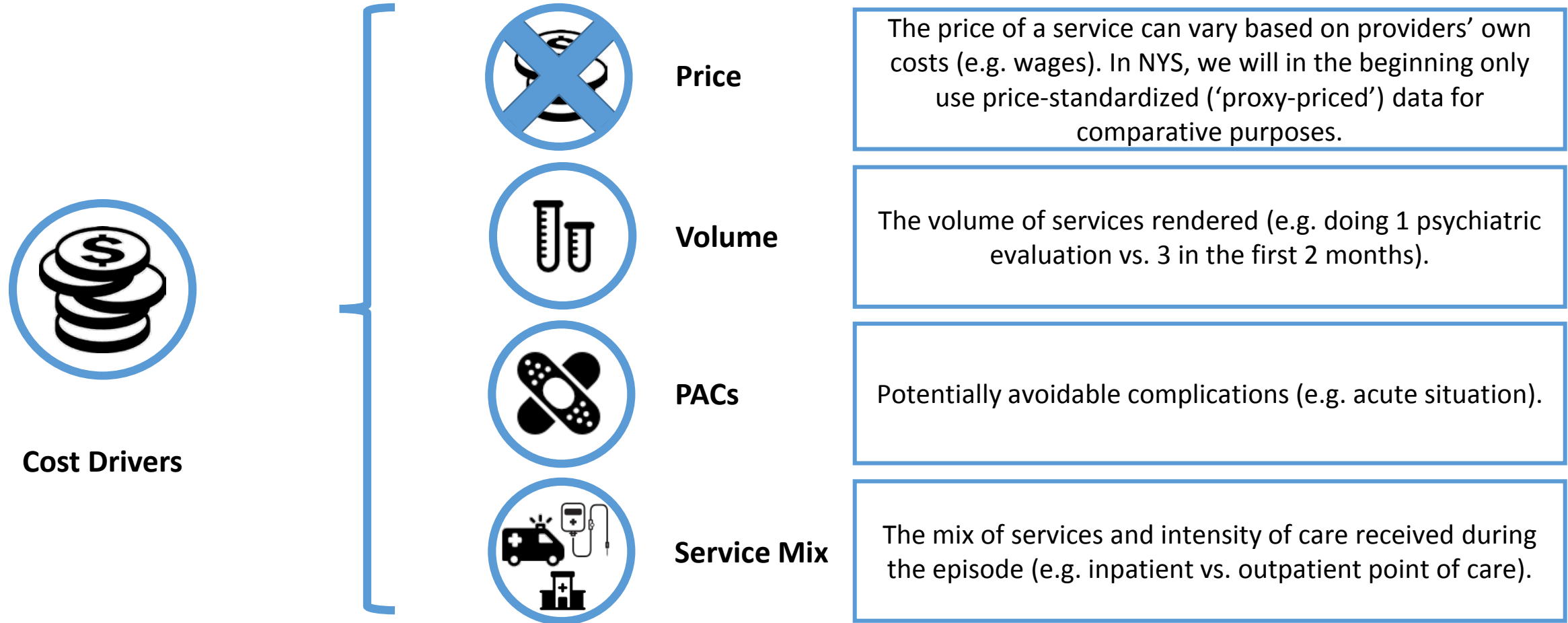
**Anxiety Subtypes:** Acute Stress Disorder, Generalized Anxiety Disorder, Specific Phobia, Panic Disorder, etc.

**Depression Subtypes:** Major Depressive Disorder, Persistent Depressive Disorder, Seasonal Affective Disorder, etc.

- **Identification Risk Factors**

- Risk factors come from historic claims (prior to start of an episode) and same list is applied across all episode types
- Subtypes identified from claims at start of the episode and specific to episode type

# Four Important Costs Drivers for Episodes are Price, Volume, PACs and Service Mix – Recap





## E. Depression & Anxiety Episode

# Depression & Anxiety Episode



**Trigger**

- One or more claims that carry a diagnosis code for depression and/or anxiety and meet the trigger criteria that is specified for this episode

**Confirming trigger**

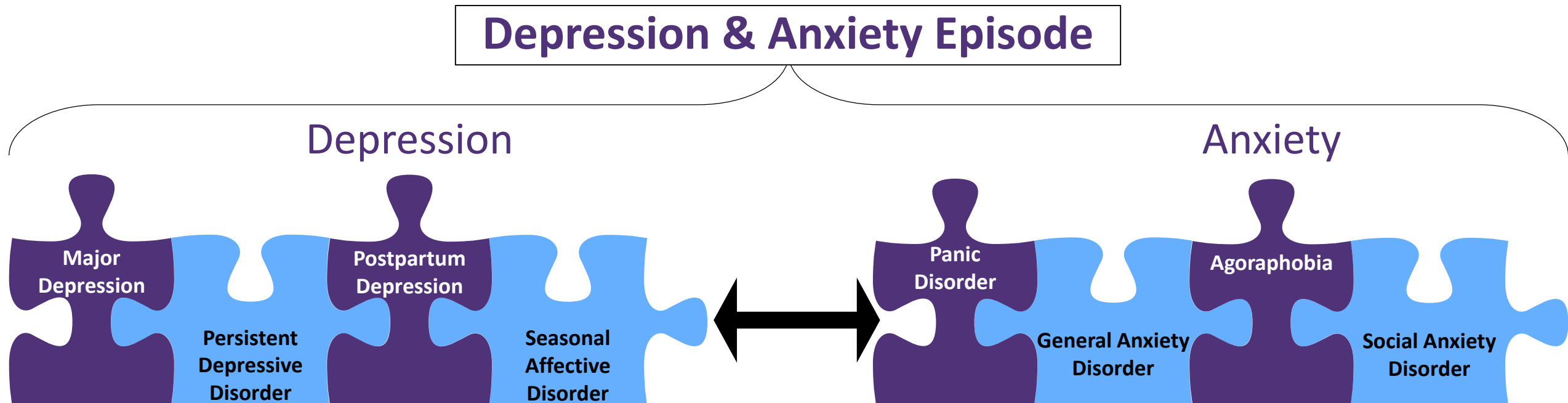
- Another trigger as stated above at least 30 days after the first trigger

**Included in episode:**

- All typical and complication costs for depression and anxiety during the duration of the episode
- Complication includes, but are not limited to:
  - Suicide or self inflicted injury
  - Overdose, poisoning – wrong drug
  - Accidental falls
  - Chronic skin ulcer

# Scope of Depression & Anxiety Episode

- An example of some of the depression and anxiety disorders captured within the episode are listed below:



# Depression & Anxiety episodes account for approximately \$316M in Annual Medicaid Spend



Total Annual Cost of Depression & Anxiety (to the State)

**\$316M**

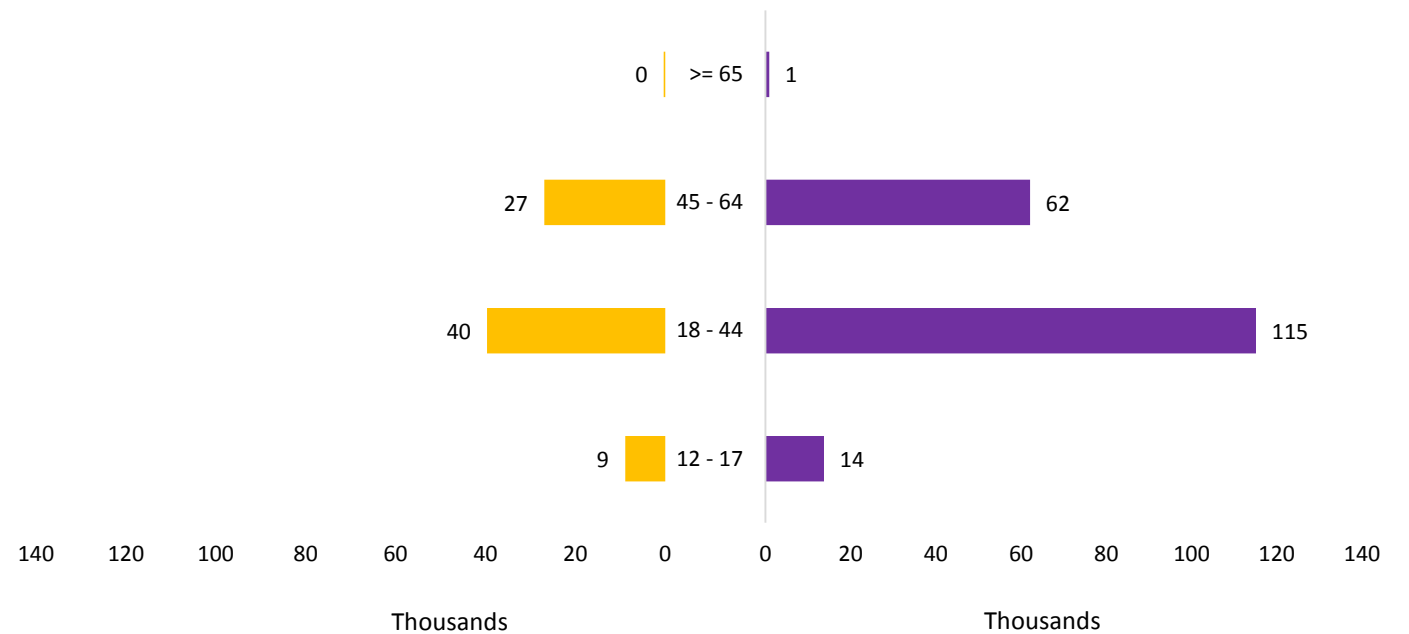


Average Costs per Episode for Members with a Depression & Anxiety Episode

**\$1,159**

Annual Age Distribution of Members with a Depression & Anxiety Episode

Male Female



**Costs Included:**

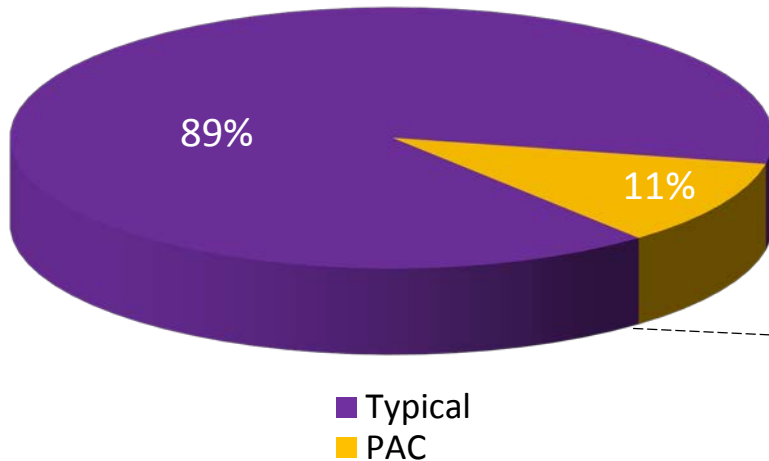
- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

# PAC Costs Represent \$33.7M of All Depression & Anxiety Annual Costs

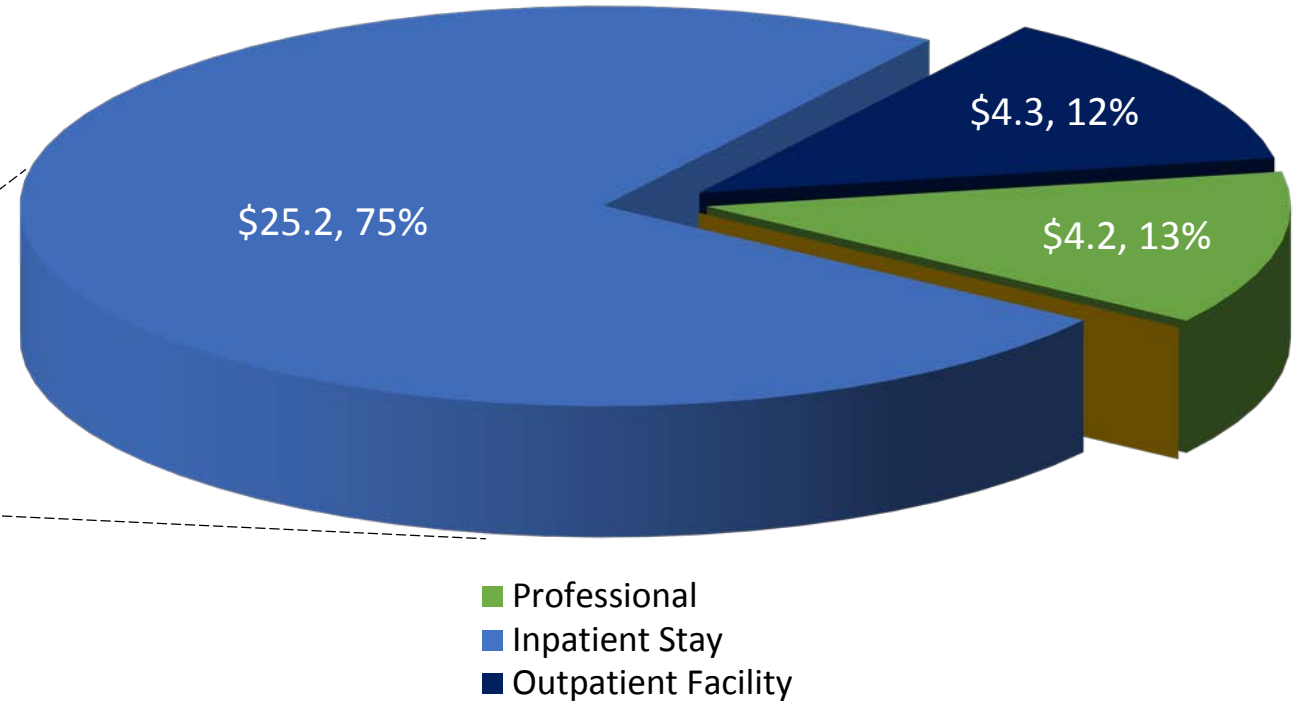
### Dollar Allocation of Typical Costs and PAC costs

Total Amount Spent on Depression & Anxiety: \$316M



### Dollar Allocation for PAC Services (in Millions)

Total Amount of PAC Services: \$33.7M



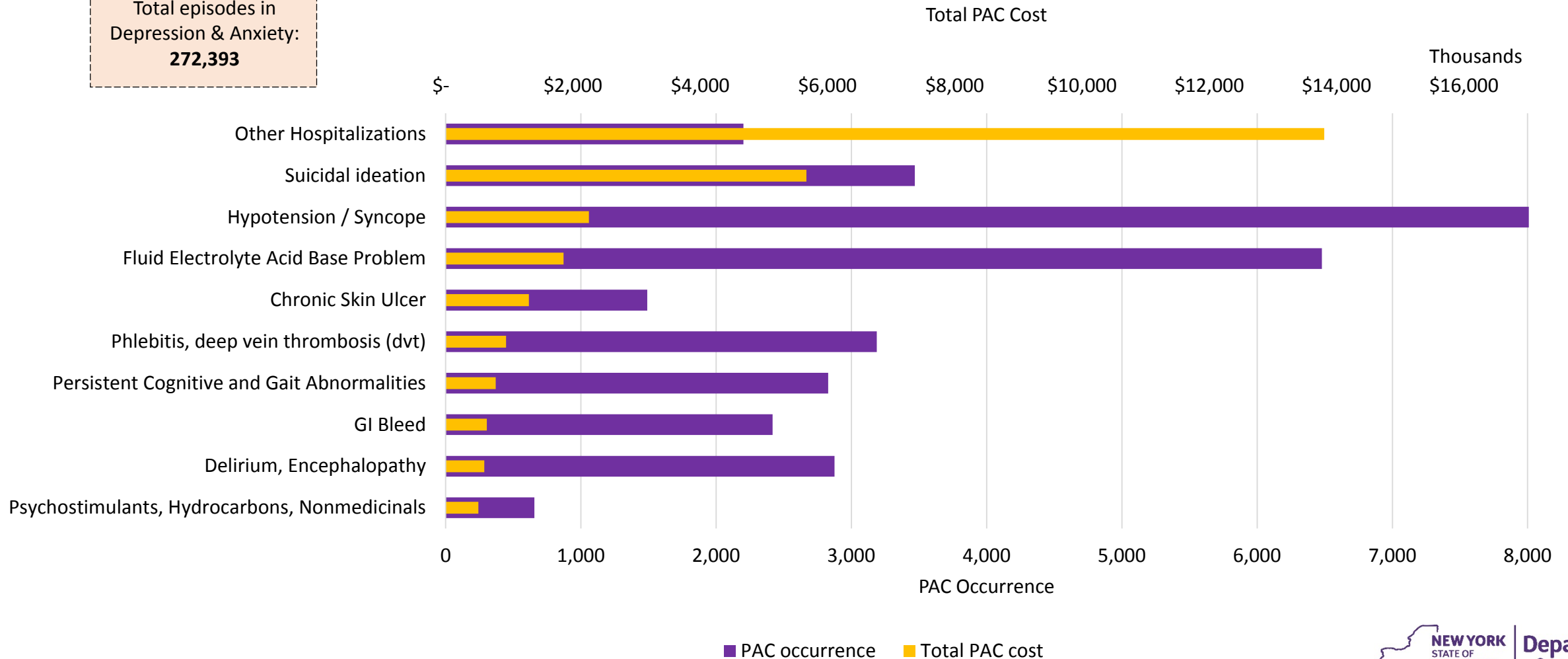
#### Costs Included:

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

# Top 10 Depression & Anxiety PACs Represent 92% of the Total Cost of Depression & Anxiety PACs

Total episodes in Depression & Anxiety: **272,393**



Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

## F. Trauma & Stressor Episode

# Trauma & Stressor Episode



**Trigger**

- One or more claims that carry a diagnosis code for trauma and/or stressor and meet the trigger criteria that is specified for this episode

**Confirming trigger**

- Another trigger as stated above at least 30 days after the first trigger

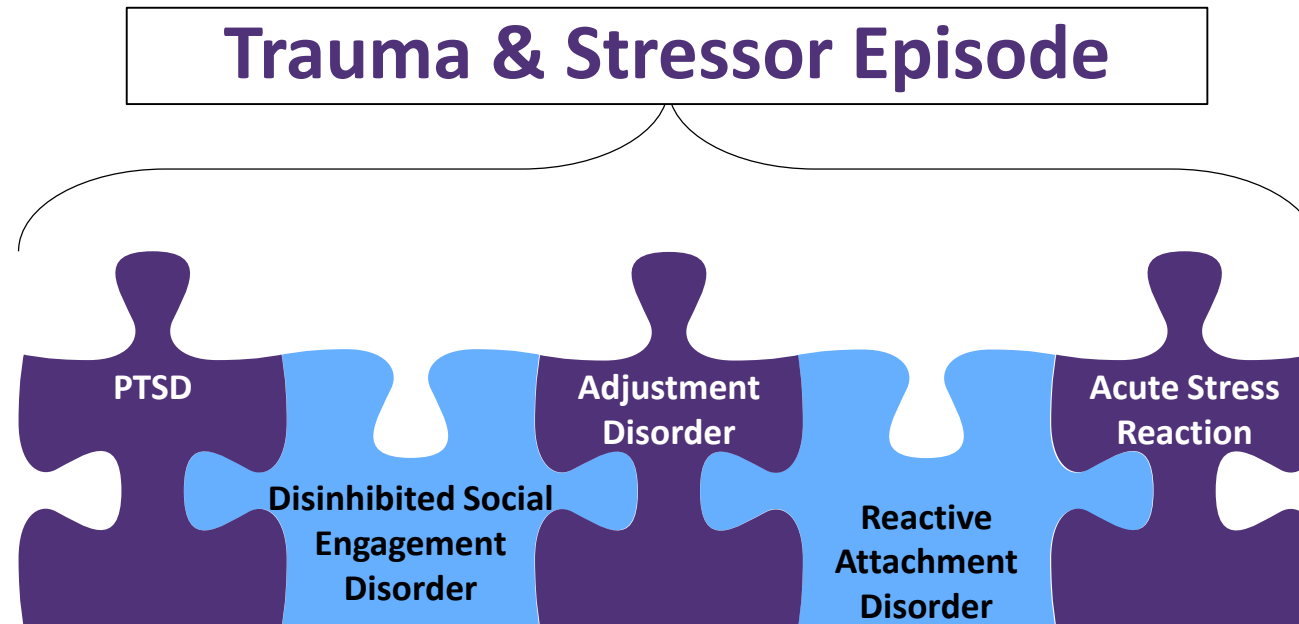
**Included in episode:**

- All typical and complication costs for trauma and stressor during the duration of the episode
- In addition to hospitalizations, complications include, but are not limited to:
  - Suicidal ideation
  - Hypotension / Syncope
  - Fluid Electrolyte Acid Base Problems
  - Phlebitis, deep vein thrombosis
  - Persistent Cognitive and Gait Abnormalities



## Scope of Trauma & Stressor Episode

- An example of some of the trauma and stressor disorders captured within the episode are listed below:



# Trauma & Stressor episodes account for nearly \$73M in Annual Medicaid Spend



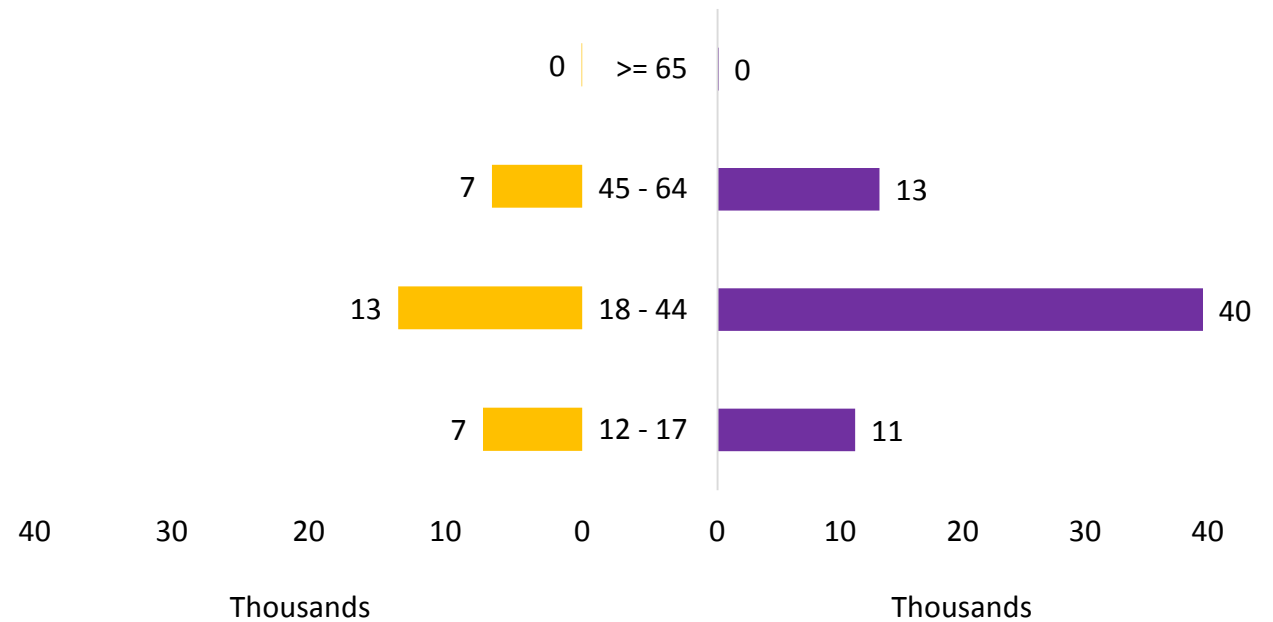
Total Annual Cost of Trauma & Stressor (to the State)  
**\$73M**



Average Costs per Episode for Members with a Trauma & Stressor Episode  
**\$776**

Annual Age Distribution of Members with a Trauma & Stressor Episode

Male Female



**Costs Included:**

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

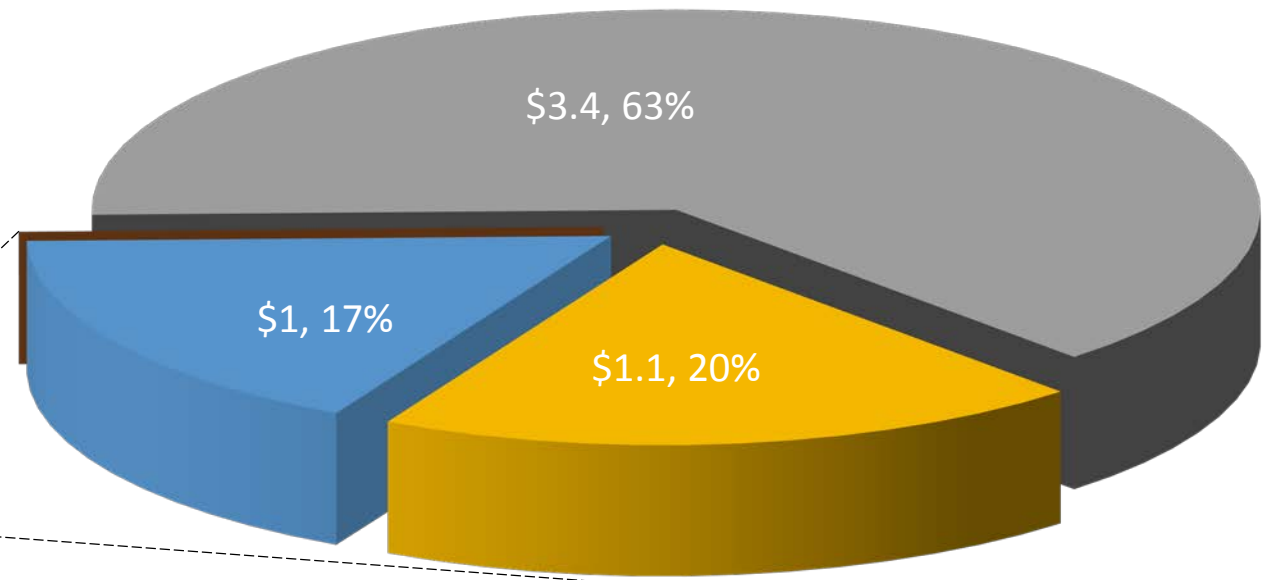
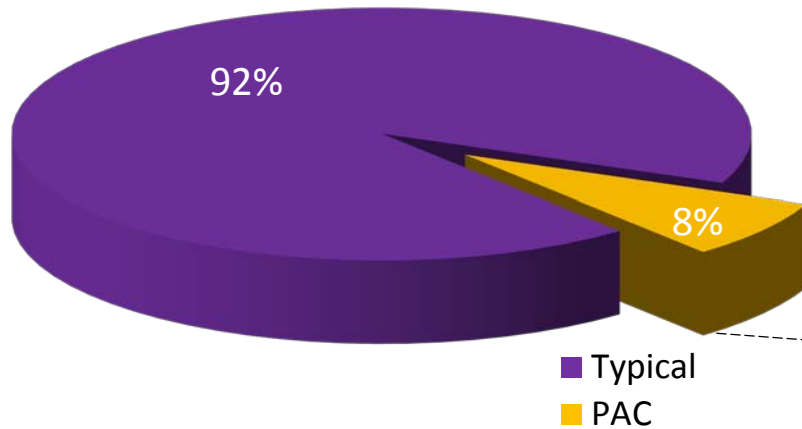
# PAC Costs Represent \$5.5M of All Trauma & Stressor Costs

## Dollar Allocation for PAC Services (in Millions)

Total Amount of PAC Services: \$5.5M

## Dollar Allocation of Typical Costs and PAC costs

Total Amount Spent on Trauma & Stressor: \$73M



- Professional
- Inpatient Stay
- Outpatient Facility

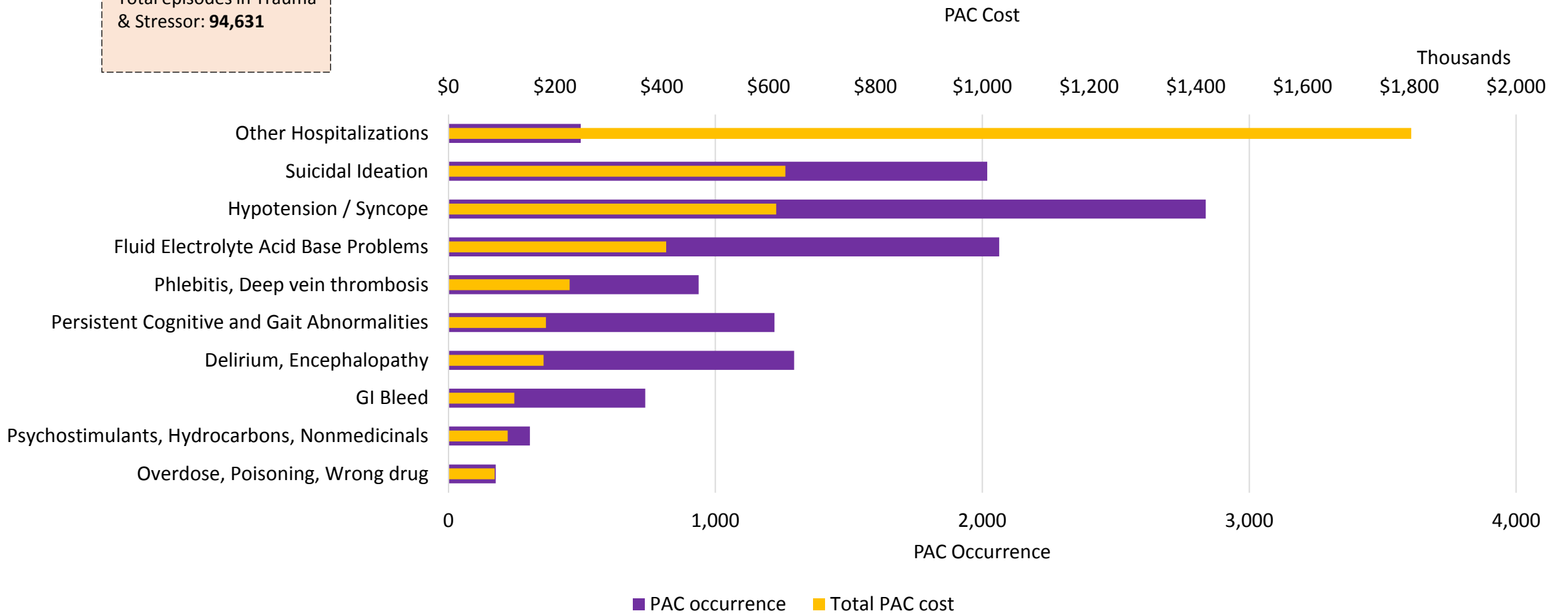
**Costs Included:**

- Fee-for-service and MCO payments (paid encounters);
- Caveat: add-on payments included in some cost data, not in others (GME/IME, HCRA, Capital). Data not yet standardized.

Source: CY2014 Medicaid claims, Real Pricing, Level 5, General Population

# Top 10 Trauma & Stressor PACs Represent 90% of the Total Cost of Trauma & Stressor PACs

Total episodes in Trauma & Stressor: **94,631**



## G. Quality Measures

Depression & Anxiety and Trauma & Stressor

# Remember: Criteria for Selecting Quality Measures

## CLINICAL RELEVANCE

- **Focused on key outcomes of integrated care process**

*I.e. outcome measures are preferred over process measures; outcomes of the total care process are preferred over outcomes of a single component of the care process (i.e. the quality of one type of professional's care).*

- **For process measures: crucial evidence-based steps in integrated care process that may not be reflected in the patient outcome measures**
- **Existing variability in performance and/or possibility for improvement**

## RELIABILITY AND VALIDITY

- **Measure is well established by reputable organization**

*By focusing on established measures (owned by e.g. NYS Office of Quality and Patient Safety (OQPS), endorsed by the National Quality Forum (NQF), HEDIS measures and/or measures owned by organizations such as the Joint Commission, the validity and reliability of measures can be assumed to be acceptable.*

- **Outcome measures are adequately risk-adjusted**  
*Measures without adequate risk adjustment make it impossible to compare outcomes between providers.*

# Remember: Criteria for Selecting Quality Measures

## FEASIBILITY

- **Claims-based measures are preferred over non-claims based measures (clinical data, surveys)**
- **When clinical data or surveys are required, existing sources must be available**

*I.e. the link between the Medicaid claims data and this clinical registry is already established.*

- **Preferably, data sources be patient-level data**  
*This allows drill-down to patient level and/or adequate risk-adjustment. The exception here is measures using samples from a patient panel or records. When such a measure is deemed crucial, and the infrastructure exists to gather the data, these measures could be accepted.*

- **Data sources must be available without significant delay**

*I.e. data sources should not have a lag longer than the claims-based measures (which have a lag of six months).*

## KEY VALUES

- **Behavioral health transformation focus**  
*i.e., measures are person-centered, recovery-oriented, integrated, data-driven and evidence-based*

# Measure Review Process

Similar process as was used in that last meeting: decide on measures by theme.

- Assessment and Screening
- Monitoring and Education
- Medication and Treatment Management
- Outcomes of care

After reviewing the list, assign measures to a categorization “bucket.”





# Categorizing and Prioritizing Measures by Category (or 'Buckets')



## **CATEGORY 1**

Approved quality measures that are felt to be both clinically relevant, reliable and valid, and feasible.



## **CATEGORY 2**

Measures that are clinically relevant, valid and probably reliable, but where the feasibility could be problematic. These measures should be investigated during the 2016 or 2017 pilot.



## **CATEGORY 3**

Measures that are insufficiently relevant, valid, reliable and/or feasible.

# Selection of Measures – IMPACT Measures

## Depression

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NOF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Assessment, Treatment and Follow-up	1	Depression Screening, Diagnosis and Monitoring with PHQ-9 (IMPACT Model)	Process	X						No	Yes	
	2	Diagnosis (IMPACT Model)	Process	X						No	Yes	
	3	Initiation of Treatment (IMPACT Model)	Outcome	X						Yes	No	
	4	Measurement of Treatment Outcomes (IMPACT Model)	Outcome	X						Yes	No	
	5	Adjustment of Treatment Based on Outcomes (IMPACT Model)	Outcome	X						Yes	No	
	6	Symptom Reduction (IMPACT Model)	Outcome	X						Yes	No	

Depression

# Additional Measures for Consideration – Assessment and Screening

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Assessment and Screening	1	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	Process						X	Yes	No	
	2	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Process						X	Yes	No	
	3	Major Depressive Disorder (MDD): Diagnostic Evaluation	Process						X	Yes	No	
	4	Preventive Care and Screening for Clinical Depression and Follow-up Plan	Process	X			X		X	Yes	Yes	
	5	(Screening, Brief Intervention, and Referral to Treatment) SBIRT screening	Process			X				Yes	Yes	
	6	Multidimensional Mental Health Screening Assessment	Process					X		No	Yes	
	7	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Process						X	Yes	No	

Depression

# Additional Measures for Consideration – Treatment and Follow-up (pre- 30 days)

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization	
										Medicaid Claims Data	Clinical Data		
Treatment and Follow-up (pre- 30 days)	1	Follow-Up After Hospitalization for Mental Illness within 7 Days	Process	X	X		X	X		Yes	Yes		
	2	Follow-Up After Hospitalization for Mental Illness within 30 Days	Process	X	X		X	X		Yes	Yes		
	3	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Process					X			Yes	No	
	4	Readmission to mental health inpatient care within 30 days of discharge	Outcome			X					Yes	Yes	

Depression

# Additional Measures for Consideration – Follow-up (post- 30 days)

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Follow-up (post- 30 days)	1	Depression Response at Twelve Months – Progress Towards Remission	Outcome					X		Yes	Yes	
	2	Depression Remission at Six Months	Outcome					X	X	No	Yes	
	3	Depression Remission at Twelve Months	Outcome					X	X	No	Yes	
	4	Timely filling of appropriate medication prescriptions post discharge (30 days and 100 days)	Outcome			X					No	No

Depression

# Additional Measures for Consideration – Follow-up (post- 30 days) (continued)

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Follow-up (post- 30 days)	5	Antidepressant Medication Management	Process	X	X		X			Yes	Yes	
	6	Potentially preventable ED visits (for persons with BH diagnosis)	Outcome	X						Yes	No	
	7	Potential preventable readmission for SNF (skilled nursing facilities) patients	Outcome	X						Yes	No	
	8	Percent of Long Stay Residents who have Depressive Symptoms	Outcome				X			Yes	Yes	
	9	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process	X	X					Yes	No	

# Selection of Measures – Assessment and Screening

## Anxiety

Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NQF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical Data	
Assessment and Screening	1	Generalized Anxiety Disorder 7-item (GAD 7) Scale	Process			X				No	Yes	
	2	Acute Stress Disorder Interview (ASDI)	Process							No	Yes	
	3	Acute Stress Disorder Scale (ASDS)	Process							No	Yes	

# Recommended Trauma & Stressor Screening and Assessment Tools – PC-PTSD

Trauma &  
Stressor

- **Primary Care–Post-Traumatic Stress Disorder (PC-PTSD) Screening** – is a **4-item screen** that was designed for use in primary care and other medical settings
- **Delivery Instructions** – In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
  - Have had nightmares about it or thought about it when you did not want to? – YES / NO
  - Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? – YES / NO
  - Were constantly on guard, watchful, or easily startled? – YES / NO
  - Felt numb or detached from others, activities, or your surroundings? – YES / NO
- **Scaling** – Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items



## Recommended Trauma & Stressor Screening and Assessment Tools – PCL-5

- If preliminary screening for PTSD with PC-PTSD is positive, a follow-up comprehensive assessment with the **PTSD Checklist for DSM-5 (PCL-5)** is recommended
- The PCL-5 is a **20-item self-report measure** that can be completed in waiting rooms and assesses the 20 *DSM-5* symptoms of PTSD. The PCL-5 has a variety of purposes, including:
  - Monitoring symptom change during and after treatment
  - Screening individuals for PTSD
  - Making a provisional PTSD diagnosis
- The **self-report rating scale is 0-4 for each symptom**, with a total possible score of 80
  - A provisional PTSD diagnosis can be made by treating each item rated as 2 or higher as a symptom endorsed, then following the DSM-5 diagnostic rule which requires at least: **1 B item** (questions 1-5), **1 C item** (questions 6-7), **2 D items** (questions 8-14), **2 E items** (questions 15-20) to be endorsed in order for a positive PTSD diagnosis
  - A positive PTSD diagnosis is made for scores 33 or higher

## Recommended Trauma & Stressor Screening and Assessment Tools – CAPS-5

- **The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)** is recognized at the *gold standard* for assessing PTSD. It is a 30-item questionnaire, corresponding to the DSM-5 diagnosis for PTSD
- The CAPS-5 is a **30-item structured interview** that can be used to:
  - Make current (past month) diagnosis of PTSD
  - Make lifetime diagnosis of PTSD
  - Assess PTSD symptoms over the past week
  - Targets the onset, duration, and impact of symptoms
- CAPS-5 symptom severity ratings are based on symptom frequency and intensity on a **scale of 0-4**
  - Scoring methodology and positive PTSD screening criteria are similar to the PCL-5

# Selection of Measures – Screening and Assessment



Topic	#	Quality Measure	Type of Measure	DSRIP	QARR/HEDIS	Suggested by OHM/OASAS	CMS	NOF	NBQF (SAMSHA)	Availability		CAG categorization
										Medicaid Claims Data	Clinical data	
Screening and Assessment	1	Primary Care PTSD Screen (PC-PTSD)	Process			X				No	Yes	
	2	PTSD Checklist for DSM-5 (PCL-5)	Process			X				No	Yes	
	3	Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)	Process							No	Yes	

# Appendix

Depression & Anxiety and Trauma & Stressor

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Depression Screening (IMPACT Model)	University of Washington	Claims	% of patients with documentation of annual screening for depression with the PHQ-2 or similar screening measure.		
Diagnosis (IMPACT Model)	University of Washington	Claims	% of patients with a positive screen who receive a structured depression assessment (e.g. PHQ-9) to help confirm a diagnosis of depression within 4 weeks of screening.		
Initiation of Treatment (IMPACT Model)	University of Washington	Claims	% of primary care patients diagnosed with depression who initiated treatment (antidepressant medication, psychotherapy, or ECT) or attended a mental health specialty visit within 4 weeks of initial diagnosis.		
Measurement of Treatment Outcomes (IMPACT Model)	University of Washington	Claims	% of primary care patients treated for depression who receive a structured clinical assessment (i.e., PHQ-9) of depression severity at: <b>Baseline:</b> within 2 weeks prior or subsequent to treatment. initiation <b>Follow-up:</b> within 8 to 12 weeks following treatment initiation. <b>Continuation:</b> within 3 to 6 months following treatment initiation.		
Adjustment of Treatment Based on Outcomes (IMPACT Model)	University of Washington	Claims	% of primary care patients treated for depression with a PHQ-9 score of $\geq 10$ at follow up who receive an adjustment to their depression treatment (e.g. change in antidepressant medication or psychotherapy) or attend a mental health specialty consult within 8-12 weeks of initiating treatment.		
Symptom Reduction (IMPACT Model)	University of Washington	Claims	% of patients treated for depression who have a decrease $> 50\%$ in depression symptom levels from baseline as measured by the PHQ-9 or similar quantifiable measure and a PHQ-9 score $< 10$ within 6 months of initiating treatment.		

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Claims	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD).
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Claims	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Patient visits with an assessment for suicide risk.	All patients aged 6 through 17 years with a diagnosis of major depressive disorder.
Major Depressive Disorder (MDD): Diagnostic Evaluation	AMA-PCPI NQF - 0103	Claims	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified.	Patients with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified.	All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD).

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Preventive Care and Screening for Clinical Depression and Follow-up Plan	CMS  NQF 0418 (adult)	Claims	Percentage of patients aged 12 years and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.	<p>Patient’s screening for clinical depression using an age appropriate standardized tool AND follow-up plan is documented</p> <p>The standardized screening tools help predict a likelihood of someone developing or having a particular disease. The screening tools suggested in this measure screen for possible depression. Questions within the suggested standardized screening tools may vary but the result of using a standardized screening tool is to determine if the patient screens positive or negative for depression. If the patient has a positive screen for depression using a standardized screening tool, the provider must have a follow-up plan as defined within the measure. If the patient has a negative screen for depression, no follow-up plan is required.</p>	All patients aged 12 years and older.
(Screening, Brief Intervention, and Referral to Treatment) <b>SBIRT Screening</b>					

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Multidimensional Mental Health Screening Assessment	M3 Information LLC	Clinical	This is a process measure indicating the percent of patients who have had this assessment completed in a period of time. Specifically, adult patients age 18 and older in an ambulatory care practice setting who have a Multidimensional Mental Health Screening Assessment administered at least once during the twelve month measurement period (e.g., once during the calendar year) when staff-assisted care supports are in place to assure accurate diagnosis, effective treatment, and follow-up. "Staff-assisted care supports" refers to clinical staff that assist the primary care clinician by providing some direct care and/or coordination, case management, or mental health treatment. A Multidimensional Mental Health Screening Assessment is defined as a validated screening tool that screens for the presence or risk of having the more common psychiatric conditions, which for this measure include major depression, bipolar disorder, post-traumatic stress disorder (PTSD), one or more anxiety disorders (specifically, panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and/or social phobia), and substance abuse.	Adult patients age 18 and older in an ambulatory care practice setting, where staff-assisted care supports are in place to assure accurate diagnosis, effective treatment, and follow-up, who have a Multidimensional Mental Health Screening Assessment administered at least once during the stated twelve month measurement period (i.e., once during the measurement year (MY)).	Adult patients age 18 and older in an ambulatory care practice setting, where staff-assisted care supports are in place, who had at least one visit during the MY.



# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	Center for Quality Assessment and Improvement in Mental Health	Claims	Percentage of patients 18 years of age or older with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Patients in the denominator with evidence of an assessment for alcohol or other substance use following or concurrent with the new diagnosis, and prior to or concurrent with the initiation of treatment for that diagnosis.	Patients in the Initial Patient Population with a new diagnosis of unipolar depression or bipolar disorder during the first 323 days of the measurement period, and evidence of treatment for unipolar depression or bipolar disorder within 42 days of diagnosis. The existence of a 'new diagnosis' is established by the absence of diagnoses and treatments of unipolar depression or bipolar disorder during the 180 days prior to the diagnosis.
Follow-Up After Hospitalization for Mental Illness within 7 Days	HEDIS	Claims/ clinical data	This measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.	Discharges for members age 6 years and older as of the date of discharge who were hospitalized for treatment of selected mental illness diagnoses and who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.
Follow-Up After Hospitalization for Mental Illness within 30 Days	HEDIS	Claims/ clinical data	This measure is used to assess the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.	An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient visits, or partial hospitalizations that occur on the date of discharge.	Discharges for members age 6 years and older as of the date of discharge who were hospitalized for treatment of selected mental illness diagnoses and who were discharged from an acute inpatient setting (including acute care psychiatric facilities) with a principal diagnosis of mental illness on or between January 1 and December 1 of the measurement year.

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	NCQA	Claims	<p>The % of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.</p> <p>Four rates are reported:</p> <ul style="list-style-type: none"> <li>-The % of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.</li> <li>-The % of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.</li> <li>-The % of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.</li> <li>-The % of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.</li> </ul>	<p>The numerator for each consists of two rates:</p> <p><b>Mental Health</b></p> <ul style="list-style-type: none"> <li>-Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge.</li> <li>-Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge.</li> </ul> <p><b>Alcohol or Other Drug Dependence</b></p> <ul style="list-style-type: none"> <li>-Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge.</li> <li>-Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge.</li> </ul>	<p>Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.</p>

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Readmission to mental health inpatient care within 30 days of discharge					
Depression Response at Twelve Months – Progress Towards Remission	MN Community Measurement	Claims/ clinical data	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve a response at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine.
Depression Remission at Six Months	MN Community Measurement	Claims	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at six months (+/- 30 days) are also included in the denominator.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at six months as demonstrated by a six month (+/- 30 days) PHQ-9 score of less than five.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Depression Remission at Twelve Months	MN Community Measurement	Claims	<p>Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score &gt; 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.</p> <p>This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.</p>	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine who achieve remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.	Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial (index) PHQ-9 score greater than nine.
<p>Timely filling of appropriate medication prescriptions post discharge (30 days and 100 days)</p> <ul style="list-style-type: none"> <li>- Psychotropic Medication</li> <li>- Antipsychotic Medication</li> <li>- Mood Stabilizer/Antidepressant Anti-Addiction Medication</li> <li>- Mood-Disorder</li> </ul>	BHO I	OMH/OASAS		<p>Please see: Section VII and VIII</p> <p><a href="https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf">https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf</a></p>	<p>Please see: Section VII and VIII</p> <p><a href="https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf">https://www.omh.ny.gov/omhweb/special-projects/dsrip/docs/bho-reference.pdf</a></p>

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Antidepressant Medication Management (AMM)	NCQA	Claims/clinical data	<p>The percentage of members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication, and who remained on an antidepressant medication treatment. Two rates are reported.</p> <p>a) Effective Acute Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 84 days (12 weeks).</p> <p>b) Effective Continuation Phase Treatment. The percentage of newly diagnosed and treated members who remained on an antidepressant medication for at least 180 days (6 months).</p>	<p>a) Effective Acute Phase Treatment: At least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period following the Index Prescription Start Date (IPSD) (inclusive). The continuous treatment allows gaps in medication treatment up to a total of 30 days during the 114-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, there may be no more than 30 gap days. Count any combination of gaps (e.g., two washout gaps of 15 days each, or two washout gaps of 10 days each and one treatment gap of 10 days).</p> <p>b) Effective Continuation Phase Treatment: At least 180 days (6 months) of continuous treatment with antidepressant medication (Table AMM-D) during the 231-day period following the IPSD (inclusive). Continuous treatment allows gaps in medication treatment up to a total of 51 days during the 231-day period. Gaps can include either washout period gaps to change medication or treatment gaps to refill the same medication.</p> <p>Regardless of the number of gaps, gap days may total no more than 51. Count any combination of gaps (e.g., two washout gaps, each 25 days or two washout gaps of 10 days each and one treatment gap of 10 days).</p>	Members 18 years of age and older with a diagnosis of major depression and were newly treated with antidepressant medication.

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Potentially preventable ED visits (for persons with BH diagnosis)	3M	Claims			
Potential preventable readmission for SNF (skilled nursing facilities) patients	3M	Claims			
Percent of Long Stay Residents who have Depressive Symptoms	CMS	Claims	This measure is used to assess the percent of long-stay residents who have had symptoms of depression during the 2-week period preceding the Minimum Data Set (MDS) 3.0 target assessment date.	Long-stay residents with a selected target assessment where the target assessment meets either of two conditions.	All long-stay residents with a selected target assessment, except those with exclusions.
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)	NCQA	Claims	<p>The percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following.</p> <ul style="list-style-type: none"> <li>- Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.</li> <li>- Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</li> </ul>	<p>Initiation of AOD Dependence Treatment: Initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the index episode start date.</p> <p>Engagement of AOD Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).</p>	Patients age 13 years of age and older who were diagnosed with a new episode of alcohol or other drug dependency (AOD) during the first 10 and ½ months of the measurement year (e.g., January 1- November 15).

# 2016 Depression and Anxiety Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Generalized Anxiety Disorder 7-item (GAD 7) Scale		Clinical	Choose the one description for each item that best describes how many days you have been bothered by each of the following over the past 2 weeks: -Feeling nervous, anxious, or on edge -Unable to stop worrying -Worrying too much about different things -Problems relaxing -Feeling restless or unable to sit still -Feeling irritable or easily annoyed -Being afraid that something awful might happen		
Acute Stress Disorder Interview (ASDI)		Clinical	Is the only structured clinical interview that has been validated against DSM-IV criteria for ASD. It appears to meet standard criteria for internal consistency, test-retest reliability, and construct validity. The interview was validated by comparing it with independent diagnostic decisions made by clinicians with experience in diagnosing both ASD and PTSD.		
Acute Stress Disorder Scale (ASDS)		Clinical	Is a self-report measure of ASD symptoms that correlates highly with symptom clusters on the ASDI. It has good internal consistency, test-retest reliability, and construct validity.		

# 2016 Trauma & Stressor Quality Measures –

Quality Measure	Measure Steward	Data Source	Description	Numerator Statement	Denominator Statement
Primary Care PTSD Screen (PC-PTSD)	National Center for PTSD	Clinical	The Primary Care PTSD Screen (PC-PTSD) is a 4-item screen that was designed for use in primary care and other medical settings, and is currently used to screen for PTSD in Veterans using VA health care. The screen includes an introductory sentence to cue respondents to traumatic events. The screen does not include a list of potentially traumatic events.		
PTSD Checklist for DSM-5 (PCL-5).	National Center for PTSD	Clinical	<p>The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD. The PCL-5 has a variety of purposes, including:</p> <ul style="list-style-type: none"> <li>- Monitoring symptom change during and after treatment.</li> <li>- Screening individuals for PTSD.</li> <li>- Making a provisional PTSD diagnosis.</li> </ul> <p>The gold standard for diagnosing PTSD is a structured clinical interview such as the Clinician-Administered PTSD Scale (CAPS-5). When necessary, the PCL-5 can be scored to provide a provisional PTSD diagnosis.</p>		
Clinician-Administered PTSD Scale for DSM-5 (CAPS-5).	National Center for PTSD	Clinical	<p>The CAPS is the gold standard in PTSD assessment. The CAPS-5 is a 30-item structured interview that can be used to:</p> <ul style="list-style-type: none"> <li>- Make current (past month) diagnosis of PTSD.</li> <li>- Make lifetime diagnosis of PTSD.</li> <li>- Assess PTSD symptoms over the past week.</li> </ul> <p>In addition to assessing the 20 DSM-5 PTSD symptoms, questions target the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms since a previous CAPS administration, overall response validity, overall PTSD severity, and specifications for the dissociative subtype (depersonalization and derealization).</p>		