Preface

The Veterans Health Administration (VHA) in the U.S. Department of Veterans Affairs (VA) provides mental health and medical treatment for veterans. In order to deliver top-quality medical care to veterans, VA must ensure that program goals are being met and that the services available are adequate. To this end, the VA Office of Policy and Planning contracted with Altarum Institute and the RAND–University of Pittsburgh Health Institute (RUPHI) to conduct an independent study to evaluate its mental health programs. This evaluation is mandated by Congress under the Government Results and Performance Act of 1993 and under Title 38 of the U.S. Code (Veteran’s Benefits). The results of this study will be used to inform VHA policy and operational decisions for mental health.

Critical to this evaluation was the development of a comprehensive set of mental health performance indicators based upon available VHA administrative and medical record data. The team applied the Institute of Medicine quality of care framework in the identification of performance measures. The Institute of Medicine has defined six quality domains: effectiveness, efficiency, equitability, safety, and patient centered care. Furthermore, VHA identified critical domains of quality within its own organization, including: diagnosis and assessment, treatment, chronic disease management and rehabilitation.

This report presents the technical specifications for the performance indicators developed during the study. The project team drew upon existing performance indicators developed for the mental health population, clinical practice guidelines for mental health diagnoses, and the clinical expertise of team members and advisors in the development of the indicators. The strength of evidence for each indicator was assigned based upon guidelines from the Agency for Healthcare Research and Quality, as adopted by VHA.

The VHA has contributed directly to the development of the quality indicators described in this technical manual through an advisory group composed of representatives from the VHA Patient Care Services, the VHA Office of Mental Health, several field practitioners, and contractors. This advisory group collaborates with the evaluation team through input on the evaluation’s scope and methodologies.

The contents of this report will be of interest to policymakers, health care organizations, and clinical practitioners who are engaged in activities related to the improvement of mental healthcare quality.
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SUMMARY

Questions are being raised nationally about access to and quality of mental health care, both within the Veterans Health Administration (VHA) and in the public and private sectors more broadly. Numerous studies have documented the discrepancies between mental health care that is known to be effective and mental health care that is actually delivered. These gaps are important because mental health conditions are a leading cause of disability and death and have serious economic, social, and personal consequences. Concurrently, U.S. policy makers and medical professionals are increasingly recognize that quality mental health care can lead to better, healthier lives for those with mental illness, and that performance measurement plays a key role in improving health care delivery and, ultimately, patient outcomes.

In 2006, the U.S. Department of Veterans Affairs (VA) funded an independent study to evaluate the quality of mental health services provided to veterans. This study is mandated by the Government Results and Performance Act of 1993, which requires federal agencies to independently evaluate high-volume, high-cost programs, and Title 38 of the U.S. Code, which regulates Veteran's Benefits. It represents one of the largest and most comprehensive evaluations of mental health services ever conducted. The evaluation focuses on five high-volume, high-cost mental health diagnoses that have the potential to greatly impair quality of life for veterans:

- Schizophrenia
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Major depressive disorder
- Substance use disorder.

This evaluation of the VHA mental health services is designed to present new information about how well VA is translating the promise of improved mental health care into better, healthier lives for veterans. In particular, the study team will examine whether specific gaps in services identified as targeted areas of improvement in the MHSP have been reduced by the implementation of the plan, and whether investments and/or other enhancements in VA mental health and substance use treatment services under the plan have had a positive impact on capacity, utilization, staffing, and individual users over the study period.

In order to develop and select measures that would be viewed as meaningful and useful in addition to valid, the team's work was guided by policy documents that identified the aims and characteristics of high quality health care. The Institute of Medicine’s quality of care paradigm was used explicitly to categorize all potential measures and to ensure indicators covered all six domains of effectiveness, safety, efficiency, timeliness, patient-centeredness and equity. The VHA Mental Health Strategic Plan was modeled after the Report by the President’s New Freedom Commission on Mental Health; both identified the consumer and family as the drivers of mental health care, focusing attention on the concept of recovery and on the elimination of disparities in the availability and quality of mental health services. Together these documents provided the social and political context for development and selection of the measures herein. Below we have documented the methodology employed in the development of mental health indicators.

Indicator development process

1. *Conduct a Systematic Search for Previously Identified, Grade I Performance Indicators.*

   We conducted a systematic review of the literature including studies, technical reports, reviews, electronic databases, etc., manual review of relevant bibliographies, and outreach to
experts and industry representatives to identify an exhaustive pool of relevant performance indicators that were either in the public domain or were being prepared for near-term dissemination. All relevant measures were retrieved and the team reviewed the methodology used in their design to assess their quality. We abstracted each performance indicator, noting its data source, the disorder to which it applied the strength of the evidence for the process measured by the indicator, and IOM domain.

2. **Identify recommendations with empirical support that are not covered by the existing measures, and create new performance indicators to address these gaps.**

   We reviewed VA and APA Clinical Practice Guidelines for the 5 disorders included in the program evaluation (the VA CPG for psychoses includes recommendations for both schizophrenia and bipolar disorder), and listed all individual recommendation statements. Multi-part recommendations were separated into individual parts and duplicative recommendations were deleted. We defined key terms, examined the recommendations for inconsistency or ambiguity, and produced a list of explicit, unambiguous measures that had empirical support for the process-outcome link. Where discrepancies existed between the APA and VA guidelines the team consulted outside experts and discussed the discrepancy until consensus was reached.

3. **Select measures for further technical specification.**

   Because of the large number of candidate measures, we engaged in a systematic selection process. First, we identified whether the data needed to populate the indicators existed in the necessary form in either the administrative or in the medical record, and recommendations that could not be defined operationally because of lack of data were eliminated. Next, the research team reviewed the measures for meaningfulness and feasibility, and described the measures’ predictive validity through an evaluation of the strength of the process-outcome link. A subset of measures was selected to be reviewed by external clinical experts who further pruned them on the basis of clinical significance. All measures were reviewed with a VA clinical advisory group, whose members were selected for their clinical expertise and familiarity with the subject matter. The advisory group evaluated recommendations for validity and feasibility, and usefulness for VA’s operational management and strategic leadership. Lastly, VA and VHA leadership rated the indicators on their importance to the VHA and contribution to presenting a comprehensive quality profile. As a result of this process, we identified a core set of measures that were valid, feasible, and a VA priority. Most of them described processes that were identified with acute treatment.

4. **Generate a new set of measures pertaining to the psychosocial aspects of care.**

   Because the process used above required measures to have an empirical basis of support, the domains of patient-centeredness and recovery were neglected. Although not evidence-based or guideline-supported, both domains are endorsed by the Institute of Medicine and the VA Mental Health Strategic Plan as critical to quality. We therefore used a collaborative process between the research team and the VA clinical advisory group to identify key constructs pertaining to patient-centeredness and recovery. Among the many possible constructs, we chose to focus on the psychosocial aspects of care such as attention to social supports, housing and employment. Indicator development involved recruiting experts and engaging them in the process of identifying a core set of cross-cutting psychosocial indicators. Because of the difficulty evaluating the predictive validity of the psychosocial aspects of care, they will be used descriptively.
5. Develop technical specifications for finalized indicators and categorize their strength of evidence

We generated detailed technical specifications for all finalized performance indicators with respect to VHA administrative data and electronic medical records, and identified data sources that efficiently provided the information necessary to populate the indicators. Each indicator contained an indicator statement and executive summary describing the source(s) of the specifications and clinical rationale for the selected indicator. We also included the indicator grade, which reflected the strength of the process-outcome link, and whether the indicator would be used as a benchmark or descriptively. We created numerators and denominators for each indicator based on the data that would be available, and defined the population to which the indicator applied. For example, if the indicator applied only to people in a new treatment episode, we defined the term ‘new treatment episode’. All clinical and measurement terms were defined operationally, and we summarized anticipated data collection problems and other feasibility issues. These included any problems that we could foresee prior to starting abstraction, such as data elements that might be time-consuming to collect or which required a judgement to be made by the abstractor. For complex processes of care with multiple components of varying clinical or outcome relevance (e.g., delivery of CBT/SST or assessment of mental status), we sought expert input to select and operationalize critical components. Technical specifications were reviewed by both external clinical experts and the VA Advisory group in order to ensure that specifications were both feasible given the data available, and meaningful to this particular population.

We categorized indicators according to the strength of the process-outcome link using the grading system developed by the AHRQ’s US Preventive Services Task Force. Grade I measures are those where the link between process and outcome has been established through randomized clinical trials, grade II measures are supported by well-designed, non-randomized trials, and grade III measures are supported by expert opinion. A caveat to drawing conclusions from this grading system is that sometimes the outcomes literature may not be specific enough about the ingredients of the intervention that are critical to its efficacy/effectiveness. For example, although randomized controlled trials have established the value of psychotherapy in the treatment of several disorders, not enough evidence exists to ascertain the minimum “dose” (or number of sessions) and duration required for the outcome advantage to emerge. We also note that the grading does not reflect translational validity, or the certainty that the technical specifications accurately reflect the process of care they are trying to capture.

6. Determine data abstraction elements and sequence of abstraction

Starting with the technical specifications developed above, we described the data abstraction elements and abstraction sequence for each indicator. Since many indicators required overlapping information, we removed redundancy and grouped questions for efficiency. For example, all questions about medications were placed together, since the medications prescribed to a veteran are found in a single section of the record. We created abstraction forms for each diagnosis.

7. Pilot test indicators for translational validity and performance

Clinical nurse abstractors piloted each indicator for timing and performance using pencil and paper and modifications were made in order to keep data collection time to a minimum. We
found that some data elements were not found in the part of the medical record to which we had access, and, after review with the clinical advisory group, deleted these indicators. After the initial paper and pencil pilot test, an electronic abstraction form was created and a second pilot test was performed to make sure that the questions flowed correctly and that there were no programming errors.

Discussion

In this report we present a comprehensive set of indicators for evaluating the performance of mental health care systems with two different data sources, administrative and medical records. One of the greatest difficulties in evaluating mental health care is obtaining meaningful data to measure the key elements of the system. In order to evaluate the structure of care, we developed indicators that used a combination of both data sources available, while recognizing that both sources of data, either singly or in combination, have inherent strengths and weaknesses.

The main strength of using administrative data is their availability and comprehensive enumeration of the study population. Moreover, the databases were relatively large, enabling the study team to analyze population subgroups and specific geographic areas separately, which was particularly useful, since most problems related to access and availability are not uniform across populations or within areas. In many cases, however, items were missing or the accuracy of the information provided could not be guaranteed. This is not uncommon when data are collected and used for different purposes. Other studies also support the use of administrative data combined with chart review to assess performance.

While the structure-process-outcomes evaluation model presented herein holds promise for advancing the science of mental health care quality improvement both within and outside the VHA, a few final caveats are in order.

First, in any health care system, the progression from evidence-based practice guidelines to performance indicators to improved patient outcomes is fraught with complexity. Great care must be taken to measure precisely what is intended to be measured through effective and efficient documentation so that the burden of measurement does not outpace quality care provision. In addition, continued awareness of the complicated linkages between evidence-based practice and individual patient preferences and outcomes is essential. As recent studies amply demonstrate, even the most basic of evidence-based practice improvements can result in different outcomes for different patients and for different reasons. Attention must also be paid to ensuring that quality improvement becomes a part of the fabric of care at both the organizational and individual levels, through resource investment, staff training, etc.

Second, not all mental health care systems look or operate like the VHA mental health care system. Public and private sector mental health care functions largely as a cottage industry, with the majority of psychiatrists practicing in solo or two-physician practices; information technology is less well developed; there are few centralized administrative databases; and there is no single entity or organization responsible for implementing and monitoring quality improvement strategies. While these differences must be recognized and addressed in the context of ongoing quality improvement, the same high quality standards should nevertheless apply.

Third, to what extent this model can be adapted for use in other systems and in other contexts is not clear. It is possible that certain components of the model will be more suitable for mental health quality improvement efforts at the national or state levels or in large systems (e.g., managed care networks), while others will work well in more localized contexts (e.g., community mental health centers).
VA has undertaken the most extensive, systematic, and rigorous evaluation of the mental health care delivery ever conducted. Although this quality improvement effort is still in its early stages, and much remains to be learned, the framework, methodology, and preliminary results offer a fertile ground upon which other stakeholders in the mental health field can continue to build and expand both in the near- and longer-term.
INTRODUCTION

This technical manual is presented in three main parts. Part I defines the key terms used in the description of indicators, part II describes the administrative data indicators, and part III describes the medical record indicators.

Part I, the Key Definitions Document (KDD) defines the relevant populations, types of treatment encounters, treatment episodes for each of six main diagnoses (bipolar disorder, schizophrenia, major depression disorder (MDD), post-traumatic stress disorder (PTSD), substance use disorder (SUD), and co-occurring disorders), and additional concepts such as specialty mental health, licensed mental health provider, licensed mental health prescribing provider, licensed prescribing provider, and psychotherapy. This document is a companion to support the use of any of the indicators in parts II and III.

Part II describes 31 indicators designed for administrative data analysis including indicators specific to the treatment of bipolar disorder, schizophrenia, substance use disorder, major depressive disorder, and post-traumatic stress disorder as well as cross-cutting indicators that apply to two or more of the diagnoses considered.

Part III describes 57 hybrid indicators that integrate data from administrative and medical records. In addition to documenting indicators for each of the six main diagnoses and cross-cutting indicators this section also includes suicide indicators to review assessment for suicide ideation and follow-ups for suicidal patients. And psychosocial indicators to evaluate whether mental health patients receive mental status exams appropriate to their diagnosis and psychosocial assessments and support across the domains of housing, social support, and employment.

Strength of evidence:

The Altarum/RUPHI team has adopted the same grading system as the VHA in its Clinical Practice Guidelines, described in the following table:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence is obtained from at least one properly randomized controlled trial (RCT).</td>
</tr>
<tr>
<td>II</td>
<td>Evidence is obtained from well-designed cohort, case-controlled, controlled, or time series trials without randomization.</td>
</tr>
<tr>
<td>III</td>
<td>Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.</td>
</tr>
</tbody>
</table>

We used the strength of evidence linking the process of care to desired outcomes to define whether the indicator would be used for benchmark or descriptive purposes. Benchmark indicators are those supported by grade I evidence for which data were available and could be collected. The remaining indicators are used for descriptive purposes only. Of the 88 indicators developed 21 are benchmark indicators and the remaining 67 are descriptive.
Study Period:
In several indicators, we use the term “study period,” which in this analysis includes fiscal year (FY) 2007. In certain instances we have extended the scope of analysis to include data from FY 2008 or a look-back period into FY 2006. In those cases, the change is noted in the text of the indicator.

Data Sources:
For all indicators, we are relying on administrative and medical record data to define the numerator and denominator. Indicators that require pharmacy administrative data may be operationalized on a smaller sample unless we gain approval to receive the complete pharmacy file for all patients in our universe as defined in the Key Definitions Document.

Industry standard indicators:
Where possible we have used indicators that have been cited by major mental health care performance indicator clearinghouses. These indicators have been previously developed and substantiated with evidence or clinical consensus. We will cite these clearinghouses in the rationale statements for many performance indicators in this document. Below we have included a brief summary of each of these clearinghouses from their own documentation.

Center for Quality Assessment and Improvement in Mental Health (CQAIMH)
CQAIMH inventory of quality measures provides a searchable database of more than 300 process measures for assessment and improvement of mental health and substance abuse care. These measures have been developed by government agencies, researchers, professional organizations, accreditors, health systems, employer purchasers, consumer coalitions, and commercial vendors. Each measure is accompanied by a clinical rationale, numerator and denominator specifications and information on data source, domain of quality, evidence basis and developer. The inventory can be searched by these characteristics as well as by diagnosis, demographics, type of treatment and clinical setting. Funding for the Inventory was provided by the Agency for Healthcare Research and Quality (AHRQ), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Evaluation Center@HSRI. Source: http://cqaimh.org/

STABLE: Standards for Bipolar Excellence
The STABLE Performance Measures & Toolkit provides rigorously developed tools for quality assessment and improvement of care for bipolar disorder. Fifteen performance measures were developed on the basis of research evidence, expert consensus and formal testing of reliability and validity. Detailed specifications, medical record abstraction forms and performance results from 80 outpatient sites are provided. The toolkit provides numerous resources to improve performance in clinical practice including instruments to screen for depression and mania as well as to monitor symptoms and functioning over time. In addition, there are tools to assess for suicide risk, co-morbid substance use and medication side effects; to provide patient education; and to assist with diagnostic coding. STABLE was led by a National Coordinating Council of bipolar and measurement experts as well as leaders of national professional associations. Funding was provided by AstraZeneca LLP. Source: http://www.cqaimh.org/stable.html

National Quality Forum (NQF)
The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. A shared sense of urgency about the impact of health care quality on patient outcomes, workforce
productivity, and health care costs prompted leaders in the public and private sectors to create the NQF as a mechanism to bring about national change.
Source: http://www.qualityforum.org/

Healthcare Effectiveness Data and Information Set (HEDIS) and National Committee for Quality Assurance (NCQA)

Developed and maintained by NCQA, HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 71 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.

To ensure that HEDIS stays current, NCQA has established a process to evolve the measurement set each year. NCQA's Committee on Performance Measurement, a broad-based group representing employers, consumers, health plans and others, debates and decides collectively on the content of HEDIS. This group determines what HEDIS measures are included and field tests determine how it gets measured.

11
PART I: Key Definitions Document
Defining Study-Relevant Populations

Ia. Cohort diagnoses

In the following table are ICD-9 codes used to define each of our cohorts. To be included in the study population, clients must have at least two outpatient encounters on different days or one inpatient episode during the study period for any reason. Patients are assigned to a diagnostic cohort based on the diagnosis code from Table 1A that appears in the greatest number of episodes of care during the study period, either primary or secondary.

To be eligible for the co-occurring disorders indicators clients must be assigned to one of the four mental health cohorts (e.g., MDD, PTSD, schizophrenia, bipolar disorder) and the SUD cohort. If a patient was assigned to one of these cohorts in FY06 and another in FY07, they will still qualify for the co-occurring disorders cohort.

<table>
<thead>
<tr>
<th>Cohort</th>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>295.0</td>
<td>Schizophrenia, simple type</td>
</tr>
<tr>
<td></td>
<td>295.1</td>
<td>Schizophrenia, disorganized type</td>
</tr>
<tr>
<td></td>
<td>295.2</td>
<td>Schizophrenia, catatonic type</td>
</tr>
<tr>
<td></td>
<td>295.3</td>
<td>Schizophrenia, paranoid type</td>
</tr>
<tr>
<td></td>
<td>295.4</td>
<td>Acute schizophrenic episode</td>
</tr>
<tr>
<td></td>
<td>295.5</td>
<td>Latent schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.6</td>
<td>Residual schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.7</td>
<td>Schizophrenia, schizo-affective type</td>
</tr>
<tr>
<td></td>
<td>295.8</td>
<td>Other specified types of schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.9</td>
<td>Unspecified schizophrenia</td>
</tr>
<tr>
<td>PTSD</td>
<td>309.81</td>
<td>Prolonged posttraumatic stress disorder</td>
</tr>
<tr>
<td>Bipolar</td>
<td>296.0</td>
<td>Manic disorder, single episode</td>
</tr>
<tr>
<td></td>
<td>296.1</td>
<td>Manic disorder, recurrent episode</td>
</tr>
<tr>
<td></td>
<td>296.4</td>
<td>Bipolar affective disorder, manic</td>
</tr>
<tr>
<td></td>
<td>296.5</td>
<td>Bipolar affective disorder, depressed</td>
</tr>
<tr>
<td></td>
<td>296.6</td>
<td>Bipolar affective disorder, mixed</td>
</tr>
<tr>
<td></td>
<td>296.7</td>
<td>Bipolar affective disorder, unspecified</td>
</tr>
<tr>
<td>Major Depressive Disorder</td>
<td>296.2</td>
<td>Major depressive disorder, single episode</td>
</tr>
<tr>
<td></td>
<td>296.3</td>
<td>Major depressive disorder, recurrent episode</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>303.90-303.92</td>
<td>Other and unspecified alcohol dependence</td>
</tr>
<tr>
<td></td>
<td>304.00-304.02</td>
<td>Opioid type dependence</td>
</tr>
<tr>
<td></td>
<td>304.10-304.12</td>
<td>Barbiturate and similarly acting sedative or hypnotic dependence</td>
</tr>
<tr>
<td></td>
<td>304.20-304.22</td>
<td>Cocaine dependence</td>
</tr>
<tr>
<td></td>
<td>304.30-304.32</td>
<td>Cannabis dependence</td>
</tr>
<tr>
<td></td>
<td>304.40-304.42</td>
<td>Amphetamine and other psychostimulant dependence</td>
</tr>
</tbody>
</table>

TABLE 1A. COHORT DIAGNOSES
<table>
<thead>
<tr>
<th>Cohort</th>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-Occurring Disoders</td>
<td>Co-Occuring</td>
<td>Diagnosis of SUD and MDD, PTSD, SUD, Bipolar or Schizophrenia</td>
</tr>
<tr>
<td></td>
<td>Disorders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>304.50-304.52</td>
<td>Hallucinogen dependence</td>
</tr>
<tr>
<td></td>
<td>304.60-304.62</td>
<td>Other and unspecified drug dependence</td>
</tr>
<tr>
<td></td>
<td>304.70-304.72</td>
<td>Combinations of opioid type with any other</td>
</tr>
<tr>
<td></td>
<td>304.80-304.82</td>
<td>Combinations of drug dependence excluding opioid type</td>
</tr>
<tr>
<td></td>
<td>304.90-304.92</td>
<td>Unspecified drug dependence</td>
</tr>
<tr>
<td></td>
<td>305.00-305.02</td>
<td>Alcohol abuse</td>
</tr>
<tr>
<td></td>
<td>305.20-305.22</td>
<td>Cannabis abuse</td>
</tr>
<tr>
<td></td>
<td>305.30-305.32</td>
<td>Hallucinogen abuse</td>
</tr>
<tr>
<td></td>
<td>305.40-305.42</td>
<td>Barbiturate and similarly acting sedative or hypnotic abuse</td>
</tr>
<tr>
<td></td>
<td>305.50-305.52</td>
<td>Opioid abuse</td>
</tr>
<tr>
<td></td>
<td>305.60-305.62</td>
<td>Cocaine abuse</td>
</tr>
<tr>
<td></td>
<td>305.70-305.72</td>
<td>Amphetamine or related acting sympathomimetic abuse</td>
</tr>
<tr>
<td></td>
<td>305.90-305.92</td>
<td>Other, mixed, or unspecified drug abuse</td>
</tr>
</tbody>
</table>

**Defining Study-Relevant Treatment Encounters**

**Ib. Diagnostic codes used to define treatment encounters**

The set of codes in Table 1B will be used to describe encounters or episodes occurring during treatment, to establish relevant treatment, and also to define the beginning of a new treatment episode. Codes in *italics* represent additional codes from those used to define the diagnostic cohort.
<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>ICD-9 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>295.0</td>
<td>Schizophrenia, simple type</td>
</tr>
<tr>
<td></td>
<td>295.1</td>
<td>Schizophrenia, disorganized type</td>
</tr>
<tr>
<td></td>
<td>295.2</td>
<td>Schizophrenia, catatonic type</td>
</tr>
<tr>
<td></td>
<td>295.3</td>
<td>Schizophrenia, paranoid type</td>
</tr>
<tr>
<td></td>
<td>295.4</td>
<td>Acute schizophrenic episode</td>
</tr>
<tr>
<td></td>
<td>295.5</td>
<td>Latent schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.6</td>
<td>Residual schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.7</td>
<td>Schizophrenia, schizo-affective type</td>
</tr>
<tr>
<td></td>
<td>295.8</td>
<td>Other specified types of schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.9</td>
<td>Unspecified schizophrenia</td>
</tr>
<tr>
<td></td>
<td>298.9</td>
<td>Psychosis disorder, not otherwise specified</td>
</tr>
<tr>
<td></td>
<td>295.40</td>
<td>Schizophreniform Disorder</td>
</tr>
<tr>
<td></td>
<td>298.8</td>
<td>Brief psychotic disorder</td>
</tr>
<tr>
<td></td>
<td>293.xx</td>
<td>Psychotic disorder due to a general medical condition</td>
</tr>
<tr>
<td></td>
<td>296.0</td>
<td>Manic disorder, single episode</td>
</tr>
<tr>
<td></td>
<td>296.1</td>
<td>Manic disorder, recurrent episode</td>
</tr>
<tr>
<td></td>
<td>296.4</td>
<td>Bipolar affective disorder, manic</td>
</tr>
<tr>
<td></td>
<td>296.5</td>
<td>Bipolar affective disorder, depressed</td>
</tr>
<tr>
<td></td>
<td>296.6</td>
<td>Bipolar affective disorder, mixed</td>
</tr>
<tr>
<td></td>
<td>296.7</td>
<td>Bipolar affective disorder, unspecified</td>
</tr>
<tr>
<td></td>
<td>296.8x</td>
<td>Manic-depressive psychoses, other and unspecified</td>
</tr>
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<td>PTSD</td>
<td>309.81</td>
<td>Prolonged posttraumatic stress disorder</td>
</tr>
<tr>
<td>Bipolar</td>
<td>296.0</td>
<td>Manic disorder, single episode</td>
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<td></td>
<td>296.1</td>
<td>Manic disorder, recurrent episode</td>
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<td></td>
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<td>Bipolar affective disorder, manic</td>
</tr>
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<td></td>
<td>296.5</td>
<td>Bipolar affective disorder, depressed</td>
</tr>
<tr>
<td></td>
<td>296.6</td>
<td>Bipolar affective disorder, mixed</td>
</tr>
<tr>
<td></td>
<td>296.7</td>
<td>Bipolar affective disorder, unspecified</td>
</tr>
<tr>
<td></td>
<td>296.8x</td>
<td>Manic-depressive psychoses, other and unspecified</td>
</tr>
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<td>295.0</td>
<td>Schizophrenia, simple type</td>
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<td>295.1</td>
<td>Schizophrenia, disorganized type</td>
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<td>Schizophrenia, catatonic type</td>
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<td></td>
<td>295.3</td>
<td>Schizophrenia, paranoid type</td>
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<td></td>
<td>295.4</td>
<td>Acute schizophrenic episode</td>
</tr>
<tr>
<td></td>
<td>295.5</td>
<td>Latent schizophrenia</td>
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<tr>
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<td>295.6</td>
<td>Residual schizophrenia</td>
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<td></td>
<td>295.7</td>
<td>Schizophrenia, schizo-affective type</td>
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<td></td>
<td>295.8</td>
<td>Other specified types of schizophrenia</td>
</tr>
<tr>
<td></td>
<td>295.9</td>
<td>Unspecified schizophrenia</td>
</tr>
<tr>
<td></td>
<td>298.9</td>
<td>Psychosis disorder, not otherwise specified</td>
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<td></td>
<td>295.40</td>
<td>Schizophreniform Disorder</td>
</tr>
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<td></td>
<td>298.8</td>
<td>Brief psychotic disorder</td>
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<td></td>
<td>293.xx</td>
<td>Psychotic disorder due to a general medical condition</td>
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<td></td>
<td>296.2</td>
<td>Major depressive disorder, single episode</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>ICD-9 Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------</td>
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<td>-------------------------------------------------</td>
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<td>Major Depressive Disorder</td>
<td>296.2</td>
<td>Major depressive disorder, single episode</td>
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<td>Major Depressive Disorder</td>
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<td>300.4</td>
<td>Dysthymia</td>
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<td></td>
<td>293.83</td>
<td>Mood Disorder due to Medical Condition</td>
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<td></td>
<td>296.90</td>
<td>Mood Disorder NOS</td>
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<tr>
<td></td>
<td>309.1</td>
<td>Prolonged Depressive Reaction</td>
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<td></td>
<td>296.99</td>
<td>Other Specified Affective Disorders</td>
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<tr>
<td>Substance Use Disorder</td>
<td>292.9</td>
<td>Opioid related disorder NOS</td>
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<td></td>
<td>303.90-303.92</td>
<td>Other and unspecified alcohol dependence</td>
</tr>
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<td></td>
<td>304.00-304.02</td>
<td>Opioid type dependence</td>
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<tr>
<td></td>
<td>304.10-304.12</td>
<td>Barbiturate and similarly acting sedative or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hypnotic dependence</td>
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<tr>
<td></td>
<td>304.20-304.22</td>
<td>Cocaine dependence</td>
</tr>
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<td>304.30-304.32</td>
<td>Cannabis dependence</td>
</tr>
<tr>
<td></td>
<td>304.40-304.42</td>
<td>Amphetamine and other psychostimulant</td>
</tr>
<tr>
<td></td>
<td></td>
<td>dependence</td>
</tr>
<tr>
<td></td>
<td>304.50-304.52</td>
<td>Hallucinogen dependence</td>
</tr>
<tr>
<td></td>
<td>304.60-304.62</td>
<td>Other and unspecified drug dependence</td>
</tr>
<tr>
<td></td>
<td>304.70-304.72</td>
<td>Combinations of opioid type with any other</td>
</tr>
<tr>
<td></td>
<td>304.80-304.82</td>
<td>Combinations of drug dependence excluding</td>
</tr>
<tr>
<td></td>
<td></td>
<td>opioid type</td>
</tr>
<tr>
<td></td>
<td>304.90-304.92</td>
<td>Unspecified drug dependence</td>
</tr>
<tr>
<td></td>
<td>305.00-305.02</td>
<td>Alcohol abuse</td>
</tr>
<tr>
<td></td>
<td>305.20-305.22</td>
<td>Cannabis abuse</td>
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<td></td>
<td>305.30-305.32</td>
<td>Hallucinogen abuse</td>
</tr>
<tr>
<td></td>
<td>305.40-305.42</td>
<td>Barbiturate and similarly acting sedative or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>hypnotic abuse</td>
</tr>
<tr>
<td></td>
<td>305.50-305.52</td>
<td>Opioid abuse</td>
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<tr>
<td></td>
<td>305.60-305.62</td>
<td>Cocaine abuse</td>
</tr>
<tr>
<td></td>
<td>305.70-305.72</td>
<td>Amphetamine or related acting sympathomimetic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>abuse</td>
</tr>
<tr>
<td></td>
<td>305.90-305.92</td>
<td>Other, mixed, or unspecified drug abuse</td>
</tr>
</tbody>
</table>
Defining New Treatment Episodes

IIa. Bipolar Disorder

The new treatment episode for bipolar disorder is defined as:

- A recent, diagnosis-related admission\(^1\) or transfer to an inpatient/residential mental health bed,

**OR**

- An outpatient encounter where bipolar disorder (Table 1B) is the primary diagnosis following a break in care.

Break in care is defined as:

- NO bipolar-related medications for 5 or more months

**AND**

- NO outpatient encounters where bipolar disorder is either the primary or the secondary diagnosis for 5 or more months.\(^2\)

**Patient cohorts:** All patients in the bipolar disorder cohort (Table 1A).

**Definitions:**

- **Bipolar Disorder Encounter:** ICD-9 codes including 296.0, 296.1, 296.4, 296.5, 296.6, 296.7, 296.8x, 295.0, 295.1, 295.2, 295.3, 295.4, 295.5, 295.6, 295.7, 295.8, 295.9, 298.9, 295.40, 298.8, 293.xx

- **Bipolar Medication:** Any medications for which a prescription was filled. These include drugs from the following VA Drug Class Codes found in VHA Pharmacy Prescription Data:
  - CN400, Anticonvulsants
  - CN600, Antidepressants
  - CN601, Tricyclic Antidepressants
  - CN602, Monamine Oxidase Inhibitor Antidepressants
  - CN609, Antidepressants, Other
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics

---

\(^1\) The new episode of care begins on the date of admission or transfer; however, the discharge diagnosis will be used for purposes of describing the admission/transfer.

\(^2\) A break in care is defined as 5 or more months without condition-related medications or condition-related outpatient encounters. The definition of a break in care is fairly restrictive in order to address concerns that poor medication compliance could include patients who have a 90-day prescription and are still taking medications but inconsistently.
o CN709, Antipsychotics, Other
o CN750, Lithium Salts

• Inpatient admission\textsuperscript{3} where any psychiatric diagnosis is the primary diagnosis (ICD-9 codes: 290.xx-319.xx) and, if the primary diagnosis is not a diagnosis in Table 1B, at least one secondary diagnosis comes from Table 1B.
• If it is impossible to determine which diagnosis for an outpatient encounter is the primary diagnosis, then a diagnosis in Table 1B must be listed as one of the diagnoses for the encounter.\textsuperscript{4}

Instructions:
The start of the new treatment episode for bipolar disorder will be defined by:

1) The admission date or transfer date for any inpatient hospitalization as defined above.

OR

2) An outpatient encounter where bipolar disorder (Table 1B) is the primary diagnosis following a clean period of five or more months (based on a 90-day prescription) for which there is:
   • NO prescription filled for selected medications,
   
   \textbf{AND (in the same time period of five or more months)}
   
   • NO outpatient encounter in any clinic where bipolar disorder is the primary or secondary diagnosis.

The first visit after the clean period in which bipolar disorder is the primary diagnosis will indicate the start date for the new treatment episode.

IIb. \textbf{Schizophrenia}
The new treatment episode for schizophrenia is defined as:

• A recent, diagnosis-related admission or transfer to an inpatient/residential mental health bed,

OR

• An outpatient encounter where schizophrenia (Table 1B) is the primary diagnosis following a break in care.

\textsuperscript{3} Defining the NTE based on inpatient discharges was modified such that the primary diagnosis must be any psychiatric diagnosis (210.xx-319.xx) and, if the primary diagnosis was not one of those in Table 1B, an added requirement is that a diagnosis from Table 1B must be listed as a secondary diagnosis.

\textsuperscript{4} Definition for how an outpatient encounter triggers a NTE was modified to be made consistent with the practicalities of the data being extracted from medical records by WVMI. It is not always possible to determine which of the diagnoses listed for an outpatient encounter is the primary diagnosis based on the clinical notes. In these cases, a diagnosis from Table 1B must be listed as one of the diagnoses for the encounter.
Break in care is defined as:
  o NO schizophrenia-related medications for 5 or more months
  AND
  o NO outpatient encounters where schizophrenia disorder is either the primary or the secondary diagnosis for 5 or more months.\(^5\)

**Patient cohorts:** All patients in the schizophrenia disorder cohort (Table 1A).

**Definitions:**

- Schizophrenia Encounter: ICD-9 codes including 295.x, 298.9, 295.40, 298.8, 293.xx, 296.0, 296.1, 296.4, 296.5, 296.6, 296.7, 296.8x.

- Schizophrenia Medication: Any medications for which a prescription was filled. These include drugs from the following VA Drug Class Codes found in VHA Pharmacy Prescription Data:
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other

- Inpatient/residential mental health admission where any psychiatric diagnosis is the primary diagnosis (ICD-9 codes: 290.xx-319.xx) and, if the primary diagnosis is not a diagnosis in Table 1B, at least one secondary diagnosis comes from Table 1B.

**Instructions:**

The start of the new treatment episode for schizophrenia will be defined by:

1) The admission date or transfer date for any inpatient hospitalization as defined above.

**OR**

2) An outpatient encounter where schizophrenia (Table 1B) is the primary diagnosis following clean period of five or more months (based on a 90-day prescription) for which there is:
   - NO prescription filled for selected medications,
   **AND (in the same time period of five or more months)**
   - NO outpatient encounter in any clinic where schizophrenia is the primary or secondary diagnosis.

The first visit after the clean period in which schizophrenia is the primary diagnosis will indicate the start date for the new treatment episode.

\(^5\) A break in care is defined as 5 or more months without condition-related medications or condition-related outpatient encounters. The definition of a break in care is a fairly restrictive in order to address concerns that poor medication compliance could include patients who have a 90-day prescription and are still taking medications but inconsistently.
IIc. Major Depressive Disorder (MDD)

The new treatment episode for MDD is defined as:

- A recent, diagnosis-related admission or transfer to an inpatient/residential mental health bed,

OR

- An outpatient encounter where MDD (Table 1B) is the primary diagnosis following a break in care.

Break in care is defined as:

- NO MDD-related medications for 5 or more months

AND

- NO encounters where MDD disorder is either the primary or the secondary diagnosis for 5 or more months.\(^6\)

Patient cohorts: All patients in the MDD cohort (Table 1A).

Definitions:


- MDD Medication: Any medications for which a prescription was filled. These include drugs from the following VA Drug Class Codes found in VHA Pharmacy Prescription Data:
  - CN600, Antidepressants
  - CN601, Tricyclic Antidepressants
  - CN602, Monamine Oxidase Inhibitor Antidepressants
  - CN609, Antidepressants, Other
  - CN750, Lithium Salts

- Inpatient/residential mental health admission where any psychiatric diagnosis is the primary diagnosis (ICD-9 codes: 290.xx-319.xx) and, if the primary diagnosis is not a diagnosis in Table 1B, at least one secondary diagnosis comes from Table 1B.

Instructions:

The start of the new treatment episode for MDD will be defined by:

\(^6\) A break in care is defined as 5 or more months without condition-related medications or condition-related outpatient encounters. The definition of a break in care is a fairly restrictive in order to address concerns that poor medication compliance could include patients who have a 90-day prescription and are still taking medications but inconsistently.
1) The admission date or transfer date for any inpatient hospitalization as defined above.

OR

2) An outpatient encounter where MDD (Table 1B) is the primary diagnosis following clean period of five or more months (based on a 90-day prescription) for which there is:
   - NO prescription filled for selected medications,
   - AND (in the same time period of five or more months)
   - NO outpatient encounter in any clinic where MDD is the primary or secondary diagnosis.

The first visit after the clean period in which MDD is the primary diagnosis will indicate the start date for the new treatment episode.

IId. Post-Traumatic Stress Disorder (PTSD)

The new treatment episode for PTSD is defined as:
   - A recent, diagnosis-related admission or transfer to an inpatient/residential mental health bed,
   - OR
   - An outpatient encounter where PTSD is the primary diagnosis following a break in care.

Break in care is defined as:
   - NO PTSD-related medications for 5 or more months
   - AND
   - NO outpatient encounters where PTSD is either the primary or the secondary diagnosis for 5 or more months.  

Patient cohorts: All patients in the PTSD cohort (Table 1A).

Definitions:
   - PTSD Encounter: ICD-9 codes including 309.81.

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7 A break in care is defined as 5 or more months without condition-related medications or condition-related outpatient encounters. The definition of a break in care is a fairly restrictive in order to address concerns that poor medication compliance could include patients who have a 90-day prescription and are still taking medications but inconsistently. Initially, a break in care was defined using a 12-month timeframe; we may modify this timeframe pending a discussion with PTSD experts.
• PTSD Medication: Any medications for which a prescription was filled. These include drugs from the following VA Drug Class Codes or NDC codes found in VHA Pharmacy Prescription Data:
  - CN600, Antidepressants
  - CN601, Tricyclic Antidepressants
  - CN602, Monoamine Oxidase Inhibitor Antidepressants
  - CN609, Antidepressants, Other
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
  - Prazosin (see Appendix A for associated NDC codes)

• Inpatient/residential mental health admission where any psychiatric diagnosis is the primary diagnosis (ICD-9 codes: 290.xx-319.xx) and, if the primary diagnosis is not a diagnosis in Table 1B, at least one secondary diagnosis comes from Table 1B.

Instructions:
The start of the new treatment episode for PTSD will be defined by:

1) The admission date or transfer date for any inpatient hospitalization as defined above.

OR

2) An outpatient encounter where PTSD is the primary diagnosis following clean period of 5 or more months for which there is:
   - NO prescription filled for selected medications,
   - AND (in the same time period of twelve or more months)
   - NO outpatient encounter in any clinic where PTSD is the primary or secondary diagnosis.

The first visit after the clean period in which PTSD is the primary diagnosis will indicate the start date for the new treatment episode.

IIe. Substance Use Disorder (SUD)
The new treatment episode for SUD is defined as:

- A recent, diagnosis-related admission or transfer to an inpatient/residential mental health bed,

OR

- An outpatient encounter where SUD is the primary diagnosis following a break in care.

Break in care is defined as:
- NO SUD-related medications for 5 or more months
  AND
- NO outpatient encounters where SUD is either the primary or the secondary diagnosis for 5 or more months.\(^8\)

**Patient cohorts:** All patients in the SUD cohort (Table 1A).

**Definitions:**
- SUD Encounter: ICD-9 codes including 303.9, 304.0x-304.9x, 305.0x-305.9x (where ‘x’ equals 0, 1, or 2).
- SUD-Related Medication: Any medications for which a prescription was filled. These include drugs from the following VA Drug Class Codes or NDC codes found in VHA Pharmacy Prescription Data or from stop codes:
  - AD100, Alcohol Deterrents (for alcohol abuse/dependence, 303.9, 305.0)
  - Naltrexone (for alcohol abuse/dependence, 303.9, 305.0): see Appendix A for the associated NDC codes
  - Methadone (for opiate addiction, 304.0, 304.7, 305.5): defined by stop codes for opioid substitution (stop code: 523)
  - Buprenorphine (for opiate abuse/dependence, 304.0, 304.7, 305.5): see Appendix A for the associated NDC codes
- Inpatient/residential mental health admission where any psychiatric diagnosis is the primary diagnosis (ICD-9 codes: 290.xx-319.xx) and, if the primary diagnosis is not a diagnosis in Table 1B, at least one secondary diagnosis comes from Table 1B.

**Instructions:**
The start of the new treatment episode for SUD will be defined by:

1) The admission or transfer date for any inpatient hospitalization as defined above.  
   OR
2) An outpatient encounter where SUD is the primary diagnosis following a clean period of five or more months (based on a 90-day prescription) for which there is:
   - NO prescription filled for selected medications,
   AND (in the same time period of five or more months)
   - NO outpatient encounter in any clinic where SUD is the primary or secondary diagnosis.

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\(^8\) A break in care is defined as 5 or more months without condition-related medications or condition-related outpatient encounters. The definition of a break in care is a fairly restrictive in order to address concerns that poor medication compliance could include patients who have a 90-day prescription and are still taking medications but inconsistently.
The first visit after the clean period in which SUD is the primary diagnosis will indicate the start date for the new treatment episode.

IIf. Care for Co-Occurring Disorders
To be eligible for the co-occurring disorders indicators, clients must be assigned to one of the four mental health cohorts (e.g., MDD, PTSD, schizophrenia, bipolar disorder) and the SUD cohort.

Defining an Index Visit for those with co-occurring disorders: For relevant co-occurring disorders performance indicators, we will identify the start date for evaluation based on the identification of an index visit for veterans identified as having a co-occurring disorder as defined above. The index visit is the first encounter during the study period that meets one of the following criteria:

1. The first encounter in which both the veteran’s mental health condition and SUD are present among the ICD-9 codes listed on the administrative file (either the mental health condition or SUD should be primary).

2. If the first encounter of the study period is for a mental health encounter (primary diagnosis only – Table 1B) without mention of an SUD diagnosis, the previous 6 month period and the 6 month period following that encounter are scanned for evidence of an encounter for SUD (primary or secondary diagnosis – Table 1B). If the SUD encounter precedes the mental health encounter by less than six months, the mental health encounter is labeled the index visit for purposes of evaluating the performance indicators. If there is no prior SUD encounter but there is an SUD encounter within the six months following the mental health encounter, that SUD encounter is labeled the index visit for purposes of evaluating the performance indicators.

3. Alternatively, if the first encounter of the study period is an encounter for SUD (primary diagnosis only – Table 1B) without mention of a mental health diagnosis, the six months prior to and following that encounter are scanned to find evidence of a mental health encounter (primary or secondary diagnosis – Table 1B). If the mental health encounter precedes the SUD encounter by less than six months, the SUD encounter is labeled the index visit for purposes of evaluating the performance indicators. If the mental health encounter follows the SUD encounter by less than six months, the mental health encounter is labeled the index visit for purposes of evaluating the performance indicators.

4. If the first encounter of the study period of either type (mental health or SUD without mention of the other diagnosis) is not preceded by or followed by another relevant encounter within six months, the encounter stream is followed through the study period until the above criteria are met.
   o Note: It may be possible for someone to be classified as having a co-occurring disorder and not have an index visit during the study period.
Additional Concepts

IIIa. Specialty Mental Health
Includes diagnosis-related (either primary or secondary using Table 1B) visits to any specialty mental health provider and includes both psychiatry and substance abuse care. The following codes from the Medical SAS Outpatient Datasets (PROV1-PROV10) define specialty mental health care:

- 010000, 010100, 010200-010206, 010300-010302, 010400-010421, 070101, 070102, 070807, 070901, 070947, 070953, 100324-100330, 110100, 114100, 114800-114810, 114900, 115000, 118324, 181001, 182901-182913

IIIb. Licensed Mental Health Provider
Includes diagnosis-related (either primary or secondary using Table 1B) visits to physicians (MD, DO), physician assistants, nurse practitioners/clinical nurse specialists and psychologists/psychoanalysts with a mental health specialty. The following codes from the Medical SAS Outpatient Datasets (PROV1-PROV10) define licensed mental health providers:

- 110100, 114100, 114800-114810, 115000, 118324, 181001, 182901-182913, MD/DO
- 010300-010421, Psychologists/Psychoanalysts
- 100324-100330, PA/CNS
- 100616, NP
- 010100, Clinical Social Worker

IIIc. Licensed Mental Health Prescribing Provider
Includes diagnosis-related (either primary or secondary using Table 1B) visits to physicians (MD, DO), physician assistants, and nurse practitioners/clinical nurse specialists with a mental health specialty and can prescribe medications. The following codes from the Medical SAS Outpatient Datasets (PROV1-PROV10) define licensed mental health prescribing providers:

- 114100, 114800-114810, 115000, 118324, 182901-182913, MD/DO
- 100324-100330, PA/CNS
- 100616, NP
**IIId. Licensed Prescribing Provider**

Includes diagnosis-related (either primary or secondary using Table 1B) visits to physicians (MD, DO), physician assistants, and nurse practitioners/clinical nurse specialists with any specialty (not limited to mental health) and can prescribe medications. The following codes from the Medical SAS Outpatient Datasets (PROV1-PROV10) define licensed prescribing providers:

- 100000, 100100, 100200, 100300-100335, PA/CNS
- 100600-100618, NP

**IIIf. Specialty SUD Care**

Defined as one or more SUD outpatient visits in the first 30 days following the start of an new treatment episode. Appropriate visits include stop codes for SUD treatment found in the Medical SAS Outpatient Dataset:

- 513: Substance Abuse – Individual
- 514: Substance Abuse – Home Visit
- 519: Substance Use Disorder/PTSD Teams
- 523: Opioid Substitution
- 545: Telephone/Substance Abuse
- 547: Intensive Substance Abuse Treatment
- 560: Substance Abuse - Group

**IIIf. Psychotherapy**

Any diagnosis-related (either primary or secondary using Table 1B) clinic encounters for which the following CPT codes are present:
• 90806, 90807, 90808, 90809 Office or Other Outpatient Facility, Insight Oriented, Behavior Modifying and/or Supportive Psychotherapy, excluding psychotherapy with medical evaluation and management services less than 30 minutes

• 90812, 90813, 90814, 90815, Office or Other Outpatient Facility, Interactive Psychotherapy (Note: these codes most likely apply to psychotherapy with children but will be retained for evaluation purposes in case they may be used with adult patients), excluding psychotherapy with medical evaluation and management services less than 30 minutes

• 90818, 90819, 90821, 90822, Inpatient Hospital, Partial Hospital or Residential Treatment Facility, excluding psychotherapy with medical evaluation and management services less than 30 minutes

• 90826, 90827, 90828, 90829, Inpatient Hospital, Partial Hospital or Residential Treatment Facility, Interactive Psychotherapy (Note: these codes most likely apply to psychotherapy with children but will be retained for evaluation purposes in case they may be used with adult patients), excluding psychotherapy with medical evaluation and management services less than 30 minutes

• 90845, Psychoanalysis

• 90853, Group Psychotherapy (other than of a multiple-family group)

• 90857, Interactive Group Psychotherapy (Note: these codes most likely apply to psychotherapy with children but will be retained for evaluation purposes in case they may be used with adult patients.)
PART II: ADMINISTRATIVE DATA INDICATORS
Executive Summary: This indicator is based on a quality measure cited by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) and developed by Lehman et al (1998, updated 2004) for the AHRQ-funded Schizophrenia PORT program. CQAIMH states that “Antipsychotic medications have been shown to be efficacious in the treatment of acute psychotic exacerbations of schizophrenia and in reducing the likelihood of relapse.” According to the American Psychiatric Association Clinical Practice Guidelines, “The evidence supporting the effectiveness of first-generation antipsychotic medications in reducing psychotic symptoms in acute schizophrenia comes from studies carried out in the 1960s as well as numerous subsequent clinical trials,” and “pharmacological treatments should be initiated as soon as is clinically feasible, because acute psychotic exacerbations are associated with emotional distress, disruption to the patient’s life, and a substantial risk of [violent] behavior.” Numerous studies have shown that antipsychotic treatments are effective in the acute phase of schizophrenia. The strength of the evidence led the researchers involved in the AHRQ-funded Schizophrenia Patient Outcomes Research Team (PORT) to recommend this practice which they rated as having ‘good research-based evidence’ (Lehman et al, 1998, updated 2004). The VA Clinical Practice Guidelines also support the use of antipsychotic drugs in schizophrenia treatment.

While antipsychotic medications have been clinically shown to be effective in the treatment of schizophrenia, we cannot account for medication refusals or contraindications in this analysis. This indicator addresses the following IOM domain: effectiveness

References:
Center for Quality Assessment and Improvement in Health Care, Quality indicators published online at www.cqaimh.org. Accessed in October 2007
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition (February 2004); American Psychiatric Association; Am J Psychiatry

Numerator:
- Patients prescribed an antipsychotic for 12 weeks following the start of a new treatment episode
b) Patients prescribed an antipsychotic for less than 12 weeks following the start of a new treatment episode

c) Patients with no filled prescription for an antipsychotic during the 12 weeks following the start of a new treatment episode

**Denominator:** All patients with schizophrenia in a new treatment episode

**Patient cohorts:** Patients with schizophrenia diagnosis.

**Definitions:**

- **New Treatment Episode:** See the Key Definitions Document
  - If the new treatment episode begins in the inpatient setting, the start of a new treatment episode is defined as the admission date
  - If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period

- **12 weeks of an antipsychotic:** Defined as 60 or more days supplied of an antipsychotic in the 12 weeks following the date of the first filled prescription subsequent to the start of a new treatment episode
  - If the new treatment episode begins in the inpatient setting, the patient is considered to be fully compliant with their medications while in the hospital and so the number of days supplied should include the length of stay in the hospital that begins the new treatment episode (using the variable ‘LS’ from the Medical SAS Inpatient Dataset)
  - The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.

- **Less than 12 weeks of an antipsychotic:** Defined as at least one filled prescription but with less than 60 days supplied in the 12 weeks following the date of the first filled prescription subsequent to the start of a new treatment episode

- **No filled prescription:** Defined as no filled prescriptions for any antipsychotic within 12 weeks of the start of the new treatment episode

- **Antipsychotic medications:** One or more prescriptions filled for a patient using the following drug class and NDC codes:
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other

**Strength of Evidence:** Grade III – This is the level of evidence for the indicator as specified, as we cannot account for medication refusals, poor treatment adherence, and other factors beyond the control of the prescriber in this analysis. However, the evidence cited in the executive summary has a strength of evidence of Grade I.

**Feasibility/Data Collection Issues:**

- We do not include patients receiving depot antipsychotics in the numerator of this indicator.
Updates:

• The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
Performance Measure Technical Documentation

Module: Schizophrenia
Indicator Statement: Proportion of schizophrenia patients with long-term utilization of antipsychotic medications
Indicator number: B

Executive Summary: This indicator is based on a quality measure cited by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH), which states that “Antipsychotic medications have been shown to be efficacious in the treatment of acute psychotic exacerbations of schizophrenia and in reducing the likelihood of relapse.” Likewise, for outpatients, “Controlled trials have shown that patients who receive antipsychotic medication for 1 year after an acute psychiatric episode experience a lower likelihood of relapse compared to patients treated with a placebo.” The evidence for this indicator was generated by Lehman et. al. (1998, updated 2004) for the AHRQ-funded Schizophrenia PORT program who report that “on average, persons on maintenance therapy experienced symptom relapse over a follow-up year at a rate of about 20 to 25 percent compared with about 55 percent for those on placebo. The value of maintenance therapy beyond the first year has not been studied extensively.” According to the American Psychiatric Association Clinical Practice Guidelines, “Antipsychotic medications substantially reduce the risk of relapse in the stable phase of illness and are strongly recommended.” The VA Clinical Practice Guidelines also support the use of antipsychotic drugs in schizophrenia treatment.

While antipsychotic medications have been clinically shown to be effective in the treatment of schizophrenia, we cannot account for medication refusals or contraindications in this analysis. This indicator addresses the following IOM domain: effectiveness

References:
Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition (February 2004); American Psychiatric Association; Am J Psychiatry
Center for Quality Assessment and Improvement in Health Care, Quality indicators published online at www.cqaimh.org. Accessed in October 2007
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04

Numerator: Those individuals who received an antipsychotic medication for the following periods of time:
  a) Patients with 12 months supply of an antipsychotic medication during the study period
  b) Patients with at least one filled prescription of an antipsychotic during the study period
  c) Patients with no filled prescription for an antipsychotic during the study period
**Denominator:** All patients with a schizophrenia diagnosis

**Patient cohorts:** Patients with a diagnosis of Schizophrenia

**Definitions:**
- 12 months of continuous antipsychotic medication: Defined as at least 300 days of the medication supplied during a 12-month period following the date of the first filled prescription during the study period.
  - The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
- Any use of an antipsychotic: Defined as at least one filled prescription for an antipsychotic during the study period
- No antipsychotic: Defined as no filled prescriptions for an antipsychotic during the study period
- Antipsychotic medications: Defined as one or more prescriptions using the following VA Drug Class Codes found in VHA Pharmacy Prescription Data:
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other

**Strength of Evidence:** Grade III – This is the level of evidence for the indicator as specified, as we cannot account for medication contraindications in this analysis. However, the evidence cited in the executive summary has a strength of evidence of Grade I.

**Feasibility/Data Collection Issues:**
- We do not include patients receiving depot antipsychotics in the numerator of this indicator.

**Updates:**
- The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
Executive Summary: This indicator is based on a quality measure cited by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) based on a study conducted by Poplin et al (1998), and a recent report by Kreyenbuhl et. al. (2007). CQAIMH states, “prescription of multiple medications requires caution related to potential drug interactions and side effects.” Kreyenbuhl et. al. support this assertion, noting that “treatment with multiple antipsychotic agents may present risks to patients, such as increased adverse effects and drug interactions, decreased treatment adherence, increased costs for patients and health care systems, and a possible increased risk of mortality.” As reported by Ganguly et al (2004), “antipsychotic polypharmacy is widely prevalent, is prescribed for long durations, and is an increasing phenomenon among (publicly insured) schizophrenia patients, indicating a significant discrepancy with treatment guidelines.” The American Psychiatric Association Clinical Practice Guidelines do not support the use of multiple antipsychotic medications.

There is however almost no rigorous research on the effects of antipsychotic polypharmacy: most of the evidence has been generated by case reports or open, uncontrolled, nonrandomized studies (Waddington et. al. (1998); Centorrino et al (2004). Furthermore, there is some documentation that antipsychotic polypharmacy does not increase side effects (Ganesan 2008), although there is no methodologically sound empirical evidence that the practice is effective or free of safety concerns. For these reasons, this indicator will be used descriptively as an indication of practice variation, rather than as a benchmark of quality of care. This indicator addresses the following IOM domain: safety and effectiveness

References:
Center for Quality Assessment and Improvement in Health Care, Quality indicators published online at www.cqaimh.org. Accessed in October 2007
Ganesan, Soma. Antipsychotic polypharmacy does not increase the risk for side effects. Schizophrenia Research 98 (2008) 323–324
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of
Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04


**Numerator:** Those patients in the denominator with simultaneous prescriptions for at least two oral antipsychotic agents for 90 or more days during the study period

**Denominator:** All patients diagnosed with Schizophrenia prescribed at least one antipsychotic agent during the study period

**Patient cohorts:** Patients with cohort diagnosis of Schizophrenia

**Definitions:**
- Oral antipsychotic medications: Defined as one or more filled prescriptions for one of the following medications (NDC codes for these medications can be found in Appendix A to the Key Definitions Document).
  - Chlorpromazine
  - Thioridazine
  - Mesoridazine
  - Thiothixene
  - Trifluoperazine
  - Perphenazine
  - Molindone
  - Loxapine
  - Fluphenazine
  - Haloperidol
  - Clozapine
  - Olanzapine
  - Oquetiapine
  - Risperidone
  - Ziprasidone
  - Aripiprazole
- Simultaneous prescriptions: Defined as 90 or more days supplied for two or more different oral antipsychotic agents during a single 120-day period

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- None.

**Updates:**
- Even if there are more than one prescription filled in a single month, the total days supplied will be the sum of all prescriptions filled within the appropriate time period.
Performance Measure Technical Documentation

Module: Schizophrenia

Indicator Statement: Proportion of selected schizophrenia patients who receive antidepressant medication for comorbid depression in addition to their antipsychotic regimen

Indicator number: D

Executive Summary: This indicator is based on an indicator cited by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH). The evidence for this indicator was generated by Lehman et. al. (1998, updated 2004) for the AHRQ-funded Schizophrenia PORT program who report that “antidepressants seem to benefit patients who have episodic signs and symptoms of depressive illness in addition to schizophrenia, if they are administered in phases of illness other than the active, psychotic exacerbation phase. Antidepressants can be efficacious without exacerbating psychotic symptoms when used adjunctively with antipsychotics.” The CQAIMH indicator statement notes: “depressive symptoms or syndromes are frequently seen among individuals with schizophrenia. Research studies show that depression can be efficaciously treated with an antidepressant medication in this population, and practice guidelines recommend their use. However, many such patients are not treated.” The American Psychiatric Association notes that “Antidepressants are added as an adjunct to antipsychotics when the depressive symptoms meet the syndromal criteria for major depressive disorder, are severe and causing significant distress...antidepressants have been found to be useful in the treatment of depression in schizophrenia. However, very few studies have examined the effects of antidepressants in patients treated with second-generation antipsychotic medications, making it difficult to evaluate the current utility of adjunctive antidepressant agents.”

We cannot account for antidepressant medication refusals or contraindications in this analysis. For this reason, this indicator will be used descriptively. This indicator addresses the following IOM domain: effectiveness.

References:
- Center for Quality Assessment and Improvement in Health Care, Quality indicators published online at www.cqaimh.org. Accessed in October 2007
- Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition (February 2004); American Psychiatric Association; Am J Psychiatry

Numerator: Patients in the denominator with simultaneous antidepressant and antipsychotic prescriptions in the study period

Denominator: Patients diagnosed with schizophrenia and comorbid depression who are not in a new treatment episode
**Patient cohorts:** Patients with a diagnosis of Schizophrenia

**Definitions:**
- **New Treatment Episode:** See the Key Definitions Document
  - Note: Patients with one or more new treatment episodes during the study period will be excluded from the denominator
- **Comorbid depression:** Defined as one inpatient admission and one outpatient encounter or two outpatient encounters with a primary or secondary diagnosis of depression (ICD-9 codes: 296.2, 296.3, 311) in the six months prior to the first encounter where schizophrenia is the primary or secondary diagnosis in the study period
- **Antidepressant medications:** Defined as one or more filled prescriptions with the following VA Drug Class Codes found in VHA Pharmacy Prescription Data:
  - CN600, Antidepressants
  - CN601, Tricyclic Antidepressants
  - CN602, Monamine Oxidase Inhibitor Antidepressants
  - CN609, Antidepressants, Other
- **Antipsychotic medications:** Defined as one or more filled prescriptions with the following VA Drug Class Codes found in VHA Pharmacy Prescription Data:
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
- **Simultaneous antidepressant and antipsychotic prescriptions:** Defined as 90 or more days supplied for an antidepressant AND an antipsychotic agent during the same 120-day period

**Strength of Evidence:** Grade II

**Feasibility/Data Collection Issues:**
- None

**Updates:**
- None.
Performance Measure Technical Documentation

**Module:** Schizophrenia  
**Indicator Statement:** Proportion of schizophrenia patients with an appropriate frequency of visits with a licensed prescribing provider or licensed mental health prescribing provider  
**Indicator number:** E

**Executive Summary:** This indicator is based on clinical expert recommendations supported by the VA’s Clinical Practice Guidelines for psychoses (CPG). The frequency of visits during maintenance-phase treatment is not defined by the VA CPG or the American Psychiatric Association’s Clinical Practice Guidelines, although the APA Guidelines also stress the importance of continuity of treatment during the non-acute phase of treatment for schizophrenia. In addition, the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) cites the indicator ‘Availability of Medication Management & Psychotherapy for Patients with Schizophrenia’ which states that “because symptoms can fluctuate over time and because these medications can have adverse side effects, clinical practice guidelines recommend regular monitoring of patients. There has been little research to assess what constitutes adequate or optimal frequency of monitoring. The 1996 Expert Consensus Guideline for Treatment of Schizophrenia recommended monthly visits, at a minimum, for stable outpatients with schizophrenia and more frequent contact for patients with unstable symptoms or functioning. This measure is part of a set of measures proposed for testing and has not been adopted by the developing organization.” Described by CQAIMH as “members from the denominator who had at least four medication management or psychotherapy visits with a psychiatrist during a 12 month period” (source: NCQA, HEDIS 3.0. Test measures, 1999: This measure was never included in the HEDIS measure set).] We have used as a benchmark the frequency of visits for similar diagnoses suggested by NCQA as a guideline.

This is a Grade III indicator, supported by clinical consensus and expert opinion rather than robust clinical evidence. This indicator addresses the following IOM domain: effectiveness, timeliness, and safety.

**References:**
- Center for Quality Assessment and Improvement in Health Care, Quality indicators published online at www.cqaimh.org. Accessed in October 2007

**Numerator:** Those patients in the denominator with at least one visit per quarter (four visits per year) during the study period:  
  a) With a licensed prescribing provider  
  b) With any mental health licensed prescribing provider

**Denominator:** All patients in the schizophrenia diagnostic cohort
**Patient cohorts:** Patients with a schizophrenia diagnosis

**Definitions:**
- Licensed Prescribing Provider: See the Key Definitions Document
- Licensed Mental Health Prescribing Provider: See the Key Definitions Document
- Inclusion criteria for denominator: If the patient had at least one diagnosis-related visit (primary or secondary using Table 1B from the Key Definitions Document) in the fourth quarter of FY06, begin counting visits for the numerator with the first quarter of FY07. If the patient does not have a relevant visit in the last quarter of FY06, begin with the first visit in FY07 and count forward for four quarters.

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- None.

**Updates:**
- None.
Module: Bipolar I Disorder
Indicator Statement: Proportion of selected bipolar I disorder patients receiving blood level monitoring for lithium
Indicator number: A

Executive Summary: This indicator is based on STABLE performance measure number 10, “Percent of patients treated for bipolar disorder who have evidence of a serum medication level within 12 weeks of beginning treatment with lithium. “In their practice guidelines, the American Psychiatric Association supports this indicator, noting that “for many patients, the therapeutic range within which beneficial effects outweigh toxic effects is quite narrow, so that small changes in serum level may lead to clinically significant alterations in the beneficial and harmful effects of lithium...the frequency of monitoring...should be no less than every 6 months for stable patients.” The CANMAT guidelines for the management of patients with bipolar I disorder (Yatham and Kennedy 2005) note that regular monitoring of serum medication levels is required for patients on lithium or divalproex, and “common practice is to establish two consecutive serum levels in the therapeutic range during the acute phase. Thereafter, serum levels should be repeated every 3-6 months unless the clinical situation warrants otherwise.”

This indicator is based on robust clinical evidence supporting the ideal therapeutic range of serum medication levels, and a clinical consensus regarding the frequency with which monitoring should take place. It is also an industry standard with regard to quality care for bipolar I disorder. This indicator addresses the following IOM domains: effectiveness and safety.

References:
Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement
Yatham LN, Kennedy, SH, et al.; Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines for the managements of patients with bipolar disorder: consensus and controversies, Bipolar Disorders 2005: 7(Suppl. 3): 5-69
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04

Numerator: Patients included in the denominator who have received serum drug level monitoring for Lithium at least once in the 12 weeks following the start of a new prescription during the new treatment episode.
Denominator: Patients diagnosed with bipolar I disorder and at least one filled prescription for Lithium within four months following the start of a new treatment episode

Patient cohorts: Patients with a diagnosis of bipolar I disorder

Definitions:
- **New Treatment Episode**: See the Key Definitions Document
- Lithium can be identified by any prescription with a VA Drug Class Code of CN750 (Lithium Salts)
  - The date of the first prescription for lithium following the start of the new treatment episode begins the clock for serum drug level monitoring in the appropriate timeframe (12 weeks)
  - If the new treatment episode begins in the inpatient setting, the date of the first filled prescription following discharge starts the clock for serum drug level monitoring in the appropriate timeframe (12 weeks)
- Serum drug level monitoring: Defined as one or more lab tests (from the DSS Clinical NDE; TESTNAME = '0004') in the 12 weeks following the date that the first lithium prescription was filled

Strength of Evidence: Grade I

Feasibility/Data Collection Issues:
- None.

Updates:
- None.
Performance Measure Technical Documentation

Module: Bipolar I Disorder

Indicator Statement: Proportion of selected bipolar I disorder patients treated with mood stabilizer medications

Indicator number: B

Executive Summary: This indicator is based on STABLE performance measure 6, “Percent of patients with Bipolar I disorder with depressive symptoms with evidence of use of a mood stabilizing or antimanic agent during the first 12 weeks of pharmacotherapy treatment.” The STABLE indicator differs from this specification in that it excludes from the denominator population those patients for whom an antimanic agent is contraindicated or refused by the patient as documented in the chart. The American Psychiatric Association (APA) guidelines support this measure, and state that the first-line of pharmacological treatment for bipolar I episodes, both manic and depressive, includes the use of mood stabilizers. Similarly, Smith et. al. (2007) review randomized controlled trials and find that mood stabilizers were consistently effective at preventing relapse.

A modified version of this indicator is an industry standard, as it was approved by NQF when STABLE included additional specifications relating to medical records review, such as allowing for situations when mood stabilizing medication was not clinically indicated or not prescribed for medical reasons. While mood stabilizers have been clinically shown to be effective at preventing relapse among patients with bipolar I disorder, we cannot account for medication refusals or contraindications in this analysis. This indicator addresses the following IOM domain: effectiveness.

References:
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04

Numerator:

a) Patients prescribed a mood stabilizer for 12 weeks following the start of a new treatment episode
b) Patients prescribed a mood stabilizer for less than 12 weeks following the start of a new treatment episode
c) Patients with no filled prescription for a mood-stabilizing agent during the 12 weeks following the start of a new treatment episode
**Denominator:** All patients with bipolar I disorder in a new treatment episode

**Patient cohorts:** Patients with bipolar I disorder diagnosis.

**Definitions:**
- **New Treatment Episode:** See the Key Definitions Document
  - If the new treatment episode begins in the inpatient setting, the start of a new treatment episode is defined as the admission date.
  - If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period.
- **12 weeks of mood stabilizers:** Defined as 60 or more days supplied of a mood stabilizer in the 12 weeks following the date of the first filled prescription subsequent to the start of a new treatment episode
  - If the new treatment episode begins in the inpatient setting, the patient is considered to be fully compliant with their medications while in the hospital and so the number of days supplied should include the length of stay in the hospital that begins the new treatment episode (using the variable 'LS' from the Medical SAS Inpatient Dataset).
  - The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
- **Less than 12 weeks of mood stabilizers:** Defined as at least one filled prescription but with less than 60 days supplied in the 12 weeks following the date of the first filled prescription subsequent to the start of a new treatment episode.
- **No filled prescription:** Defined as no filled prescriptions for any mood stabilizer within 12 weeks of the start of the new treatment episode.
- **Mood Stabilizer:** One or more prescriptions filled for a patient using the following drug class and NDC codes:
  - CN400, Anticonvulsants (the following drugs will be identified by NDC codes rather than VA Drug Class Code – see the Key Definitions Document for relevant NDC codes)
    - Valproic Acid
    - Carbamazepine
    - Oxcarbazepine
    - Lamotrigine
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
  - CN750, Lithium Salts

**Strength of Evidence:** Grade I

**Feasibility/Data Collection Issues:**
- Data will be presented for all mood stabilizers and then by drug class code.

**Updates:**
- Deleted references to investigational drugs in the definition of mood stabilizers.
• Days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
Module: Bipolar I Disorder

Indicator Statement: Proportion of patients with bipolar I disorder treated with mood stabilizer medications during the course of bipolar I disorder treatment

Indicator number: C

Executive Summary: This indicator is reported in CQAIMH and is based on the STABLE performance measure 6, and the American Psychiatric Association (APA) guidelines, which state that the first-line of pharmacological treatment for the acute and maintenance phases of manic and depressive bipolar episodes includes the use of mood stabilizers. Similarly, Smith et. al. (2007) review randomized control trials and find that mood stabilizers were consistently effective at preventing relapse.

While mood stabilizers have been clinically shown to be effective at preventing relapse among patients with bipolar disorder, we cannot account for medication refusals or contraindications in this analysis. For this reason, this indicator will be used for descriptive purposes only. This indicator addresses the following IOM domain: effectiveness

References:
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04

Numerator: Patients included in the denominator with evidence of
a) 12 months of any mood-stabilizing medication
b) Any use of a mood-stabilizing agent during the study period
c) No filled prescription for a mood stabilizer

Denominator: All patients with bipolar I disorder

Patient cohorts: Patients with bipolar I disorder diagnosis.

Definitions:
• 12 months of mood stabilizer medication: Defined as at least 300 days of the medication supplied during a 12-month period following the date of the first filled prescription during the study period. The 300 days of medication should be sequential and should not include simultaneous use of medications over a shorter period of time.
• Any use of a mood stabilizer: Defined as at least one filled prescription for a mood stabilizer during the study period
• No mood stabilizer: Defined as no filled prescriptions for a mood stabilizer during the study period
• Mood Stabilizer: One or more prescriptions filled for a patient using the following drug class and NDC codes:
  - CN400, Anticonvulsants (the following drugs will be identified by NDC codes rather than VA Drug Class Code – see the Key Definitions Document for relevant NDC codes)
    - Valproic Acid
    - Carbamazepine
    - Oxcarbazepine
    - Lamotrigine
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
  - CN750, Lithium Salts

**Strength of Evidence:** Grade I

**Feasibility/Data Collection Issues:**
- Data will be presented for all mood stabilizers and then by drug class code
- We do not include gabapentin and topiramate in the list of mood stabilizers that qualify, due to the limitations of their evidence base

**Updates:**
- The definition of 12 months of mood stabilizer medication should consider 300 consecutive days of medication prescribed rather than the sum total of all medication days. For example, we would include 300 total days of medication, regardless of whether they are the same medication or not as long as they are prescribed sequentially. If two drug prescriptions overlap and the total number of days supplied equals 300 but is administered over a shorter period of time, we would not count the patient as having 300 days of the medication supplied.
- We excluded investigational drugs from the definition of mood stabilizers.
Performance Measure Technical Documentation

Module: Bipolar I Disorder

Indicator Statement: Proportion of patients with bipolar I disorder who receive antidepressant treatment without concurrent antipsychotic treatment or other mood stabilizers

Indicator number: D

Executive Summary: This indicator is based on a STABLE performance measure number 7 “Avoidance of antidepressant monotherapy in BDI.” The STABLE indicator differs from this specification in that it excludes from the denominator population those patients for whom an additional bipolar I disorder pharmacotherapy (lithium, anticonvulsant agent, antipsychotic) is contraindicated or refused by the patient as documented in the chart. The STABLE indicator also looks only at the first 12 weeks of pharmacotherapy treatment (numerator a). The American Psychiatric Association (APA) guidelines support this measure, stating that antidepressant monotherapy is not recommended for patients with bipolar I disorder. Furthermore, Suppes et. al. (2005) for the Texas Implementation of Medication Algorithms project conclude that, “due to the risks of mania induction and cycle acceleration, antidepressant monotherapy is not recommended an appropriate maintenance treatment for patients with bipolar disorder I, most recent episode depressed.”

We cannot account for patient refusals of additional pharmacotherapy or contraindications to additional pharmacotherapy in this analysis. This indicator addresses the following IOM domain: effectiveness and safety.

References:
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04

Numerator: Patients who receive only antidepressant monotherapy
   a) In a 12 week period following the start of a new treatment episode
   b) During the study period for all patients

Denominator:
   a) All patients with bipolar I disorder in a new treatment episode
   b) All patients with bipolar I disorder during the study period

Patient cohorts: Patients with bipolar I disorder diagnosis
Definitions:
• New Treatment Episode: See the Key Definitions Document
• Antidepressant monotherapy in a new treatment episode: Defined as one or more prescriptions for an antidepressant filled in the 12 weeks following the start of a new treatment episode with no evidence of filled prescriptions for any antipsychotics or other mood stabilizers during the same time period
  o For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of discharge from the hospital (Note: this definition differs from the general definition of the start of an inpatient new treatment episode in the Key Definitions Document, and from the definition of an inpatient new treatment episode as defined in bipolar B.).
  o If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period
• Antidepressant monotherapy in the study period: Defined as one or more prescriptions for an antidepressant filled during the study period with no evidence of filled prescriptions for any antipsychotics or other mood stabilizers during the same time period
• Antidepressant Medications: Patients with one or more filled prescriptions for antidepressants during the specified time period, defined by the following drug class codes:
  o CN 600: Antidepressants
  o CN 601: Tricyclic antidepressants
  o CN 602: Monamine Oxidase Inhibitor Antidepressants
  o CN 609: Antidepressants, other
• Antipsychotic Medications: Patients with one or more filled prescriptions for antipsychotics during the specified time period, defined by the following drug class codes:
  o CN700, Antipsychotics
  o CN701, Phenothiazine/Related Antipsychotics
  o CN709, Antipsychotics, Other
• Mood Stabilizers: Patients with one or more filled prescriptions for mood stabilizers during the specified time period, defined by the following drug class codes:
  o CN750: Lithium salts
  o Valproic acid, Carbamazepine, Lamotrigine, and Oxcarbazepine: see Appendix A of the Key Definitions Document for associated NDC codes.

Strength of Evidence: Grade I

Feasibility/Data Collection Issues:
• None.

Updates:
• We excluded investigational drugs from the definition of antipsychotic medications.
Performance Measure Technical Documentation

**Module:** Bipolar I Disorder  
**Indicator Statement:** Proportion of patients with bipolar I disorder with an appropriate frequency of visits with a licensed prescribing provider or licensed mental health prescribing provider  
**Indicator number:** E

**Executive Summary:** This indicator is based on clinical expert recommendations supported by the VA’s Clinical Practice Guidelines (CPG). The frequency of visits during maintenance-phase treatment is not defined by the clinical practice guidelines, but instead we have used the frequency of visits for similar diagnoses suggested by NCQA as a guideline. The American Psychiatric Association does not recommend a specific frequency of visits, but notes that “establishing and maintaining a supportive and therapeutic relationship [between patient and physician] is critical to the proper understanding and management of an individual patient,” and, “the identification of early symptoms of relapse is facilitated by the presence of a consistent relationship between the psychiatrist and the patient.” Suppes et. al. (2005), in the Texas Implementation of Medication Algorithms, note that in the maintenance phase of treatment, patients should be seen every two to three months. The VA Clinical Practice Guidelines do not provide any specific recommendations regarding frequency of visits during the maintenance phase for the treatment of psychosis. The VA CPG includes Bipolar I Disorder as one of the many disorders under the Psychoses guidelines.

This is a Grade III indicator, supported by clinical consensus and expert opinion rather than robust clinical evidence. This indicator addresses the following IOM domain: effectiveness and safety.

**References:**

**Numerator:** Those patients in the denominator with at least one visit per quarter (four visits per year) during the study period:
- a) With a licensed prescribing provider
- b) With any mental health licensed prescribing provider

**Denominator:** Patients diagnosed with bipolar I disorder
**Patient cohorts:** Patients with a bipolar I disorder cohort diagnosis

**Definitions:**
- Licensed Prescribing Provider: See the Key Definitions Document
- Licensed Mental Health Prescribing Provider: See the Key Definitions Document
- Inclusion criteria for denominator: If the patient had at least one diagnosis-related visit (primary or secondary using Table 1B from the Key Definitions Document) in the fourth quarter of FY06, begin counting visits for the numerator with the first quarter of FY07. If the patient does not have a relevant visit in the last quarter of FY06, begin with the first visit in FY07 and count forward for four quarters.

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- Data may be presented descriptively as frequency counts of the number of visits per quarter in addition to those patients meeting the threshold of one visit per quarter

**Updates:**
- None.
POSTTRAUMATIC STRESS DISORDER

Performance Measure Technical Documentation

Module: Post Traumatic Stress Disorder
Indicator Statement: Proportion of patients receiving any Specialized Intensive PTSD Programs (SIPP)
Indicator number: A

Executive Summary: This indicator is based on work by Rosenheck et. al. (2006), which states that “the availability of specialized PTSD programs is an important indicator of the quality of health care provided by the VA,” and thus this indicator will provide descriptive evidence of the utilization of SIPP by veterans. The APA Clinical Practice guidelines also support the use of specialized therapies that use a range of psychotherapy, pharmacotherapy, and other interventions. However, in a study of VA inpatient treatment facilities for PTSD, Fontana and Rosenheck (1997) find that “Veterans in the short-stay PTSD units and in the general psychiatric units showed significantly more improvement during follow-up than veterans in the long stay PTSD units,” however they do not report the results of general and short-stay units separately. Of course, patients being referred to long term PTSD care are likely more complicated cases, but nevertheless, the evidence is unclear as to the degree of benefit from long-term SIPP programs. The VA Clinical Practice Guidelines support the use of specialized PTSD programs where indicated. This indicator addresses the following IOM domains: effectiveness.

References:
Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder (2004); American Psychiatric Association

Numerator: Number of patients receiving any SIPP care
a) In the 60 days following the start of a new treatment episode
b) During the study period

Denominator: Patients diagnosed with PTSD
a) In a new treatment episode
b) All patients

Patient cohorts: Patients with cohort diagnosis of PTSD

Definitions:
- New Treatment Episode: See Key Definitions Document
  - For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of admission to the hospital
  - If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related event
outpatient encounter following the 5 month clean period

- SIPP care defined as the presence of two or more specialty PTSD outpatient encounters or one or more specialty PTSD inpatient admissions
  - Specialty PTSD outpatient care: Defined as two or more diagnosis-related encounters (primary or secondary from Table 1B in the Key Definitions Document) from the following stop codes or bed sections:
    - Stop codes: 542, 516, 562, 524, 589, 540, 561, 525, 519, 580, 581,
    - Bed sections: 26 (PTSD Residential Rehabilitation Programs - PRRPs), 88 (PTSD Domiciliary Units - PTSD Dom), 38 (PTSD CWT/TR)
  - Specialty PTSD inpatient care: Defined as one or more diagnosis-related (primary diagnosis only from Table 1B in the Key Definitions Document) inpatient admissions using the following bed section codes:
    - 79 (Specialized Inpatient PTSD Units - SIPUSs)
    - 91 (Evaluation and Brief Treatment PTSD Units - EBTPUs)
      - Note: For patients who begin a new treatment episode in the inpatient setting, specialty PTSD inpatient care consists of inpatient admissions that occur after discharge from the index admission.

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- None.

**Updates:**
- None.
MAJOR DEPRESSIVE DISORDER

Performance Measure Technical Documentation

Module: Major Depressive Disorder

Indicator Statement: Proportion of selected MDD patients receiving appropriate short-term antidepressant medication therapy

Indicator number: A

Executive Summary: This indicator is based on an indicator cited by the National Quality Measures Clearinghouse (also cited by CQAIMH) and developed by HEDIS (NCQA), in the three-part “Antidepressant Medication Management” (AMM) measures. The indicator states that “Early detection and sustained intervention by primary care physicians and medical specialists can lead to increased use of appropriate antidepressant treatment for adults suffering from depressive disorders. Many people with a depressive illness do not seek treatment or have difficulty staying on medication for the necessary periods of time. Managed care organizations should examine the barriers that may be preventing patients from receiving treatment for depressive disorders for the necessary duration. Of particular importance is ensuring appropriate follow-up visits to improve the effective use of antidepressant medications. The new treatment episode, which lasts through the first 12 weeks of treatment, allows the clinician to monitor drug response and assure a full remission of symptoms. However, remission may be followed by relapse unless a continuation phase (4 to 9 months) is instituted. Finally, for a select group of patients with a major depressive disorder, a maintenance phase must be adopted to prevent future recurrences of symptoms and distress.”

Rost et. al. (2005), in a study of clinical outcomes for depression associated with the AMM measures find that “the HEDIS indicator currently in use predicts a 23% improvement in clinical outcomes in the broader population in need.” Furthermore, As stated in the APA CPG, RCTs have established that acute response requires at least 4-6 weeks of treatment (Quitkin et al 1984). This measure is consistent with the VA Clinical Practice Guidelines for the treatment of MDD, which state that a patient presenting with depression should generally receive pharmacotherapy with moderate to severe symptoms, significant impairment of functioning, and/or suicidal ideation. The VA CPG suggests assessing the patients response to medication in six and twelve weeks. It is also consistent with the APA CPG (2002) which recommends antidepressant pharmacological treatment with substantial clinical confidence (top rating).

This indicator is a Grade I indicator, supported by RCT evidence, expert consensus and clinical evidence of its association with improved outcomes (Rost 2005). This indicator addresses the following IOM domain: effectiveness.

References:


Management of Major Depressive Disorder in Adults in the Primary Care Setting.
Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2000. Office of Quality and Performance publication 10Q-CPG/MDD-00

Quitkin FM, Rabkin JG, Ross D, McGrath PJ: Duration of antidepressant drug treatment: what is an adequate trial? Arch Gen Psychiatry 1984; 41:238–245

Numerator:
   a) Those patients in the denominator prescribed an antidepressant for 12 weeks following the start of a new treatment episode
   b) Those patients in the denominator prescribed an antidepressant for less than 12 weeks following the start of a new treatment episode
   c) Those patients with no filled prescription for an antidepressant during the 12 weeks following the start of a new treatment episode

Denominator: Patients diagnosed with MDD in a new treatment episode

Patient cohorts: Patients with cohort diagnosis of MDD

Definitions:
   • New Treatment Episode: See Key Definitions Document
      o If the new treatment episode begins in the inpatient setting, the start of a new treatment episode is defined as the admission date
      o If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period
   • 12 weeks of antidepressants: Defined as 84 or more days supplied of an antidepressant in a 114 day period beginning with the date of the first filled prescription following the start of a new treatment episode
      o If the new treatment episode begins in the inpatient setting, the patient is considered to be fully compliant with their medications while in the hospital and so the number of days supplied should include the length of stay in the hospital that begins the new treatment episode (using the variable ‘LS’ from the Medical SAS Inpatient Dataset)
      o The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
   • Less than 12 weeks of antidepressants: Defined as at least one filled prescription for an antidepressant but with less than 84 days supplied in the 114 days following the date of the first filled prescription subsequent to the start of a new treatment episode
   • No filled prescription: Defined as no filled prescriptions for any mood stabilizer within 114 days of the start of the new treatment episode
   • Antidepressant medication: prescriptions filled within 12 weeks of the start of the new treatment episode using the following drug class codes:
      • CN600, Antidepressants
      • CN601, Tricyclic Antidepressants
• CN602, Monamine Oxidase Inhibitor Antidepressants
• CN609, Antidepressants, Other

**Strength of Evidence:** Grade III; this indicator has been modified from its original specifications in HEDIS based on its incompatibility with our definition of a new treatment episode.

**Feasibility/Data Collection Issues:**
• Length of antidepressant treatment will be used for descriptive purposes only.
• We can construct the HEDIS measure of effective pharmacologic treatment using numerators a and b: \( \frac{a}{a+b} \). This is the industry standard (adopted by NQF as indicators AMB5 – 12 weeks, AMB7 – 6 months) and we will measure it along with the indicator we have developed here.
• The three numerators represented in this indicator are mutually exclusive and add up to 100%. In addition to constructing the HEDIS indicator described above, we will construct this indicator as a series of stacked bars so that each numerator is reflected in a summary graphic.

**Updates:**
• We have excluded investigational drugs from the definition of antidepressant medication.
• We have added additional detail under the feasibility/data collection issues to reflect that this indicator will be presented as both the HEDIS indicator construction \( \frac{a}{a+b} \) and as stacked bars to incorporate all three numerators in data presentation.
• We added a note that the days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
**Performance Measure Technical Documentation**

**Module:** Major Depressive Disorder  
**Indicator Statement:** Effective continuation phase pharmacologic treatment for MDD (AMM)  
**Indicator number:** B

**Executive Summary:** This indicator is based on an indicator cited by the National Quality Measures Clearinghouse (also cited by CQAIMH) and developed by HEDIS (NCQA), in the three-part “Antidepressant Medication Management” (AMM) measures. The indicator states, “Depressive disorders can impair personal, social and family functioning, decrease work productivity, and increase the risk of suicide. Randomized clinical trials show antidepressants to be efficacious for treating major depression and preventing relapse. However, antidepressants must be continued for 4 to 9 months after initiation to minimize the likelihood of relapse.” Rost et. al. (2005), in a study of clinical outcomes for depression associated with the AMM measures find that “the HEDIS indicator currently in use predicts a 23% improvement in clinical outcomes in the broader population in need.” This measure is consistent with the VA Clinical Practice Guidelines for the treatment of MDD, which state that a patient presenting with depression with moderate to severe symptoms, significant impairment of functioning, and/or suicidal ideation should generally receive pharmacotherapy.

This indicator addresses the following IOM domain: effectiveness.

**References:**
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2000. Office of Quality and Performance publication 10Q-CPG/MDD-00

**Numerator:**
- a) Those patients in the denominator prescribed an antidepressant for 180 days following the start of a new treatment episode
- b) Those patients in the denominator prescribed an antidepressant for less than 180 days following the start of a new treatment episode
- c) Those patients with no filled prescription for an antidepressant during the 180 days following the start of a new treatment episode

**Denominator:** Patients diagnosed with MDD in a new treatment episode

**Patient cohorts:** Patients with cohort diagnosis of MDD
Definitions:
• New Treatment Episode: See Key Definitions Document
• Antidepressant medication: At least one prescription filled using the following drug class codes:
  • CN600, Antidepressants
  • CN601, Tricyclic Antidepressants
  • CN602, Monamine Oxidase Inhibitor Antidepressants
  • CN609, Antidepressants, Other
• 180 days of antidepressants: Defined as 180 or more days supplied of an antidepressant in a 231 day period beginning with the date of the first filled prescription following the start of a new treatment episode
  o If the new treatment episode begins in the inpatient setting, the patient is considered to be fully compliant with their medications while in the hospital and so the number of days supplied should include the length of stay in the hospital that begins the new treatment episode (using the variable ‘LS’ from the Medical SAS Inpatient Dataset)
  o The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.

Strength of Evidence: Grade I

Feasibility/Data Collection Issues:
• None.

Updates:
• We have excluded investigational drugs from the definition of antidepressant medications.
• We added a note that the days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)
Indicator Statement: Proportion of all patients with MDD diagnosis who are receiving long-term treatment with antipsychotics
Indicator Number: C

Executive Summary: The following indicator is based on a number of indicators developed across organizations and sources, all of which support the avoidance of polypharmacy and the avoidance of antipsychotic use for non-psychotic conditions. The documentation for this indicator comes from a measure proposed by American Managed Behavioral Healthcare Association (AMBHA), which was originally not restricted only to patients with a diagnosis of major depression. The current indicator has been modified accordingly. The original title of the AMBHA-proposed indicator was “Antipsychotic Use for Non-Psychotic Conditions.” AMBHA provides the following rationale:

Antipsychotic meds are effective in the treatment of psychotic symptoms associated w/ schizophrenia, affective disorders and other conditions. Over the past 2 decades there has been concern about use of these agents outside evidence-based indications. Antipsychotic drugs, particularly traditional (non-atypical) agents, have significant rates of disabling neurologic side effects including tardive dyskinesia, extrapyramidal symptoms, and cognitive impairment. Observational studies have documented extensive antipsychotic use in populations such as aggressive children and adolescents, elderly with behavioral dyscontrol, learning disabled individuals, and individuals with autism or other pervasive developmental disorders. Further research is needed on the efficacy and risks of antipsychotic drugs in these pops, and on the risk benefit ratio of the newer, atypical agents. One study found that decreasing use of antipsychotic drugs among elderly nursing home residents was associated with better functioning. This measure is part of a set of measures proposed for testing and has not been adopted by the developing organization.

There is, however, preliminary evidence supporting the use of atypical antipsychotics, particularly Aripiprazole, to augment antidepressant pharmacotherapy for individuals with MDD (Philips 2008). The evidence in favor of this practice is limited. Because of the controversy surrounding this practice, we will use this indicator as a descriptive indication of practice variation.

This indicator addresses the following IOM domains: safety and effectiveness

Numerator: The number of patients from the denominator whose medicine regimen includes antipsychotic use for longer than 3 months during the study period

Denominator: Patients with MDD diagnosis for whom there is no diagnosis of psychosis and no diagnosis of dementia

Patient cohorts: Patients with MDD diagnosis

Definitions:
• Psychosis diagnosis: Exclude from the denominator any patient who has one or more outpatient encounters or any inpatient admissions with a primary diagnosis of psychosis, defined by the following ICD-9 codes:
  o 297.0 Paranoid state, simple
- 297.1 Delusional disorder
- 297.2 Paraphrenia
- 297.3 Shared psychotic disorder
- 297.8 Other specified paranoid states
- 297.9 Unspecified paranoid state
- 298.0 Depressive type psychosis
- 298.1 Excitative type psychosis
- 298.2 Reactive confusion
- 298.3 Acute paranoid reaction
- 298.4 Psychogenic paranoid psychosis
- 298.8 Other and unspecified reactive psychosis
- 298.9 Unspecified psychosis

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- Patients with a notation or ICD-9 code for dementia or psychosis will be excluded from the denominator because antipsychotics may be appropriate for this population.
- There may be a bias in coding – if there are fluctuations in mood, an antipsychotic may be appropriate even if the patient is not bipolar. This indicator is not necessarily reflecting poor care.
- The days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.

**Updates:**
- We have excluded investigational drugs from the definition of antipsychotic use.
- We added a note that the days of medication should be sequential and should not include simultaneous use of two or more qualifying medications over a shorter period of time.
SUBSTANCE USE DISORDER

Performance Measure Technical Documentation

Module: Substance Use Disorder
Indicator Statement: Proportion of selected SUD patients with appropriate initiation of treatment for alcohol and other drug dependence
Indicator number: A

Executive Summary: This indicator is based on the conceptual model of the process of care for AOD services developed by McCorry et. al., and adopted by the Washington Circle Policy Group in a paper by McCorry et al (2000), an organization supported by the Center for Substance Abuse Treatment. The Washington Circle indicators have been adopted by the National Committee for Quality Assurance, the Department of Veterans Affairs, and the state of Oklahoma Department of Mental Health and Substance Abuse Services (Garnick et al 2007), and the Healthcare Effectiveness data & information set (HEDIS) Vol. 2.

McCorry et. al. (2000) state that “Studies indicate that only a small fraction of the population with AOD disorders enters treatment. Identification of individuals with AOD disorders is an important first step in the process of care, but one that does not routinely lead to initiation of treatment. Plans must also ensure that individuals with an AOD diagnosis initiate treatment…Studies indicate that a lack of ‘immediately available’ treatment services may also pose a barrier to treatment initiation.” Furthermore, Garnick et al (2007) find that both initiation and engagement of alcohol and other drug dependence treatment was associated with decreased criminal activity in the year following treatment. On the other hand, Harris et al (2007) examined the association between adherence to the Washington Circle indicators and effectiveness among a veteran population. They found that “identification and engagement rates were unrelated to 7-month outcomes… initiation rates were not associated with improvement in alcohol composite scores but were modestly associated with greater improvements in ASI drug composite scores”

This indicator is also consistent with the VA Clinical Practice guidelines, which emphasizes that substance use diagnosed in primary care should be followed up in primary care or with a referral to specialty care, suggesting that. “Recent evidence suggests that approaches emphasizing engagement with the patient over long periods of time, case management, and integration of substance abuse treatment interventions with treatment for the coexisting conditions result in reduced substance use and associated complications.”

This is a Grade III indicator, supported by clinical consensus and expert opinion rather than robust clinical evidence. In fact, the evidence linking this indicator with improved outcomes is mixed. However the Washington Circle indicators have become an industry standard for the treatment of substance abuse disorder, endorsed by both the National Quality Forum in its 2007 consensus document for the treatment of substance use disorder, and in the HEDIS 2006 indicators. This indicator addresses the following IOM domain: effectiveness and timeliness
References:
American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Substance Use Disorders, August 2005
HEDIS® 2006: Health Plan Employer Data and Information Set
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01

Numerator: Those patients in the denominator with appropriate treatment initiation

Denominator:
  a) SUD patients with a new treatment episode for SUD, where the initiation of the new treatment episode is with any provider
  b) SUD patients with a new treatment episode for SUD, where the initiation of the new treatment episode is in specialty mental health care;
  c) SUD patients with a new treatment episode for SUD, where the initiation of the new treatment episode is not in specialty mental health care

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the Key Definitions Document
  o For this indicator, we will only include those who have a new treatment episode in the outpatient setting.
• First SUD visit with any provider: Defined as the first diagnosis-related visit (primary or secondary using Table 1B from the Key Definitions Document) following the clean period (5 month break in care).
  o Note: The Key Definitions Document defines the start of an outpatient new treatment episode as the first diagnosis-related outpatient visit with a primary diagnosis of SUD. We expand the definition here to reflect visits where SUD is either the primary or the secondary diagnosis because
among those with a co-occurring disorder, the assignment of SUD to the primary or secondary diagnosis placeholder may be arbitrary.

- First SUD visit in Specialty Mental Health Care: See the Key Definitions Document for the definition of specialty mental health care providers in the outpatient setting; defined as the first diagnosis-related visit (primary or secondary using Table 1B from the Key Definitions Document) with a specialty mental health provider following the clean period (5 month break in care)

- First SUD visit outside of specialty mental health care: Defined as any diagnosis-related visit (primary or secondary using Table 1B from the Key Definitions Document) with a provider not otherwise included in the definition of a specialty mental health care provider (as defined in the Key Definitions Document) following the clean period (5 month break in care)

- Treatment initiation: defined as any diagnosis-related visit (primary diagnosis only using Table 1B from the Key Definitions Document) in the 14 days following the start of the new treatment episode, not including visits occurring on the same day as the start of the NTE; if the patient is hospitalized within 14 days of the start of the new treatment episode, the admission date is the start of treatment initiation
  - Exclude: emergency room visits using stop codes 101 and 102

**Feasibility/Data Collection Issues:**
- This indicator mirrors the performance measure used by the Palo Alto VA.
- Only Denominator (a) is prescribed by the HEDIS/Washington Circle indicator. Denominators (b) and (c) were added by the project team.

**Updates:**
- Added additional instructions to the definition of treatment initiation – treatment initiation includes any visits that follow the start date of the NTE but cannot include visits that occur on that start date.
Performance Measure Technical Documentation

Module: Substance Use Disorder

Indicator Statement: For selected SUD patients, mean time to initiation of appropriate follow-up SUD treatment

Indicator number: B

Executive Summary: This indicator is derived from SUD indicator A, which was based on the conceptual model of the process of care for AOD services developed by the Washington Circle Policy Group in a paper by McCorry et al (2000), an organization supported by the Center for Substance Abuse Treatment. The Washington Circle indicators have been adopted by the National Committee for Quality Assurance, the Department of Veterans Affairs, and the state of Oklahoma Department of Mental Health and Substance Abuse Services (Garnick et al 2007). McCorry states that “Studies indicate that only a small fraction of the population with AOD disorders enters treatment. Identification of individuals with AOD disorders is an important first step in the process of care, but one that does not routinely lead to initiation of treatment. Plans must also ensure that individuals with an AOD diagnosis initiate treatment…Studies indicate that a lack of ‘immediately available’ treatment services may also pose a barrier to treatment initiation.” A study by Brown et. al. found that a majority of individuals on a waiting list (52%) reported that their interest in entering treatment had decreased since they had been placed on the list, indicating a negative association between wait times and motivation to treatment. This indicator is also consistent with the VA Clinical Practice guidelines, which emphasizes that substance use diagnosed in primary care should be followed up in primary care or with a referral to specialty care, suggesting that “Recent evidence suggests that approaches emphasizing engagement with the patient over long periods of time, case management, and integration of substance abuse treatment interventions with treatment for the coexisting conditions result in reduced substance use and associated complications.”

This is a Grade III indicator, supported by clinical consensus and expert opinion rather than robust clinical evidence. In this case we have modified the indicator to be descriptive of the average number of days to treatment initiation rather than a benchmark number of days, as in SUD A. This indicator addresses the following IOM domain: effectiveness and timeliness

References:
American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Substance Use Disorders, August 2005
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs,
Numerator: For those in the denominator,
   a) Patients with any follow up in the 90 days following the start of the new treatment episode
   b) For those patients with follow up within 90 days, number of days until first outpatient follow-up visit

Denominator: Patients with an SUD diagnosis in a new treatment episode

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade III

Definitions:
   • New Treatment Episode: See the Key Definitions Document
     o For this indicator, we will only include those who have a new treatment episode in the outpatient setting.
   • Start of a New Treatment Episode (outpatient): Defined as the first diagnosis-related visit (primary or secondary using Table 1B from the Key Definitions Document) following the clean period (5 month break in care)
     o Note: The Key Definitions Document defines the start of an outpatient new treatment episode as the first diagnosis-related outpatient visit with a primary diagnosis of SUD. We expand the definition here to reflect visits where SUD is either the primary or the secondary diagnosis because among those with a co-occurring disorder, the assignment of SUD to the primary or secondary diagnosis placeholder may be arbitrary.
   • Follow-up care [Initiation of AOD treatment] (numerator a):
     o Where patient starts new treatment episode in the outpatient setting: defined as any diagnosis-related visit (primary diagnosis using Table 1B from the Key Definitions Document) in the 90 days following the start of the new treatment episode;
       ▪ Exclude: emergency room visits using stop codes 101 and 102
   • Days until first follow-up visit (numerator b): defined as the difference between the date of the start of a new treatment episode and the date of the first follow-up visit as defined for numerator a
     o EXCLUDE patients who do not pass numerator a

Feasibility/Data Collection Issues:
   • This indicator may catch access as opposed to perceived need

Updates:
   • None.
Performance Measure Technical Documentation

Module: Substance Use Disorder

Indicator Statement: Proportion of selected SUD patients who engage in timely treatment for alcohol and other drug dependence

Indicator number: C

Executive Summary: This indicator is based on the conceptual model of the process of care for AOD services developed by the Washington Circle Policy Group in a paper by McCorry et al (2000), an organization supported by the Center for Substance Abuse Treatment. The Washington Circle indicators have been adopted by the National Committee for Quality Assurance, the Department of Veterans Affairs, and the state of Oklahoma Department of Mental Health and Substance Abuse Services (Garnick et al 2007), and the Healthcare Effectiveness data & information set (HEDIS) Vol. 2.

McCorry states that “A review of length of stay studies found that the length of time in treatment is related to post-treatment reduction in drug use, reduced criminal activity, and improved employment status. Studies of alcohol-dependent clients have shown that longer stays in treatment and treatment completion are associated with greater reduction in alcohol use, even after controlling for severity at admission. Thus, treatment engagement is positively associated with positive treatment outcomes…Given the positive association between retention and treatment success, a plan’s ability to engage clients in treatment is an important intermediate measure that is closely related to outcomes.” This indicator is also consistent with the VA Clinical Practice guideline for the management of substance use disorder, which emphasizes that substance use diagnosed in primary care should be followed up in primary care or with a referral to specialty care.

In an observational study, Simpson et al (1995) noted that client engagement in substance abuse treatment was associated with better treatment outcomes, and Garnick et al (2007) find that both initiation and engagement of alcohol and other drug dependence treatment was associated with decreased criminal activity in the year following treatment. On the other hand, Harris et al (2007) examined the association between adherence to the Washington Circle indicators and effectiveness among a veteran population. They found that “identification and engagement rates were unrelated to 7-month outcomes… initiation rates were not associated with improvement in alcohol composite scores but were modestly associated with greater improvements in ASI drug composite scores.”

This is a Grade III indicator, supported by clinical consensus and expert opinion rather than robust clinical evidence. In fact, the evidence linking this indicator with improved outcomes is mixed. However the Washington Circle indicators have become an industry standard for the treatment of substance abuse disorder, endorsed by both the National Quality Forum in its 2007 consensus document for the treatment of substance use disorder, and in the HEDIS 2006 indicators. This indicator addresses the following IOM domain: effectiveness and timeliness

References:
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01

**Numerator:** Those members in the denominator who within 30 days of the start of a new treatment episode have engaged with SUD treatment

**Denominator:** All patients with an SUD diagnosis in a new treatment episode

**Patient cohorts:** Patients with SUD diagnosis

**Strength of Evidence:** Grade III

**Definitions:**
- **New Treatment Episode:** See the Key Definitions Document
- **Start of a New Treatment Episode (outpatient):** Defined as the first diagnosis-related visit (primary or secondary using Table 1B in the Key Definitions Document) following the clean period (5 month break in care)
  - Note: The Key Definitions Document defines the start of an outpatient new treatment episode as the first diagnosis-related outpatient visit with a primary diagnosis of SUD. We expand the definition here to reflect visits where SUD is either the primary or the secondary diagnosis because among those with a co-occurring disorder, the assignment of SUD to the primary or secondary diagnosis placeholder may be arbitrary.
- **Start of a New Treatment Episode (inpatient):** Defined as the date of a diagnosis-related inpatient admission (primary diagnosis using Table 1B in the Key Definitions Document)
- **Engagement of SUD treatment:** Defined as two or more diagnosis-related outpatient encounters on separate days (primary diagnosis only from Table 1B in the Key Definitions Document) in the 30 days following the start of a new treatment episode
  - For patients who start the new treatment episode in the inpatient setting, the 30 day follow-up starts with the date of discharge from the inpatient setting

**Feasibility/Data Collection Issues:**
- This indicator mirrors the performance measure used by the Palo Alto VA.
Updates:
  • We have made explicit in our definition of engagement of SUD treatment that the two encounters following the start of a new treatment episode must be on separate days.
Performance Measure Technical Documentation

Module: Substance Use Disorder
Indicator Statement: Early discharge rates from residential care for Substance Use Disorder
Indicator number: D

Executive Summary: This indicator is based on findings from Peterson et. al., who find in a study of the determinants of readmission in VA inpatient substance abuse programs that readmission performance in substance abuse treatment is positively associated with having fewer early discharges, and that patients who drop out of SAT early are likely to do so within the first week of treatment. In this study, programs that had more patients discontinue treatment within one week performed more poorly in terms of a higher case-mix-adjusted readmission rate. The patients who drop out of these programs are not likely to have received much of the intended treatment, and they may not have adequately stabilized from their brief stay. Joe, Hubbard and Simpson found that retention in methadone maintenance was associated with more experienced staff making the initial diagnosis and conducting treatment planning, providing more frequent medical, psychological, and legal services early in treatment, and providing a balanced combination of individual and group counseling. This indicator is also supported by the VA Clinical Practice Guidelines, which suggest that the promotion of initial treatment engagement and retention may lead to better substance use outcomes.

This is a Grade III indicator, supported by clinical consensus and expert opinion rather than robust clinical evidence. For this reason, it will be a descriptive indicator. This indicator addresses the following IOM domain: effectiveness

References:
Peterson, Keith; Ralph Swindle, Ciaran Phibbs, Barbara Recine, Rudolph Moos, “Determinants of Readmission Following Inpatient Substance Abuse Treatment: A National Study of VA Programs,” *Medical Care*, Vol 32, No. 6. (June 1994)
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01

Numerator:
- a) Inpatient admission in the denominator where patient was discharged from residential care for SUD within one week of admission
- b) Total length of stay in days per related inpatient admission for patients in the denominator discharged from residential care for SUD

Denominator: SUD-related inpatient admissions during the study period for patients with cohort diagnosis of SUD

Patient cohorts: Patients with SUD diagnosis

Definitions:
- SUD-Related Residential Care:
All residential SUD admissions where the primary diagnosis is SUD (from Table 1B in the Key Definitions Document) or, when SUD is the secondary diagnosis, the primary diagnosis is a mental health condition (ICD-9 codes: 290.xx-319.xx) using the following bed section codes: 25, 26, 27, 37, 77, 85, 86, 87, 88, 89, 90

Strength of Evidence: Grade III

Feasibility/Data Collection Issues:
- This is a discharge-based indicator and should include all inpatient discharges for SUD patients
- Note that this will include those patients with co-occurring disorders, and the subset of patients with co-occurring disorders will be analyzed separately

Updates:
- None.
Module: Substance Use Disorder

Indicator Statement: Duration of opiate agonist therapy for selected SUD patients

Indicator number: E

Executive Summary: This indicator is based on the VA Clinical Practice Guidelines for SUD, which state that “OAT is inaccurately considered by some providers to be a treatment of last recourse; however, evidence consistently shows that patients have better outcomes when maintained with an agonist than a placebo (Newman and Whitehall, 1979; Strain et al., 1993a; Strain et al., 1993b) or than when provided long-term detoxification (Sees et al., 2000). Discharge from OAT programs is generally followed by relapse and other adverse outcomes (Gerstein et al., 1994; Magura & Rosenblum, in press). Unless there are legal or other extenuating circumstances, (such as active duty in DoD), OAT should be considered for any patient with a diagnosis of opioid addiction. For patients who previously relapsed, re-treatment should be a consideration. As part of the decision process, it is important to determine if appropriate agonist dosing was utilized and whether there were psychosocial barriers that could be better addressed upon re-attempting OAT.”

The APA Clinical Practice Guidelines for SUD state that, “Numerous clinical trials have tested methadone for the treatment of opioid dependence...The number of studies examining methadone for treating opioid withdrawal is more limited than the number examining methadone in maintenance treatment of opioid dependence. Outcomes from methadone withdrawal are generally poor, especially when compared with the success associated with methadone maintenance treatment.” Likewise, in the case of buprenorphine, “Numerous randomized, double-blind clinical trials have studied the efficacy and safety of sublingual buprenorphine for the outpatient treatment of opioid dependence,” but buprenorphine has shown similar outcomes to methadone in the treatment of opiate withdrawal.

This indicator addresses the following IOM domain: Effectiveness

References:
American Psychiatric Association, Practice Guidelines for the Treatment of Patients with Substance Use Disorders, August 2005
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs., and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01
dependence: a randomized controlled trial. Journal of the American Medical Association, 283 (10), 1303-1310.

**Numerator**: Length (in days) of opiate agonist treatment for patients in the denominator in the 12 months following the start of treatment

**Denominator**: Veterans in the SUD cohort with opiate dependence in a new treatment episode undergoing opiate agonist treatment.

**Patient cohorts**: Patients with an SUD diagnosis

**Definitions**:
- Opiate Dependence: Defined as the primary diagnosis (ICD-9 code: 304.00-304.02, 304.7) on the first outpatient visit following the start of the new treatment episode
- Opiate Agonist Treatment (Denominator): Defined as having two or more encounters during the study period with the 523 stop code.
- Length of Opiate Agonist Treatment:
  - Methadone: Number of days for which patient has consecutive visits to the 523 stop code, with consecutive visits defined as no more than 3 “skips” between visits.
  - Buprenorphine: Defined as days supplied of buprenorphine (see Appendix A of the Key Definitions Document for associated NDC codes) in the 12 months following the start of treatment

**Feasibility/Data Collection Issues**:
- We will analyze the different opioid agonists separately.
- Will not be able to distinguish people on these medications for detoxification versus maintenance. This will make interpretation difficult, but the variation in treatment length across VISNs is still of interest. Generally buprenorphine detoxification is less than a week. Methadone detoxification may be up to 6 months.

**Updates**:
- None.
CROSS-CUTTING INDICATORS

Performance Measure Technical Documentation

Module: All

Indicator Statement: Proportions of selected patients from all cohorts routinely monitored for side effects of treatment with mood stabilizer or anti-psychotic medications

Indicator number: A

Executive Summary: This indicator is based on an indicator cited by the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) based on a study by Marcus et. al. (1999). The CQAIMH website states, “Controlled studies have established the effectiveness of mood stabilizers for bipolar I disorder and other conditions, however, they have also identified potential for adverse drug effects on specific organ systems. [Mood stabilizers] can cause thrombocytopenia, hypothyroidism and in rare cases hepatitis and pancreatitis. Because of the potential for these effects, practice guidelines recommend annual blood tests to monitor blood cell counts and liver enzyme levels.” Kilbourne et. al. (2007) support this, stating that mood stabilizers are associated with increased risk of effects on liver function, and thyroid and kidney abnormalities. The APA Clinical Practice Guidelines for Bipolar I Disorder note that blood count and liver function tests should be performed every three months on patients receiving treatment with carbamazepine, and renal and thyroid function testing should take place every 6 months to 1 year in patients undergoing lithium treatment.

For antipsychotics, the APA CPG for Schizophrenia state, “Monitoring of side effects based on the side effect profile of the prescribed antipsychotic is warranted. During the stable phase of treatment it is important to routinely monitor all patients treated with antipsychotics for extrapyramidal side effects and the development of tardive dyskinesia [I]. Because of the risk of weight gain associated with many antipsychotics, regular measurement of weight and body mass index (BMI) is recommended [I]. Routine monitoring for obesity-related health problems (e.g., high blood pressure, lipid abnormalities, and clinical symptoms of diabetes) and consideration of appropriate interventions are recommended particularly for patients with BMI in the overweight and obese ranges [II]. Clinicians may consider regular monitoring of fasting glucose or hemoglobin A1c levels to detect emerging diabetes, since patients often have multiple risk factors for diabetes, especially patients with obesity [I]. In addition, the VA CPG for psychoses recommends baseline assessment of weight/BMI, glycemic control, and lipids. Further, VA Clinical Practice Guidelines for Psychoses state that “Patients on an antipsychotic should be assessed on a regular basis for their response to an antipsychotic and the presence of side effects. Knowledge of the most common side effects of the agent(s) they are receiving should guide this evaluation.” There is no VA CPG particularly related to bipolar I disorder and thus the use of mood stabilizers.

While there is no robust evidence directly linking side effect monitoring with improved outcomes (perhaps because side effect monitoring and effective side effect management may improve adherence; see Reid 1990 for a meta analysis that suggests
that there is a link), side effect monitoring is crucial to guarantee the safety of the patient, and there are well-established guidelines that state that side effect monitoring is a critical component of pharmacotherapy for these medications. However, this indicator has not been adopted as an industry standard in the evaluation of care. This indicator addresses the following IOM domains: safety.

References:
Reid LD, Horn JR, McKenna DA. “Therapeutic drug monitoring reduces toxic drug reactions: A meta-analysis,” Therapeutic Drug Monitor 1990, 12:72-78
Center for Quality Assessment and Improvement in Health Care, Quality indicators published online at www.cqaimh.org. Accessed in October 2007
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition (February 2004); American Psychiatric Association; Am J Psychiatry

Numerator: Patients from the denominator who have undergone the following testing during the study period:

<table>
<thead>
<tr>
<th>Drug</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lithium</td>
<td>Thyroid and renal function, serum drug level monitoring for Lithium</td>
</tr>
<tr>
<td>Valproic acid</td>
<td>Blood count, liver and serum drug level monitoring for Valproic Acid</td>
</tr>
<tr>
<td>Carbamazepine</td>
<td>Blood count, liver and serum drug level monitoring for Carbamazepine</td>
</tr>
<tr>
<td>Any antipsychotic medications</td>
<td>Glycemic control, lipids</td>
</tr>
</tbody>
</table>

Denominator: Individuals within patient cohorts with one or more filled prescription for the same medication in at least three out of four quarters (during the study period, for the following medications):
1. Lithium
2. Valproic acid
3. Carbamazepine
4. Any antipsychotic medications

Patient cohorts: All patient cohorts
Definitions:

- Mood stabilizers: Defined as at least one prescription filled in each quarter for at least three quarters of the study period (any three quarters – they do not need to be continuous):
  - Lithium: Any prescriptions filled in the inpatient or outpatient setting using the VA Drug Class Code CN750
  - Valproic Acid and Carbamazepine: Any prescriptions filled in the inpatient or outpatient setting (see Appendix A of the Key Definitions Document for associated NDC codes).
- Any antipsychotic medications: Any prescriptions filled in the inpatient or outpatient setting using the following VA Drug Class Codes: CN700, CN701, CN709
- Side effect monitoring: The following codes are derived from the DSS Clinical National Data Extracts for laboratory (LAB Extract):
  - Blood count: TESTNAME code = ‘0006’
  - Liver test (Aspartate Transaminase – AST; Transferase Alanine Amino – ALT; Phosphatase Alkaline): Defined as one or more of these three tests during the 12 month period (TESTNAME code = ‘0009’, ‘0045’, ‘0048’)
  - Renal function (Serum Creatinine): TESTNAME code = ‘0031’
  - Thyroid function (TSH): Defined as at least one of this test performed during the 12 month period (TESTNAME code = ‘0024’)
  - Glycemic control: Defined as at least one of two glucose tests or the hemoglobin A1C test during the 12 month period (TESTNAME [glucose] = ‘0010’, ‘0057’; OR TESTNAME [hemoglobin A1C] = ‘0017’)
  - Lipids: Defined as at least two of the following four tests during the 12 month period (TESTNAME [LDLC] =’0027’; [HDLC] = ‘0028’; [total cholesterol] = ‘0029’; [tryglicerides] = ‘0030’)
  - Serum drug level monitoring:
    - TESTNAME (Carbamazepin) = ‘0016’;
    - TESTNAME (Lithium) = ‘0004’;
    - TESTNAME (Valproic acid) = ‘0015’

Strength of Evidence: Grade III

Feasibility/Data Collection Issues:

- Analyses can be considered either at the person-level or the drug-level to consider patients who are on more than one of the drugs of interest.
- While this indicator is not an industry standard and thus will not be considered a benchmark of care, it has high face validity and is strongly endorsed.

Updates:

- Definitions of medication prescriptions revised to include prescriptions filled in either the inpatient or outpatient setting.
- We corrected the lab test code corresponding to Phosphatase Alkaline.
- We modified the drug test names in the numerator to be more specific about the serum drug level monitoring required for each drug.
- To “pass” this indicator, the patient must have had each test performed relevant to the drug they are taking. Having fewer than the full list of tests from the list will not be considered “passing” for this indicator.
Module: All

Indicator Statement: Number of evaluation and management visits with a prescribing provider following the start of a new treatment episode for patients undergoing pharmacotherapy

Indicator number: B

Executive Summary:

Bipolar I and Schizophrenia: This indicator is based on the VA’s Clinical Practice Guidelines (VA CPG) for Psychoses. They state that patients should be seen every one to two weeks for six weeks when patients have been prescribed “second generation antipsychotic medication other than clozapine.” After six to eight weeks, if there is not an adequate response, or if there are significant side effects, these frequent visits will give the prescriber enough information to make a decision regarding a change in medication.

SUD: The VA CPG for the management of SUD in primary care encourages close monitoring of patients undergoing pharmacotherapy for alcohol and opioid dependence. During initial treatment with opioid agonist therapies, the VA CPG recommends weekly monitoring for opioid use and monthly evaluations of blood levels. With regards to alcohol dependence, the VA CPG notes that monitored naltrexone administration significantly improves compliance (Garbutt et al., 1999), stating that “It is important to monitor the patient’s clinical condition regularly. If the patient’s drinking has worsened or is unimproved from baseline, alternative pharmacotherapies should be considered (e.g., disulfiram or possibly a treatment for comorbid psychopathology).” The National Quality Forum, in their 2007 consensus report, also support frequent monitoring for side effects, drug use, and medication response. Furthermore, the Center for Substance Abuse Treatment, in their Treatment Improvement Protocol, emphasize the importance of close monitoring by a physician during treatment with Naltrexone. F. Rotgers et al (1996), in a chapter titled “Fostering Compliance with Pharmacotherapy,” note that high rates of noncompliance with pharmacotherapy for substance abuse can be ameliorated with “regular monitoring of medication compliance through pill counts or medication serum levels…frequent contact, and the provision of extensive support and encouragement to the patient and his or her family.”

MDD: This indicator is a descriptive indicator that will augment our understanding of antidepressant medication management. It is based on an indicator cited by the National Quality Measures Clearinghouse and developed by HEDIS. It is the third indicator in the three-part “Antidepressant Medication Management” measures. The indicator states that “Early detection and sustained intervention by primary care physicians and medical specialists can lead to increased use of appropriate antidepressant treatment for adults suffering from depressive disorders. Many people with a depressive illness do not seek treatment or have difficulty staying on medication for the necessary periods of time. Managed care organizations should examine the barriers that may be preventing patients from receiving treatment for depressive disorders for the necessary duration. Of particular importance is ensuring appropriate follow-up visits to improve the effective use of antidepressant medications…The new treatment episode, which lasts through the first 12 weeks of treatment, allows the clinician to monitor drug response and assure a full remission of symptoms. However, remission may be followed by relapse unless a continuation phase (4 to 9 months) is
instituted. Finally, for a select group of patients with a major depressive disorder, a maintenance phase must be adopted to prevent future recurrences of symptoms and distress.

The APA CPG also addresses this issue: Patients who have started taking an antidepressant medication should be carefully monitored to assess their response to pharmacotherapy as well as the emergence of side effects, clinical condition, and safety [I]. Factors to consider in determining the frequency of patient monitoring include the severity of illness, the patient's cooperation with treatment, the availability of social supports, and the presence of comorbid general medical problems. Visits should also be frequent enough to monitor and address suicidality and to promote treatment adherence. In practice, the frequency of monitoring during the acute phase of pharmacotherapy can vary from once a week in routine cases to multiple times per week in more complex cases.

PTSD: This indicator is based upon a measure of continuity of care developed by Greenberg et al. (2003), which was found to be robustly associated with improved PTSD outcomes. Regularity of care was defined as the number of months in the four months following a new treatment episode that the veteran had at least one visit. These measures were particularly found to be associated with decreased probability of drug and alcohol abuse.

Although this indicator has substantial face validity and there are well-established guidelines that state that frequent prescriber monitoring is a critical component of pharmacotherapy for these medications, there is no robust evidence linking frequency of evaluation and management visits with a prescribing provider during a new treatment episode with improved outcomes. This indicator addresses the following IOM domain: Safety and effectiveness.

References:
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group,
Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2000. Office of Quality and Performance publication 10Q-CPG/MDD-00


Peterson, Keith; Ralph Swindle, Ciaran Phibbs, Barbara Recine, Rudolph Moos, “Determinants of Readmission Following Inpatient Substance Abuse Treatment: A National Study of VA Programs,” Medical Care, Vol 32, No. 6. (June 1994)

Practice Guideline for the Treatment of Patients with Bipolar Disorder (2002 Revision); American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement


Practice Guideline for the Treatment of Patients with Schizophrenia, Second Edition (February 2004); American Psychiatric Association; Am J Psychiatry


Numerator: Number of evaluation and management visits by a licensed prescribing provider for patients in the denominator:
   a) in the four months following a new treatment episode
   b) in the 12 months following a new treatment episode

Denominator: Patients with a new treatment episode during the study period who have continuous treatment with a psychiatric medication
   a) for at least four months following the start of a new treatment episode
   b) for at least 12 months following a new treatment episode

Patient cohorts: All patient cohorts

Definitions:
- New Treatment Episode: See the Key Definitions Document
  - For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of discharge from the hospital (Note: this definition differs from the general definition of the start of an inpatient new treatment episode in the Key Definitions Document).
  - If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period.
- Evaluation and management: Defined as the count of diagnosis-related (primary or secondary from Table 1B in the Key Definitions Document) outpatient evaluation and management encounters on separate days following the start of the new treatment episode (index visit should not be counted) with a licensed prescribing provider. Any encounter for which one of the following CPT codes are present with a corresponding provider code for a licensed prescribing provider should be counted:
  - Office or Other Outpatient Facility:
- Individual psychotherapy with medical evaluation and management services – 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829
- Other evaluation and management services: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
- General office consultation codes: 99241-99245
  - Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy – 90862
  - Licensed prescribing provider: See the Key Definitions Document for the relevant provider codes

- Continuous treatment with psychiatric medication (four months): Defined as 90 or more days supply of a psychiatric medication filled in the 120 days following the start of a new treatment episode
- Continuous treatment with psychiatric medication (twelve months): Defined as 300 or more days supply of a psychiatric medication filled in the 12 months following the start of a new treatment episode
- Psychiatric medications: Drugs from the following VA Drug Class Codes found in VHA pharmacy prescription data (note that opiate agonist therapies are not included in this analysis)
  - AD100, Alcohol Deterrents
  - CN400, Anticonvulsants (the following drugs will be identified by NDC codes rather than VA Drug Class Code – see the Key Definitions Document for relevant NDC codes)
    - Valproic Acid
    - Carbamazepine
    - Oxcarbazepine
    - Lamotrigine
  - CN600, Antidepressants
  - CN601, Tricyclic Antidepressants
  - CN602, Monamine Oxidase Inhibitor Antidepressants
  - CN609, Antidepressants, Other
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
  - CN750, Lithium Salts
  - Prazosin (See Appendix A of Key Definitions Document for associated NDC codes)

**Strength of Evidence**: Grade III

**Feasibility/Data Collection Issues:**
- None.

**Updates:**
- We emphasize that multiple encounters on the same day will be counted within a single visit. The numerator will reflect the number of separate days on which one or more E&M encounters occurred that meet the appropriate definition.
- We note that, although our general definition of psychotherapy has been modified to exclude any encounters of 30 minutes or less, we will maintain psychotherapy E&M codes for encounters of 30 minutes or less. Medication management visits can occur with or without treatment and can be of any length.
• We excluded investigational drugs from the definition of psychiatric medications.
Performance Measure Technical Documentation

Module: All

Indicator Statement: Proportion of patients from any cohort receiving any psychosocial treatment or psychotherapeutic sessions in the outpatient setting

Indicator number: C

Executive Summary:

Bipolar I: This measure reflects standards enumerated in the VA Clinical Practice Guidelines for Psychoses, which recommends psychotherapy interventions under a Bipolar I diagnosis. The American Psychiatric Association Clinical Practice Guidelines cite four randomized studies that show that psychosocial interventions reduce recurrence of bipolar symptoms. Miklowitz et al (2007) in their large federally-funded STEP-BP study conducted a randomized controlled trial of fifteen clinics, and found that “Intensive psychosocial treatment as an adjunct to pharmacotherapy was more beneficial than brief treatment in enhancing stabilization from bipolar depression.” STABLE measure number 15, “% of patients where appropriate psychosocial interventions are recommended within 12 weeks of initiating treatment for bipolar disorder,” is similar to this indicator, and STABLE states in the rationale statement that evidence-based psychosocial interventions have been found to improve treatment adherence, reduce likelihood of recurrence and extend time to new episodes, and that many different types of psychosocial interventions have been found to be effective in achieving these outcomes.

This indicator will provide descriptive data reflecting the American Psychiatric Association’s emphasis on psychosocial interventions. The APA states, “There are now a range of specific psychotherapeutic interventions that have been shown to be helpful when used in combination with pharmacotherapy and psychiatric management for treatment of bipolar I disorder. The best-studied treatment approaches have been developed around psycho-educational, interpersonal, family, and cognitive behavior therapies. Formal studies have been conducted for these treatments, and additional investigations are underway. Further, psychodynamic and other forms of therapy may be indicated for some patients.”

Schizophrenia: This measure reflects standards enumerated in the VA Clinical Practice Guidelines for Psychoses, which recommends psychotherapy interventions with a schizophrenia diagnosis. The American Psychiatric Association also supports this view, stating, “as part of a comprehensive treatment approach, psychosocial interventions can improve the course of schizophrenia when integrated with psychopharmacological treatments. These interventions can provide additional benefits for patients in such areas as relapse prevention, improved coping skills, better social and vocational functioning, and ability to function more independently. While pharmacotherapy focuses on symptom diminution, psychosocial interventions may provide emotional support and address particular deficits associated with schizophrenia.”

The AHRQ-funded Schizophrenia Patient Outcomes Research Team (PORT) stated that “for most persons, the combination of psychopharmacologic and psychosocial interventions improves outcomes.” The report that a number of psychosocial treatments have demonstrated efficacy, and listed “family interventions, SE, ACT, skills training, cognitive behaviorally oriented psychotherapy and the token economy social
learning intervention” among them (Lehman et al, 1998, updated 2004). Mojtabai et. al. provided a comprehensive review of the literature linking psychosocial interventions to schizophrenia outcomes in controlled studies, concluding “our results show that psychosocial treatments can play an important role in the comprehensive management of schizophrenia not only to augment the effects of medications, but also to supplement these effects in areas where conventional medications alone are less effective (e.g., negative symptoms)… there is some evidence that psychosocial interventions may be more effective in the more chronic stages of illness and, therefore, can play a more prominent role in the management of patients with chronic schizophrenia.”

**SUD:** The American Psychiatric Association Clinical Practice Guidelines state that “Psychosocial treatments are essential components of a comprehensive treatment program…Sustained motivation is required to forgo the rewards of substance use, tolerate the discomforts of early and protracted withdrawal symptoms, and gather the energy to avoid relapse despite episodes of craving that can occur throughout a lifetime. Coping skills are required to manage and avoid situations that can place the individual at a high risk for relapse.” The APA cites extensive evidence for the efficacy of psychosocial interventions in patients with substance use disorders, summarizing: “The major psychotherapeutic treatments that have been studied in patients with substance use disorders are cognitive-behavioral, behavioral, psychodynamic/interpersonal, and recovery-oriented therapies. A growing body of efficacy data from controlled clinical trials suggests that psychotherapy is superior to control conditions as a treatment for patients with a substance use disorder. However, no particular type of psychotherapy has been found to be consistently superior when compared with other active psychotherapies for treating substance use disorders. Even comparatively brief psychotherapies appear to have durable effects among patients with a substance use disorder.” The National Quality Forum, in its documentation of evidence-based treatment practices, states that “Evidence-based psychosocial treatment interventions should be initiated for all patients referred to specialty care treatment of SUDs.”

**MDD:** This indicator is based on an indicator cited by CQAIMH and developed by the APA, “Treatment for Moderate Depression,” which states that “Major depressive disorder is prevalent and disabling, often accompanied by impaired personal, social, occupational and/or family functioning. Research studies have found that the disorder goes undetected or inadequately treated. Antidepressant medications and certain types of psychotherapy (e.g., cognitive behavioral therapy, interpersonal therapy) have been shown to be efficacious in the treatment of major depressive disorder.” The APA CPG for schizophrenia also states: “A specific, effective psychotherapy alone as an initial treatment modality may be considered for patients with mild to moderate major depressive disorder [II]. The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder [I]. Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder, although rigorous studies evaluating the efficacy of psychodynamic psychotherapy have not been published [II]. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase [I]. In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase [II].
PTSD: This indicator is based on findings by the Committee on Treatment of Posttraumatic Stress Disorder, which states that “the committee finds that the evidence is sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD.” Furthermore, Rosenberg et. al. (2001) find that “A growing body of evidence shows that well-delineated, theoretically based interventions are effective in the treatment of PTSD...Multiple controlled trials have shown that the most effective interventions for PTSD are those based on CBT approaches, including exposure therapy and cognitive restructuring.”

Although there is fair to good research evidence suggesting that Psychosocial interventions are effective as adjuncts or monotherapy in the treatment of all five conditions discussed above, this indicator does not capture the type of PT offered and it is met with just 1 PT session. Also note that psychosocial visits in this context is broader than “psychosocial rehabilitation,” which has a specific meaning within the VA. This indicator addresses the following IOM domain: effectiveness.

References:
David J. Miklowitz, PhD; Michael W. Otto, PhD; Ellen Frank, PhD; Noreen A. Reilly-Harrington, PhD; Stephen R. Wisniewski, PhD; Jane N. Kogan, PhD; Andrew A. Nierenberg, MD; Joseph R. Calabrese, MD; Lauren B. Marangell, MD; Laszlo Gyulai, MD; Mako Araga, MS; Jodi M. Gonzalez, Ph.D; Edwin R. Shirley, PhD; Michael E. Thase, MD; Gary S. Sachs, MD (2007). Psychosocial Treatments for Bipolar Depression. Archives of General Psychiatry. 2007;64:419-426.
Robin B. Jarrett; Dolores Kraft; Jeanette Doyle; Barbara M. Foster; G. Greg Eaves; Paul C. Silver Preventing Recurrent Depression Using Cognitive Therapy With and Without a Continuation Phase: A Randomized Clinical Trial Arch Gen Psychiatry. 2001;58(4):381-388.
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs , and Health Affairs, Department of Defense, May 2000. . Office of Quality and Performance publication 10Q-CPG/MDD-00
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01

Numerator:
  a) Patients in the denominator (a) receiving any psychosocial visits (individual or group, includes psychotherapy) within four months following the start of a new treatment episode
  b) Patients in the denominator (b) receiving any psychosocial visits (individual or group, includes psychotherapy) in the study period.

Denominator:
  a) Individuals in all patient cohorts in a new treatment episode
  b) Individuals in all patient cohorts

Patient cohorts: All patient cohorts

Definitions:
  • New Treatment Episode: See the Key Definitions Document
    o For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of discharge from the hospital (Note: this definition differs from the general definition of the start of an inpatient new treatment episode in the Key Definitions Document).
    o If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period.
  • Psychosocial visits: Defined as one or more diagnosis-related (primary or secondary, based on Table 1.B in the Key Definitions Document) visits with the following mental health stop codes:
    • Mental health stop codes: All stop codes beginning with “5”, excluding 523, 533, 538, and 565
      o EXCLUDING those visits with the following CPT codes: 90862 (Medication management without psychotherapy), 90870 (ECT), and any encounters with CPT codes that do not begin with “9” or “H”
      o Exclude the first visit which begins the new treatment episode if it meets the definition for psychosocial visits

Strength of Evidence: Grade III – This is the level of evidence for the indicator as specified, since there is no evidence that any psychosocial or psychotherapeutic sessions lead to improved outcomes. However, the evidence cited in the executive summary generally has a strength of evidence of Grade I.

Feasibility/Data Collection Issues:
  • While this indicator is not an industry standard and thus will not be considered a benchmark of care, it has high face validity.
• A limitation of this analysis is that psychosocial visits that occur in primary care, when not coded with a corresponding CPT code, will be excluded.

Updates:
• None.
**Performance Measure Technical Documentation**

**Module:** All

**Indicator Statement:** Among those with any psychosocial visits or psychotherapeutic sessions, number of psychosocial treatment or psychotherapeutic sessions per person

**Indicator number:** D

**Executive Summary:**

**Bipolar I Disorder:** This indicator will provide descriptive data reflecting the American Psychiatric Association’s emphasis on psychosocial interventions. The APA states, “There are now a range of specific psychotherapeutic interventions that have been shown to be helpful when used in combination with pharmacotherapy and psychiatric management for treatment of bipolar I disorder. The best-studied treatment approaches have been developed around psycho-educational, interpersonal, family, and cognitive behavior therapies. Formal studies have been conducted for these treatments, and additional investigations are underway. Further, psychodynamic and other forms of therapy may be indicated for some patients.” They discuss several evaluations showing that brief interventions, between six to seven sessions, are associated with improved outcomes for patients with bipolar I disorder. The VA Clinical Practice Guidelines also emphasize the importance of therapy in reducing symptoms, improving self-esteem, and reducing cognitive deficit.

**Schizophrenia:** This measure reflects standards enumerated in the VA Clinical Practice Guidelines for Psychoses, which recommends psychotherapy interventions with a schizophrenia diagnosis. The American Psychiatric Association also supports this view, stating, “as part of a comprehensive treatment approach, psychosocial interventions can improve the course of schizophrenia when integrated with psychopharmacological treatments. These interventions can provide additional benefits for patients in such areas as relapse prevention, improved coping skills, better social and vocational functioning, and ability to function more independently. While pharmacotherapy focuses on symptom diminution, psychosocial interventions may provide emotional support and address particular deficits associated with schizophrenia.”

The AHRQ-funded Schizophrenia Patient Outcomes Research Team (PORT) stated that “for most persons, the combination of psychopharmacologic and psychosocial interventions improves outcomes. “ The reported that a number of psychosocial treatments have demonstrated efficacy,” and listed “family interventions, SE, ACT, skills training, cognitive behaviorally oriented psychotherapy and the token economy social learning intervention” among them (Lehman et al, 1998, updated 2004). Mojtabai et. al. provided a comprehensive review of the literature linking psychosocial interventions to schizophrenia outcomes in controlled studies, concluding “our results show that psychosocial treatments can play an important role in the comprehensive management of schizophrenia not only to augment the effects of medications, but also to supplement these effects in areas where conventional medications alone are less effective (e.g., negative symptoms)... there is some evidence that psychosocial interventions may be more effective in the more chronic stages of illness and, therefore, can play a more prominent role in the management of patients with chronic schizophrenia.”

**SUD:** The American Psychiatric Association Clinical Practice Guidelines state that “Psychosocial treatments are essential components of a comprehensive treatment
program...Sustained motivation is required to forgo the rewards of substance use, tolerate the discomforts of early and protracted withdrawal symptoms, and gather the energy to avoid relapse despite episodes of craving that can occur throughout a lifetime. Coping skills are required to manage and avoid situations that can place the individual at a high risk for relapse." The exact duration of SUD behavioral interventions varies by the type of substance use and the type of intervention, but evidence shows that very short interventions (one to four sessions) can be effective in improving outcomes for alcohol and cannabis dependence (Miller et al 2002, Copeland et al 2001), however, longer interventions are necessary in the treatment of opioid and cocaine dependence (Woody et al 1995, Carroll et al 1998).

**MDD:** This indicator is based on an indicator cited by CQAIMH and developed by the APA, “Treatment for Moderate Depression,” which states that “Major depressive disorder is prevalent and disabling, often accompanied by impaired personal, social, occupational and/or family functioning. Research studies have found that the disorder goes undetected or inadequately treated. Antidepressant medications and certain types of psychotherapy (e.g., cognitive behavioral therapy, interpersonal therapy) have been shown to be efficacious in the treatment of major depressive disorder.” The APA CPG for schizophrenia also states: “A specific, effective psychotherapy alone as an initial treatment modality may be considered for patients with mild to moderate major depressive disorder [II]. The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder [I]. Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder, although rigorous studies evaluating the efficacy of psychodynamic psychotherapy have not been published [II]. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase [I]. In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase [II].

**PTSD:** This indicator is based on findings by the Committee on Treatment of Posttraumatic Stress Disorder, which states that “the committee finds that the evidence is sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD.” Furthermore, Rosenberg et. al. (2001) find that “A growing body of evidence shows that well-delineated, theoretically based interventions are effective in the treatment of PTSD...Multiple controlled trials have shown that the most effective interventions for PTSD are those based on CBT approaches, including exposure therapy and cognitive restructuring.” A meta-analysis by Bradley et al (2005) showed that behavioral interventions for PTSD were effective at a range of doses, however there have not been enough clinical trials to date to determine the differential efficacy of treatment at different doses.

Although there is fair to good research evidence suggesting that psychosocial interventions are effective as adjuncts or monotherapy in the treatment of all five conditions discussed above, research is not conclusive regarding what constitutes an adequate ‘dose’ of psychotherapy. For this reason, this indicator will provide descriptive information only about mean/median dose of psychosocial interventions for each of the above conditions. Also note that psychosocial visits in this context is broader than
“psychosocial rehabilitation,” which has a specific meaning within the VA. This indicator addresses the following IOM domain: effectiveness

References:
21:55–64 David J. Miklowitz, PhD; Michael W. Otto, PhD; Ellen Frank, PhD; Noreen A. Reilly-Harrington, PhD; Stephen R. Wisniewski, PhD; Jane N. Kogan, PhD; Andrew A. Nierenberg, MD; Joseph R. Calabrese, MD; Lauren B. Marangell, MD; Laszlo Gyulai, MD; Mako Araga, MS; Jodi M. Gonzalez, PhD; Edwin R. Shirley, PhD; Michael E. Thase, MD; Gary S. Sachs, MD (2007). Psychosocial Treatments for Bipolar I Depression. Archives of General Psychiatry. 2007;64:419-426.
Jarrett Robin B., Dolores Kraft; Jeanette Doyle; Barbara M. Foster; G. Greg Eaves; Paul C. Silver Preventing Recurrent Depression Using Cognitive Therapy With and Without a Continuation Phase: A Randomized Clinical Trial Arch Gen Psychiatry. 2001;58(4):381-388.
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs , and Health Affairs, Department of Defense, May 2000. . Office of Quality and Performance publication 10Q-CPG/MDD-00
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs , and Health Affairs, Department of

**Numerator:** Number of psychosocial visits during the study period:
   a) Total psychosocial visits in the 4 months following the start of a new treatment episode
   b) Total psychosocial visits during the study period

**Denominator:** Patients with any study-relevant diagnosis with any psychosocial visits
   a) In the four months following a new treatment episode
   b) During the study period

**Patient cohorts:** All patient cohorts

**Definitions:**
- New Treatment Episode: See the Key Definitions Document
  - For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of discharge from the hospital (Note: this definition differs from the general definition of the start of an inpatient new treatment episode in the Key Definitions Document).
  - If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period.
- Psychosocial visits: Defined as the count of diagnosis-related (primary or secondary, based on Table 1.B in the Key Definitions Document) encounters with the following mental health stop codes,
  - Mental health stop codes: All stop codes beginning with “5”, excluding 523, 533, 538, and 565
    - EXCLUDING those visits with the following CPT codes: 90862 (Medication management without psychotherapy), 90870 (ECT), and any CPT codes that do not begin with “9” or “H”
    - Exclude the first visit which begins the new treatment episode if it meets the definition for psychosocial visits

**Strength of Evidence:** Grade III – This is the level of evidence for the indicator as specified, since we are counting frequencies of visits, not specifying what constitutes an adequate dose. However, the evidence cited in the executive summary generally has a strength of evidence of Grade I.
Feasibility/Data Collection Issues:

- The VA does not have standards regarding the ideal number of psychotherapy visits, due to the lack of an evidence base. For this reason, we will look at this indicator descriptively.
- We will use these data to analyze the proportion of group vs. individual treatment taking place.
- A limitation of this analysis is that psychosocial visits that occur in primary care, when not coded with a corresponding CPT code, will be excluded.

Updates:

- Rather than counting the number of days on which psychosocial encounters occurred, this indicator will count the total number of psychosocial encounters, even if there are multiple encounters on the same day.
Module: All
Indicator Statement: Proportion of patients in all cohorts receiving any psychotherapy treatment in the outpatient setting
Indicator number: E

Executive Summary:

Bipolar I: This measure reflects standards enumerated in the VA Clinical Practice Guidelines for Psychoses, which recommends psychotherapy interventions under a Bipolar I diagnosis. The American Psychiatric Association Clinical Practice Guidelines cite four randomized studies that show that psychosocial interventions reduce recurrence of Bipolar I symptoms. Miklowitz et al (2007) in their large federally-funded STEP-BP study conducted a randomized controlled trial of fifteen clinics, and found that “Intensive psychosocial treatment as an adjunct to pharmacotherapy was more beneficial than brief treatment in enhancing stabilization from bipolar I depression.” STABLE measure number 15, “% of patients where appropriate psychosocial interventions are recommended within 12 weeks of initiating treatment for bipolar I disorder,” is similar to this indicator, and STABLE states in the rationale statement that evidence-based psychosocial interventions have been found to improve treatment adherence, reduce likelihood of recurrence and extend time to new episodes, and that many different types of psychosocial interventions have been found to be effective in achieving these outcomes.

This indicator will provide descriptive data reflecting the American Psychiatric Association’s emphasis on psychosocial interventions. The APA states, “There are now a range of specific psychotherapeutic interventions that have been shown to be helpful when used in combination with pharmacotherapy and psychiatric management for treatment of bipolar I disorder. The best-studied treatment approaches have been developed around psycho-educational, interpersonal, family, and cognitive behavior therapies. Formal studies have been conducted for these treatments, and additional investigations are underway. Further, psychodynamic and other forms of therapy may be indicated for some patients.”

Schizophrenia: This measure reflects standards enumerated in the VA Clinical Practice Guidelines for Psychoses, which recommends psychotherapy interventions with a schizophrenia diagnosis. The American Psychiatric Association also supports this view, stating, “as part of a comprehensive treatment approach, psychosocial interventions can improve the course of schizophrenia when integrated with psychopharmacological treatments. These interventions can provide additional benefits for patients in such areas as relapse prevention, improved coping skills, better social and vocational functioning, and ability to function more independently. While pharmacotherapy focuses on symptom diminution, psychosocial interventions may provide emotional support and address particular deficits associated with schizophrenia.”

The AHRQ-funded Schizophrenia Patient Outcomes Research Team (PORT) stated that “for most persons, the combination of psychopharmacologic and psychosocial interventions improves outcomes.” The reported that a number of psychosocial treatments have demonstrated efficacy, and listed “family interventions, SE, ACT, skills training, cognitive behaviorally oriented psychotherapy and the token economy social
learning intervention” among them (Lehman et al, 1998, updated 2004). Mojtabai et. al. provided a comprehensive review of the literature linking psychosocial interventions to schizophrenia outcomes in controlled studies, concluding “our results show that psychosocial treatments can play an important role in the comprehensive management of schizophrenia not only to augment the effects of medications, but also to supplement these effects in areas where conventional medications alone are less effective (e.g., negative symptoms)…there is some evidence that psychosocial interventions may be more effective in the more chronic stages of illness and, therefore, can play a more prominent role in the management of patients with chronic schizophrenia.”

SUD: The American Psychiatric Association Clinical Practice Guidelines state that “Psychosocial treatments are essential components of a comprehensive treatment program…Sustained motivation is required to forgo the rewards of substance use, tolerate the discomforts of early and protracted withdrawal symptoms, and gather the energy to avoid relapse despite episodes of craving that can occur throughout a lifetime. Coping skills are required to manage and avoid situations that can place the individual at a high risk for relapse.” The APA cites extensive evidence for the efficacy of psychosocial interventions in patients with substance use disorders, summarizing: “The major psychotherapeutic treatments that have been studied in patients with substance use disorders are cognitive-behavioral, behavioral, psychodynamic/interpersonal, and recovery- oriented therapies. A growing body of efficacy data from controlled clinical trials suggests that psychotherapy is superior to control conditions as a treatment for patients with a substance use disorder. However, no particular type of psychotherapy has been found to be consistently superior when compared with other active psychotherapies for treating substance use disorders. Even comparatively brief psychotherapies appear to have durable effects among patients with a substance use disorder.” The National Quality Forum, in its documentation of evidence-based treatment practices, states that “Evidence-based psychosocial treatment interventions should be initiated for all patients referred to specialty care treatment of SUDs.”

MDD: This indicator is based on an indicator cited by CQAIMH and developed by the APA, “Treatment for Moderate Depression,” which states that “Major depressive disorder is prevalent and disabling, often accompanied by impaired personal, social, occupational and/or family functioning. Research studies have found that the disorder goes undetected or inadequately treated. Antidepressant medications and certain types of psychotherapy (e.g., cognitive behavioral therapy, interpersonal therapy) have been shown to be efficacious in the treatment of major depressive disorder.” The APA CPG for schizophrenia also states: “A specific, effective psychotherapy alone as an initial treatment modality may be considered for patients with mild to moderate major depressive disorder [II]. The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder [I]. Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder, although rigorous studies evaluating the efficacy of psychodynamic psychotherapy have not been published [II]. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase [I]. In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase [II].
PTSD: This indicator is based on findings by the Committee on Treatment of Posttraumatic Stress Disorder, which states that “the committee finds that the evidence is sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD.” Furthermore, Rosenberg et. al. (2001) find that “A growing body of evidence shows that well-delineated, theoretically based interventions are effective in the treatment of PTSD…Multiple controlled trials have shown that the most effective interventions for PTSD are those based on CBT approaches, including exposure therapy and cognitive restructuring.”

This indicator is similar to another indicator in this document, Cross Cutting C, “Any psychosocial or psychotherapeutic sessions. This indicator is different because the range of interventions has been narrowed to include only psychotherapy, as defined in the Key Definitions Document. Although there is fair to good research evidence suggesting that PT is effective as adjunct or monotherapy in the treatment of all five conditions discussed above, this indicator does not capture the type of psychotherapy offered and the criteria are met with just 1 psychotherapy session. For this reason this indicator will only be used descriptively, despite its high face validity. This indicator addresses the following IOM domain: effectiveness.

References:
David J. Miklowitz, PhD; Michael W. Otto, PhD; Ellen Frank, PhD; Noreen A. Reilly-Harrington, PhD; Stephen R. Wisniewski, PhD; Jane N. Kogan, PhD; Andrew A. Nierenberg, MD; Joseph R. Calabrese, MD; Lauren B. Marangell, MD; Laszlo Gyulai, MD; Mako Araga, MS; Jodi M. Gonzalez, PhD; Edwin R. Shirley, PhD; Michael E. Thase, MD; Gary S. Sachs, MD (2007). Psychosocial Treatments for Bipolar I Depression. Archives of General Psychiatry. 2007;64:419-426.
Robin B. Jarrett; Dolores Kraft; Jeanette Doyle; Barbara M. Foster; G. Greg Eaves; Paul C. Silver Preventing Recurrent Depression Using Cognitive Therapy With and Without a Continuation Phase: A Randomized Clinical Trial Arch Gen Psychiatry. 2001;58(4):381-388.
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs , and Health Affairs, Department of Defense, May 2000. . Office of Quality and Performance publication 10Q-CPG/MDD-00
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs,


Numerator:
   a) Patients in the denominator (a) receiving any psychotherapy within the four months following the start of a new treatment episode
   b) Patients in the denominator (b) receiving any psychotherapy during the study period

Denominator:
   a) Individuals in all patient cohorts in a new treatment episode
   b) Individuals with a study relevant diagnosis in all patient cohorts

Patient cohorts: All patient cohorts

Definitions:
   • New Treatment Episode: See Key Definitions Document
     o For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of discharge from the hospital (Note: this definition differs from the general definition of the start of an inpatient new treatment episode in the Key Definitions Document).
     o If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period.
   • Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
     o For patients in a new treatment episode, look for evidence of any psychotherapy within four months of the start of the new treatment episode (do not count the initial visit if that involves psychotherapy)
     o For all patients with a study diagnosis, look for any evidence of psychotherapy during the study period

Strength of Evidence: Grade III

Feasibility/Data Collection Issues:
   • We will use these data to analyze the proportion of group vs. individual treatment taking place
Updates:

- None.
Module: All
Indicator Statement: Among those with any psychotherapeutic sessions, number of psychotherapeutic sessions per person
Indicator number: F

Executive Summary:

**Bipolar I:** This indicator will provide descriptive data reflecting the American Psychiatric Association’s emphasis on psychosocial interventions. The APA states, “There are now a range of specific psychotherapeutic interventions that have been shown to be helpful when used in combination with pharmacotherapy and psychiatric management for treatment of bipolar I disorder. The best-studied treatment approaches have been developed around psycho-educational, interpersonal, family, and cognitive behavior therapies. Formal studies have been conducted for these treatments, and additional investigations are underway. Further, psychodynamic and other forms of therapy may be indicated for some patients.” They discuss several evaluations showing that brief interventions, between six to seven sessions, are associated with improved outcomes for patients with bipolar I disorder. The VA Clinical Practice Guidelines also emphasize the importance of therapy in reducing symptoms, improving self-esteem, and reducing cognitive deficit.

**Schizophrenia:** This measure reflects standards enumerated in the VA Clinical Practice Guidelines for Psychoses, which recommends psychotherapy interventions with a schizophrenia diagnosis. The American Psychiatric Association also supports this view, stating, “as part of a comprehensive treatment approach, psychosocial interventions can improve the course of schizophrenia when integrated with psychopharmacological treatments. These interventions can provide additional benefits for patients in such areas as relapse prevention, improved coping skills, better social and vocational functioning, and ability to function more independently. While pharmacotherapy focuses on symptom diminution, psychosocial interventions may provide emotional support and address particular deficits associated with schizophrenia.”

The AHRQ-funded Schizophrenia Patient Outcomes Research Team (PORT) stated that “for most persons, the combination of psychopharmacologic and psychosocial interventions improves outcomes.” They reported that a number of psychosocial treatments have demonstrated efficacy, and listed “family interventions, SE, ACT, skills training, cognitive behaviorally oriented psychotherapy and the token economy social learning intervention” among them (Lehman et al, 1998, updated 2004). Mojtabai et. al. provided a comprehensive review of the literature linking psychosocial interventions to schizophrenia outcomes in controlled studies, concluding “our results show that psychosocial treatments can play an important role in the comprehensive management of schizophrenia not only to augment the effects of medications, but also to supplement these effects in areas where conventional medications alone are less effective (e.g., negative symptoms)... there is some evidence that psychosocial interventions may be more effective in the more chronic stages of illness and, therefore, can play a more prominent role in the management of patients with chronic schizophrenia.”

**SUD:** The American Psychiatric Association Clinical Practice Guidelines state that “Psychosocial treatments are essential components of a comprehensive treatment
Sustained motivation is required to forgo the rewards of substance use, tolerate the discomforts of early and protracted withdrawal symptoms, and gather the energy to avoid relapse despite episodes of craving that can occur throughout a lifetime. Coping skills are required to manage and avoid situations that can place the individual at a high risk for relapse.” The exact duration of SUD behavioral interventions varies by the type of substance use and the type of intervention, but evidence shows that very short interventions (one to four sessions) can be effective in improving outcomes for alcohol and cannabis dependence (Miller et al 2002, Copeland et al 2001), however, longer interventions are necessary in the treatment of opioid and cocaine dependence (Woody et al 1995, Carroll et al 1998).

MDD: This indicator is based on an indicator cited by CQAIMH and developed by the APA, “Treatment for Moderate Depression,” which states that “Major depressive disorder is prevalent and disabling, often accompanied by impaired personal, social, occupational and/or family functioning. Research studies have found that the disorder goes undetected or inadequately treated. Antidepressant medications and certain types of psychotherapy (e.g., cognitive behavioral therapy, interpersonal therapy) have been shown to be efficacious in the treatment of major depressive disorder.” The APA CPG for schizophrenia also states: “A specific, effective psychotherapy alone as an initial treatment modality may be considered for patients with mild to moderate major depressive disorder [II]. The combination of a specific effective psychotherapy and medication may be a useful initial treatment choice for patients with psychosocial issues, interpersonal problems, or a comorbid axis II disorder together with moderate to severe major depressive disorder [I]. Cognitive behavioral therapy and interpersonal therapy are the psychotherapeutic approaches that have the best documented efficacy in the literature for the specific treatment of major depressive disorder, although rigorous studies evaluating the efficacy of psychodynamic psychotherapy have not been published [II]. Although there has been less study of the use of psychotherapy in the continuation phase to prevent relapse, there is growing evidence to support the use of a specific effective psychotherapy during the continuation phase [I]. In general, the treatment that was effective in the acute and continuation phases should be used in the maintenance phase [II].

Hansen et al (2002), in a meta-analysis of psychotherapy dose-responses, found among dose-response studies, that at least eight psychotherapy sessions were required for a 50 percent improvement rate, ranging up to 18 sessions in Hansen and Lambert’s 2003 survival analysis of patients in a standard treatment setting.

PTSD: This indicator is based on findings by the Committee on Treatment of Posttraumatic Stress Disorder, which states that “the committee finds that the evidence is sufficient to conclude the efficacy of exposure therapies in the treatment of PTSD.” Furthermore, Rosenberg et. al. (2001) find that “A growing body of evidence shows that well-delineated, theoretically based interventions are effective in the treatment of PTSD…Multiple controlled trials have shown that the most effective interventions for PTSD are those based on CBT approaches, including exposure therapy and cognitive restructuring.” A meta-analysis by Bradley et al (2005) showed that behavioral interventions for PTSD were effective at a range of doses, however there have not been enough clinical trials to date to determine the differential efficacy of treatment at different doses.
Note that this indicator is similar to Cross Cutting D, which measures the Number of psychosocial treatment or psychotherapeutic sessions greater than 30 minutes per person. In this case, however, we are only measuring number of psychotherapy sessions, which is a more limited range of cases in the denominator. Although there is fair to good research evidence suggesting that psychosocial interventions are effective as adjuncts or monotherapy in the treatment of all five conditions discussed above, this indicator may not capture the type of psychotherapy offered and it will only describe the number of sessions, not a rate of providers offering an adequate ‘dose’ of a particular psychotherapy treatment. For this reason, this indicator will be a descriptive indicator providing information about mean/median dose of psychotherapy for each of the above conditions. This indicator will address the following IOM domain: Effectiveness.

References:
David J. Miklowitz, PhD; Michael W. Otto, PhD; Ellen Frank, PhD; Noreen A. Reilly-Harrington, PhD; Stephen R. Wisniewski, PhD; Jane N. Kogan, PhD; Andrew A. Nierenberg, MD; Joseph R. Calabrese, MD; Lauren B. Marangell, MD; Laszlo Gyulai, MD; Mako Araga, MS; Jodi M. Gonzalez, PhD; Edwin R. Shirley, PhD; Michael E. Thase, MD; Gary S. Sachs, MD (2007). Psychosocial Treatments for Bipolar Depression. Archives of General Psychiatry. 2007;64:419-426.
Jarrett Robin B., Dolores Kraft; Jeanette Doyle; Barbara M. Foster; G. Greg Eaves; Paul C. Silver Preventing Recurrent Depression Using Cognitive Therapy With and Without a Continuation Phase: A Randomized Clinical Trial Arch Gen Psychiatry. 2001;58(4):381-388.
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2000. . Office of Quality and Performance publication 10Q-CPG/MDD-00
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans
Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01

**Numerator:** Number of psychotherapy visits during the study period:
   c) Total psychotherapy visits in the 4 months following the start of a new treatment episode
d) Total psychotherapy visits during the study period

**Denominator:** Patients with a study-relevant diagnosis with any psychotherapy visits
   a) In the 4 months following the start of a new treatment episode
   b) During the study period

**Patient cohorts:** All patient cohorts

**Definitions:**
- **New Treatment Episode:** See Key Definitions Document
  o For patients who begin a new treatment episode in the inpatient setting, the start of the new treatment episode is the date of discharge from the hospital (Note: this definition differs from the general definition of the start of an inpatient new treatment episode in the Key Definitions Document).
  o If the new treatment episode begins in the outpatient setting, the start of the new treatment episode is defined as the first diagnosis-related (primary diagnosis only using Table 1B in the Key Definitions Document) outpatient encounter following the 5 month clean period.
- **Number of Psychotherapy Visits:** Defined as the count of diagnosis-related psychotherapy encounters (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
  o For patients in a new treatment episode, count psychotherapy visits that occur within four months of the start of the new treatment episode (do not count the initial visit if that involves psychotherapy)
For all patients with a study-relevant diagnosis, count all psychotherapy visits that occur during the study period.

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- This indicator will be used descriptively to compare rates of psychotherapy visits per patient across geographic regions and patient characteristics (e.g., gender, race, age, etc.).

**Updates:**
- Rather than counting the number of days on which psychosocial encounters occurred, this indicator will count the total number of psychosocial encounters, even if there are multiple encounters on the same day.
Performance Measure Technical Documentation

Module: All
Indicator Statement: Patients who received adequate follow-up after an inpatient psychiatric discharge
Indicator number: G

Executive Summary: This is a measure developed by the National Committee for Quality Assurance (NCQA) and cited by the healthcare Effectiveness data & information set (HEDIS) 2006. NCQA states in its rationale statement, “It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.”

Bipolar I: The APA notes that “the psychiatrist should remain vigilant for changes in psychiatric status. While this is true for all psychiatric disorders, it is especially important in bipolar disorder because limited insight on the part of the patient is so frequent, especially during manic episodes. In addition, small changes in mood or behavior may herald the onset of an episode, with potentially devastating consequences.” In a study of psychiatric hospital discharges, Rif et. al. find that “One of the most significant predictors of prompt rehospitalization following psychiatric hospital discharge is missing follow-up outpatient appointments.”

Schizophrenia: This indicator is based on the VA’s Clinical Practice Guidelines (VA CPG). They state that patients should been seen every one to two weeks for six weeks when patients have been prescribed “second generation antipsychotic medication other than clozapine.” The Expert Consensus Guidelines (1999) support this guideline, noting that following an initial diagnosis and prescription, patients should be seen within a week to ensure continuity of care. This will assist the doctor in preventing relapse and watching for critical warning signs of medication noncompliance.

PTSD: This indicator is based on a measure developed by Rosenheck et. al. (1999), which found that the number of outpatient visits in the six months following inpatient care was positively associated with clinical outcomes such as PTSD symptomology, drug problems, and violence. On the other hand, the measure of any outpatient visits within 30 days of discharge was negatively associated with clinical outcomes, possibly reflecting the fact that more symptomatic clients are most likely to return to treatment.

SUD: This indicator is based on a CQAIMH indicator, which states that “Continuing treatment after inpatient discharge is typically necessary to address ongoing problems and decrease the likelihood of relapse.” The American Psychiatric Association Clinical Practice Guidelines also support this measure, indicating that frequency of relapse monitoring should be intensified during transitions from higher to lower levels of care. McCorry et. al. note that, “A detoxification program is not designed to resolve the long-standing psychological, social, and behavioral problems associated with AOD abuse. Detoxification is most effective when it is viewed as a first step to active treatment and is followed by assessment and referral to ongoing AOD treatment without linkage to
treatment after detoxification, research has found no significant improvements that are discernable from untreated withdrawal.

**MDD:** This indicator (numerators a and b) was developed by the National Committee for Quality Assurance (NCQA) as cited in HEDIS 2006. They state in the indicator rationale, “It is important to provide regular follow-up therapy to patients after they have been hospitalized for mental illness. An outpatient visit with a mental health practitioner after discharge is recommended to make sure that the patient's transition to the home or work environment is supported and that gains made during hospitalization are not lost. It also helps health care providers detect early post-hospitalization reactions or medication problems and provide continuing care.”

This indicator has substantial face validity and it is the standard of care to provide patients with adequate follow-up after an inpatient psychiatric stay. Furthermore, this indicator is an industry standard indicator, as it has been adopted by HEDIS. This indicator addresses the following IOM domain: effectiveness, safety and timeliness

**References:**
Management of Psychoses. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2004. Office of Quality and Performance publication 10Q-CPG/PSY-04
Management of Substance Use Disorder in the Primary Care Setting. Washington, DC: VA/DoD Evidence-Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, September 2001. Office of Quality and Performance publication 10Q-CPG/SUD-01
Management of Major Depressive Disorder in Adults in the Primary Care Setting. Washington, DC: VA/DoD Evidence Based Clinical Practice Guideline Working Group, Veterans Health Administration, Department of Veterans Affairs, and Health Affairs, Department of Defense, May 2000. Office of Quality and Performance publication 10Q-CPG/MDD-00

**Numerator:**
1) Those individuals from the denominator whose discharge was followed by at least one diagnosis-related non-emergency follow-up encounter:
   a) Within 7 days
   b) Within 30 days
2) For those with any follow-up, number of days until first follow-up visit
**Denominator:**
  a) Patients with a study-relevant diagnosis discharged from any psychiatric inpatient care during the study period
  b) Patients with a study-relevant diagnosis discharged from acute psychiatric inpatient care during the study period

**Patient cohorts:** All patient cohorts

**Definitions:**
- Any Psychiatric Inpatient Discharge: Any inpatient discharge where the primary diagnosis (DXLSF) is any psychiatric diagnosis (210.xx-319.xx).
  - Select the first discharge in the study period as the index discharge
  - Exclude: Patients whose discharge status includes death or transfer to another inpatient facility (DISTO = -2, 0, 1, 2, 3, 4)
- Acute Psychiatric Inpatient Discharge: Any inpatient discharge where the primary diagnosis (DXLSF) is any psychiatric diagnosis from Table 1B in the Key Definitions Document from the following bed sections:
  - Bed Sections: 70, 71, 91-93
  - Select the first discharge in the study period as the index discharge
  - Exclude: Patients whose discharge status includes death or transfer to another inpatient facility (DISTO = -2, 0, 1, 2, 3, 4)
- Follow-up encounter: Defined as any diagnosis-related visits (primary or secondary from Table 1B in the Key Definitions Document) following the date of discharge from the inpatient setting
  - Within 7 days: where the difference between the date of the first follow-up encounter and the date of discharge from inpatient setting is equal to or less than seven days
  - Within 30 days: where the difference between the date of the first follow-up encounter and the date of discharge from inpatient setting is equal to or less than thirty days
- Days until first follow-up visit (numerator b): Number of days from discharge date until next outpatient encounter

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- None.

**Updates:**
- The definition of time to follow-up for counting days to follow-up is modified to include any follow-up in the year following discharge, rather than follow-up only in the study period. This will make the period of follow-up equal for all veterans, regardless of when during the study period they were hospitalized.
- Diagnosis list for qualifying inpatient discharges has been expanded to any psychiatric diagnosis (210.xx-319.xx) instead of only those in Table 1B.
Performance Measure Technical Documentation

Module: All
Indicator Statement: Proportion of patients using Mental Health Intensive Case Management (MHICM)
Indicator number: H

Executive Summary: This indicator is based on a measure from the FY 2006 Q4 Technical Manual for the VHA Performance Measurement System. The VA Technical Manual for the VHA Performance Measurement System describes the adoption of the MHICM program: "A subset of the most severely impaired mentally ill requires intensive community-based case management in order to function effectively outside of an institution. There is a large body of scientific data establishing the efficacy and cost effectiveness of intensive community case management. The Clinical Care Subcommittee of the Policy Board drafted VHA Directive 2000-034 on Mental Health Intensive Case Management (MHICM), issued October 2, 2000. It called for the establishment of new MHICM programs in population areas where no such programs exist and the enhancement of existing programs that are undersized to meet current needs. These programs may be funded using dollars previously devoted to the institutional support of the severely mentally ill. In any case, deployment of intensive case management should not come at the expense of other community-based and outpatient services for the seriously mentally ill."

Note that, according to Mueser et. al., "Research shows that ACT (Assertive Community Treatment) is effective at reducing hospitalizations, stabilizing housing in the community, reducing symptom severity, improving quality of life, and lowering overall treatment costs. ACT services have typically been reserved for consumers with severe mental illness and a recent history of long-term hospitalizations or extremely impaired psychosocial functioning requiring daily assistance to live in the community. Research indicates that ACT is most beneficial for this subgroup of consumers and not the entire population of consumers with severe mental illness."

This indicator attempts to measure enrollment both among all VHA patients, and those VHA patients that are eligible for MHICM. However, because our measurement of MHICM eligibility is based upon limited evidence available in administrative data and because no study has assessed the effect of time to enrollment on ACT outcomes (as in numerator a), this indicator will not be a benchmark of quality of care, but rather a descriptive indicator. This indicator addresses the following IOM domain: effectiveness.

References:

Numerator: Patients in the denominator using MHICM

Denominator: Patients in all cohorts

Patient cohorts: All patient cohorts

Definitions:
• Mental Health Intensive Case Management utilization: Defined as 2+ outpatient encounters with MHICM during the study period. The following stop codes should be used to define MHICM encounters:
  o 546 – Mental Health Intensive Case Management Telephone
  o 552 – Mental Health Intensive Case Management
  o 568 – Mental Health Intensive Case Management Group

**Strength of Evidence:** Grade III. The evidence supporting the effectiveness of assertive community treatment programs among Bipolar I, Schizophrenia, and MDD populations is Grade I, however, there is no evidence evaluating the effectiveness of these types of treatments within 30 days of eligibility, a restriction specified in this measure.

**Feasibility/Data Collection Issues:**
• We have expanded this indicator to assess MHICM enrollment across all populations with the understanding that MHICM is not an evidence based practice for all of these populations.
• We aim to assess the use of MHICM within populations for which there is an evidence base (Bipolar I, Schizophrenia, and severe MDD) and other populations

**Updates:**
• None.
Module: All
Indicator Statement: For selected patients, timeliness of engagement of Mental Health Intensive Case Management (MHICM)
Indicator number: 1

Executive Summary: This indicator is based on a measure from the FY 2006 Q4 Technical Manual for the VHA Performance Measurement System. The VA Technical Manual for the VHA Performance Measurement System describes the adoption of the MHICM program: "A subset of the most severely impaired mentally ill requires intensive community-based case management in order to function effectively outside of an institution. There is a large body of scientific data establishing the efficacy and cost effectiveness of intensive community case management. The Clinical Care Subcommittee of the Policy Board drafted VHA Directive 2000-034 on Mental Health Intensive Case Management (MHICM), issued October 2, 2000. It called for the establishment of new MHICM programs in population areas where no such programs exist and the enhancement of existing programs that are undersized to meet current needs. These programs may be funded using dollars previously devoted to the institutional support of the severely mentally ill. In any case, deployment of intensive case management should not come at the expense of other community-based and outpatient services for the seriously mentally ill."

Note that, according to Mueser et. al., "Research shows that ACT (Assertive Community Treatment) is effective at reducing hospitalizations, stabilizing housing in the community, reducing symptom severity, improving quality of life, and lowering overall treatment costs. ACT services have typically been reserved for consumers with severe mental illness and a recent history of long-term hospitalizations or extremely impaired psychosocial functioning requiring daily assistance to live in the community. Research indicates that ACT is most beneficial for this subgroup of consumers and not the entire population of consumers with severe mental illness."

Because no study has assessed the effect of time to enrollment on ACT outcomes and in addition, the VA does not have explicit standards for time to enrollment in MHICM, this indicator will be a descriptive measure of average time to enrollment. This indicator addresses the following IOM domains: effectiveness and timeliness.

References:

Numerator:
   a) Number of patients subsequently enrolled in MHICM
   b) Number of days following date of eligibility (per numerator [a]) until client is enrolled in MHICM

Denominator: Number of patients in a study cohort who have at least three inpatient discharges or 30 cumulative inpatient days in the study period and were not enrolled in MHICM prior to meeting the inpatient utilization criteria
Patient cohorts: All patient cohorts

Definitions:

- Inpatient discharge: Any psychiatric discharge with a primary psychiatric diagnosis (DXLSF) from Table 1B of the Key Definitions Document using the following bed section codes: 70, 71, 75-79, 89, 91-93
- Inpatient days: Total count of psychiatric inpatient days from all inpatient discharges during the study period with a primary psychiatric diagnosis (DXLSF) from Table 1B of the Key Definitions Document using the following bed section codes: 70, 71, 75-79, 89, 91-93
  - Note: Length of Stay (LS from the Inpatient Medical SAS Dataset) already subtracts out bed days on pass and out of the hospital so no additional calculations/exclusions are needed. However, this calculation is for total length of stay; if a patient were admitted to one bed section and then transferred to a psychiatric bed section (or vice versa), this calculation would over-estimate the length of stay for the psychiatric bed section. There is no possible method for determining when days on pass occurred (i.e., during the relevant bed section days or during other bed section days).
- Mental Health Intensive Case Management enrollment: Defined as 2+ outpatient encounters with MHICM on separate days. The date of the second encounter marks the date of enrollment for calculating the numerator. The following stop codes should be used to define MHICM encounters:
  - 546 – Mental Health Intensive Case Management Telephone
  - 552 – Mental Health Intensive Case Management
  - 568 – Mental Health Intensive Case Management Group
- Prior Mental Health Intensive Case Management enrollment: Defined as 1+ outpatient encounters with MHICM prior to the completion of at least 3 inpatient discharges or 30 cumulative inpatient days (whichever comes first). The following stop codes should be used to define MHICM encounters:
  - 546 – Mental Health Intensive Case Management Telephone
  - 552 – Mental Health Intensive Case Management
  - 568 – Mental Health Intensive Case Management Group
- Number of days until MHICM enrollment: Count of number of days from the date of the last inpatient discharge or the last of 30 cumulative inpatient days (whichever comes first) until the date of the second MHICM encounter.
  - If the cumulative number of inpatient admissions exceeds three during the study period, begin counting number of days until enrollment with the date of discharge for the third inpatient stay
  - If the cumulative inpatient days for the year exceed 30 days, begin counting number of days until enrollment with the date of discharge for the last of those inpatient stays

Strength of Evidence: Grade III

Feasibility/Data Collection Issues:

- We have expanded this indicator to assess time to MHICM enrollment across all populations with the understanding that MHICM is not an evidence based practice for all of these populations. We aim to assess the use of MHICM within both target populations (Bipolar I, Schizophrenia, and severe MDD) and non-target populations
• Note that there are no VA standards for timeliness of MHICM enrollment.

**Updates:**
• We have modified the denominator of this indicator to exclude those who were already engaged with MHICM prior to meeting the criteria for inclusion (e.g., before they had 3 inpatient discharges or 30 cumulative inpatient days).
• We have modified the numerator to create two different numerators; the first is a simple count of those subsequently enrolled in MHICM and the second is a count of the number of days from the qualifying index date from the denominator until enrollment in MHICM per our enrollment definition.
• We have made explicit that the index date for counting days to enrollment is the first of either 3 inpatient discharges or 30 cumulative inpatient days during the study period.
• We have added a definition of prior MHICM enrollment in order to be clear about who we are excluding from the denominator of this indicator.
• We have made explicit that enrollment in MHICM is defined as two MHICM encounters (using stated stop codes) on *separate* days.
Performance Measure Technical Documentation

Module: All
Indicator Statement: Supported Employment utilization
Indicator number: J

Executive Summary:

Bipolar I, Schizophrenia: Several randomized controlled studies have shown supported employment to be effective among patients with severe mental illnesses. Bond et. al. (1997) found that supported employment programs were associated with higher rates of competitive employment, as compared to traditional vocational approaches. A study conducted by Rosenheck et. al. (2007) concluded that a supported employment program within the VA was successful at increasing rates of competitive employment, however, to less of a degree than those changes reported by Bond et. al. (1997). Rosenheck’s study included patients with Substance Use Disorder and PTSD in addition to the severe mental illnesses studied by Bond et. al.

SUD: A quasi-experimental study conducted by Rosenheck et. al. (2007) concluded that a supported employment program within the VA was successful at increasing rates of competitive employment, however, to less of a degree than those changes reported by Bond et. al. (1997). Among those patients offered supported employment, those with diagnoses of substance use disorders without psychiatric comorbidity experienced substantially greater gains in competitive employment than those with other psychiatric illnesses.

PTSD: There is little evidence supporting the effectiveness of supported employment in these patient populations; For this reason, supported employment utilization will be a descriptive indicator for the PTSD cohort. Rosenheck et. al. (2007) included patients with PTSD in his quasi-randomized study of supported employment. He found significant differences in competitive employment, however, figures for PTSD alone are not reported.

Although SE is an EBP with robust evidence of effectiveness for severely mentally ill adults (typically, people with schizophrenia, bipolar I disorder and severe MDD), there is no robust evidence linking intensity of utilization with outcomes (numerator b) and in addition, we will not be able to determine true need among the people included in denominator (a). For this reason, and we will only use this indicator descriptively. This indicator addresses the following IOM domains: effectiveness.

References:

Numerator:
1. Patients in the denominator enrolled in supported employment during the study period
2. Among those enrolled in supported employment (from numerator [1a] and [1b]), number of supported employment visits

**Denominator:**
- a) All patients in the study cohorts
- b) Patients in the bipolar and schizophrenia cohorts OR any patient with two or more outpatient visits on separate days or one inpatient admission during the study period with a diagnosis of psychosis

**Patient cohorts:** All patient cohorts

**Definitions:**
- Diagnosis of psychosis: patients with two or more outpatient encounters on separate days or any inpatient admissions with a primary or secondary diagnosis of psychosis, defined by the following ICD-9 codes:
  - 297.0 Paranoid state, simple
  - 297.1 Delusional disorder
  - 297.2 Paraphrenia
  - 297.3 Shared psychotic disorder
  - 297.8 Other specified paranoid states
  - 297.9 Unspecified paranoid state
  - 298.0 Depressive type psychosis
  - 298.1 Excitative type psychosis
  - 298.2 Reactive confusion
  - 298.3 Acute paranoid reaction
  - 298.4 Psychogenic paranoid psychosis
  - 298.8 Other and unspecified reactive psychosis
  - 298.9 Unspecified psychosis
- Supported Employment Enrollment: Patients with two or more encounters on the same or different days for the following stop codes during the study period:
  - 568: Mental Health Compensated Work Therapy/Supported Employment – Face to Face
  - 569: Mental Health Compensated Work Therapy/Supported Employment – Non-Face to Face
  - 574: Mental Health Compensated Work Therapy - Group
- Count of supported employment encounters: Count of supported employment encounters using the same stop codes provided above (multiple encounters on the same day will be counted separately and not as a single event)

**Strength of Evidence:**
- BP, SZ: Grade I
- SUD: Grade III
- PTSD: Grade III

**Feasibility/Data Collection Issues:**
- We have expanded this indicator to assess supported employment utilization across all populations with the understanding that supported employment is not an evidence based practice for all of these populations. We aim to assess the use of supported employment within both target populations (Bipolar I, Schizophrenia, and psychosis) and non-target populations.
Based on initial evaluation of the data (5/29/08), it is advisable to present in reports only that data for Denominator #B (those with Bipolar Disorder, Schizophrenia, and a diagnosis of psychosis).

Updates:

• For denominator (b), we will include those with two or more visits on different days with a primary or secondary diagnosis of psychosis.
• We have revised the definition of Supported Employment enrollment to be two or more encounters that could take place on the same or different days.
• The count of Supported Employment encounters will consider multiple encounters on a single day as separate events and each will be included in the total count.
• We have made explicit that the denominator for numerator (2) are the counts derived from numerators (1a) and (1b).
• Although this indicator was originally identified as having a Grade I strength of evidence for MDD, that applied only to severe MDD. We cannot identify the severity of MDD using administrative data and thus have excluded this condition from consideration for additional or sub-analyses.
• We added stop code 574 (Mental Health Compensated Work Therapy – Group) to the definition of Supported Employment.
Performance Measure Technical Documentation

Module: All
Indicator Statement: Family psychoeducation
Indicator number: K

Executive Summary:

Bipolar I Disorder: This indicator is based on evidence-based practice recommendations. The American Psychiatric Association’s (APA) clinical guidelines recommend family psychotherapy, "One adequately sized trial of behavioral family treatment has been completed; the investigators found that behavioral family management (in concert with adequate pharmacotherapy) resulted in a substantial decrease in depressive relapse rates when compared with a treatment-as-usual control condition.” Furthermore, family members' emotional responses to a patient's bipolar I episodes have a significant impact on how well the patient recovers from the episodes, according to 4 independent studies in 3 countries. Three controlled studies have evaluated the effects of family interventions on outcomes of Bipolar I Disorder. Miklowitz et al (2000) found that bipolar I patients randomly assigned to family psychoeducation treatment had significantly lower rates of depression (but not mania) after 9 months of family psychoeducation treatment, as compared to two family psychoeducation sessions and subsequent crisis management treatment.

Schizophrenia: The AHRQ-funded Schizophrenia Patient Outcomes Research Team (PORT) listed family intervention among the psychosocial treatments with demonstrated efficacy (grade ~1) (Lehman et al, 1998, updated 2004). Many randomized clinical trials have shown that long-term (greater than six months) family psychoeducation has a significant impact on relapse and rehospitalization rates for the patient. Meta-analyses (Pekkala 2002, Pharoah 2003) have shown that for patients whose families are involved in a family psychoeducation program, relapse rates are reduced by three-quarters in the first year. McFarlane et al (2003) note that family psychoeducational interventions for schizophrenia are “some of the most substantial and consistent empirical effects achieved by any treatment in the mental health field.”

Major Depressive Disorder: The Harvard-Pilgrim Health Care Clinical Practice Guidelines for Major Depressive Disorder include “education for the patient and family/support system” as a critical step in treating MDD. Several randomized studies have shown that family psychoeducation, particularly for the spouse, has been effective in improving outcomes for depression. The APA Clinical Practice Guidelines for MDD state, “Studies of the efficacy of marital or family therapy, either as a primary or adjunctive treatment, have been conducted among patients with depressive symptoms and not among patients with, specifically, major depressive disorder. Based on data from 17 clinical trials of marital therapy, two reviews have concluded that it is an effective means for reducing major depressive disorder symptoms and risk of relapse,” citing Hahlweg (1998) and Jacobson (1976).

PTSD: Nelson and Wright (1996) suggest that effective treatment for PTSD “should involve family psychoeducation, support groups for both partners and veterans, concurrent individual treatment, and couple or family therapy."
**SUD**: O’Farrell et. al. (2007) found that brief family treatment interventions were effective in promoting continued care among alcohol-dependent and substance-abusing patients in inpatient detoxification. Note that in the case of SUD, there is an evidence base for family psychotherapy, and not a strong evidence base for family psychoeducation.

Administrative data imperfectly accounts for family psychoeducation visits (see feasibility note below). For this reason, this will be a descriptive indicator. This indicator addresses the following IOM domain: Effectiveness.

**References:**
Practice Guideline for the Treatment of Patients with Bipolar I Disorder (2002 Revision);
American Psychiatric Association; Am J Psychiatry 159:4, April 2002 Supplement ;
Also, Guideline Watch (2006) Update, Hirschfeld RM, American Psychiatric
Association, 2006
Anthony F. Lehman, Donald M. Steinwachs, and The Co-Investigators of the PORT
Project, “Translating Research Into Practice: The Schizophrenia Patient Outcomes
Research Team (PORT): Updated Treatment Recommendations 2003”,
Hahlweg K, Markman HJ: Effectiveness of behavioral marital therapy: empirical status of
behavioral techniques in preventing and alleviating marital distress. J Consult Clin
Psychol 1988; 56:440–447 [F]
83:540–556 [F]
Functioning and Family Burden in a Controlled, Real-World Trial of Family
Psychoeducation for Schizophrenia. *Psychiatric Services*, 57:12, 1784-1791
schizophrenia: a review of the literature. *Journal of Marital and Family Therapy*,
29:223-245.
disorder symptoms in female partners of veterans with PTSD. *Journal of Marital and
Family Therapy*, 22, 455-467
intervention to promote continuing care among alcohol-dependent patients in

**Numerator:**
  a) Those patients included in the denominator who have participated in one or more
family psychoeducation encounters
  b) Those individuals receiving family psychoeducation for at least nine continuous
months

**Denominator:** All patients in the study cohorts

**Patient cohorts:** All patient cohorts

**Definitions:**
- Family psychoeducation: Any clinic encounters for which the following CPT
codes are present: 90846, 90847, 90849
- Nine continuous months of family psychoeducation: Defined as one or more
family psychoeducation encounter in each month for nine continuous months
beginning during the study period; the beginning of the nine month period can be at any point during the study period and may continue past the end of the study period.

**Strength of Evidence:**
- Bipolar I: Grade I
- Schizophrenia: Grade I
- MDD: Grade I
- PTSD: Grade III
- SUD: Grade III

**Feasibility/Data Collection Issues:**
- Specified CPT codes are for family psychotherapy, which is an imperfect measure of family psychoeducation.
- We may consider evaluating this indicator separately for bipolar I disorder, schizophrenia and MDD as there is an evidence base for using this treatment for these conditions.
- We may consider looking at frequency (number of months, or number of sessions) of family psychoeducation as well.
- A limitation to this analysis is that there are veterans who may not have family members involved in their care, we must assume that those veterans without families are equally distributed across PSAs.

**Updates:**
- None.
Module: All
Indicator Statement: Proportion of patients who have appropriate laboratory screening tests
Indicator number: L

Executive Summary: According to the VA Clinical Practice Guidelines, “Testing is directed toward detection of associated medical conditions and to rule out contraindications to medical therapy. Appropriate laboratory studies include: TSH, Complete Metabolic Panel, Hepatitis, HIV, and HCG (for females).” This recommendation is supported by Williams and Shepherd (2000) in their description of appropriate treatment of patients presenting in emergency departments with psychiatric symptoms.

Although this indicator has substantial face validity and it is the standard of care to screen patients for the reasons stated above, there is no evidence linking lab screening to outcomes. For this reason, this indicator will only be used descriptively. This indicator addresses the following IOM domains: Effectiveness and Safety

References:

Numerator: Those patients in the denominator with evidence of the following laboratory screening tests at least once during the study period:
   a) TSH
   b) Liver function test
   c) Chemistry panel:
      a. Sodium
      b. Creatinine
      c. Potassium
   d) Hepatitis
   e) HIV

Denominator: Individuals with a study-relevant diagnosis in all patient cohorts

Patient cohorts: All patient cohorts

Definitions:
- Laboratory screening tests: Defined as one or more of the following tests from the Laboratory National Data Extract
  o TSH: TESTNAME code=’0024’
  o Liver function tests defined as one or more of the following: Aspartate Transaminase – AST; Transferase Alanine Amino – ALT; Phosphatase Alkaline, Bilirubin, Albumin (TESTNAME code = ‘0009’, ‘0045’, ‘0048’, ‘0044’, ‘0049’)
  o Chemistry Panel (defined by the presence of at least one of the following tests):
    ▪ Sodium: TESTNAME code = ‘0003’
- Creatinine (Defined as either Serum Creatinine or Creatinine Clearance): TESTNAME code = ‘0011’, ‘0031’
- Potassium: TESTNAME code = ‘0002’
  - Hepatitis (defined as one or more of the following): TESTNAME code = ‘0041’, ‘0042’, ‘0043’
  - HIV (defined as one or more of the following): TESTNAME code = ‘0038’, ‘0039’, ‘0040’

**Strength of Evidence:** Grade III

**Feasibility/Data Collection Issues:**
- Although HCG (for females) is an important test, this test is not part of the national data extracts and thus cannot be tracked in our study.

**Updates:**
- Lab test codes were reviewed and corrected.
Part III: Medical Records Review Indicators
**Performance Measure Technical Documentation**

**Module:** Schizophrenia

**Indicator Statement:** New treatment episode: Assess medication side effects (SE) 2-4 months after the initiation of any antipsychotic treatment.

**Indicator Number:** 1

**Executive Summary:** The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guidelines for Management of Psychoses. The VA guideline recommends that clinicians should assess patients after 6-8 weeks of pharmacology, and that the assessment should "consider a range of antipsychotic drug side effects in assessing clinical response." This recommendation has been modified in the current indicator; the time period has been extended to 2-4 months after initiation of psychopharmacology to reflect the related VA guideline recommendation to reassess side-effects "to determine if treatment may need to be modified," which has no specific time period stated in the VA guideline or in the related American Psychiatric Association (APA) guideline (2002 and 2005 update); this was determined by the VA Mental Health Program Evaluation Consultation Group to be a reasonable and valid time period for assessment.

The VA guideline recommends assessing a number of relevant side effects in patients with Schizophrenia diagnoses, and provides the following rationale: "Antipsychotic medications, in particular the second generation antipsychotic medications, may be associated with weight gain and possible dysregulation of blood glucose and lipids." After reviewing the VA guideline recommendations, the VA Mental Health Program Evaluation Consultation Group, in concert with non-VA clinical experts in Schizophrenia, determined that the current indicator should focus on weight/BMI and akathisia as the two highest priority side effects for the Schizophrenia patient population, both in terms of prevalence and of importance in providing safe and effective care. This indicator addresses the following IOM domains: Safety, Timeliness, and Effectiveness.

**Numerator:** Patients from the denominator whose medication side effects have been assessed in the two to four months after the start of antipsychotic treatment, including:
1. Weight or BMI
2. Akathisia
3. Any assessment of side effects

**Denominator:** Patients with schizophrenia diagnosis in a new treatment episode who have been started on antipsychotic treatment.

**Patient cohorts:** Patients with schizophrenia diagnosis

**Strength of Evidence:** Grade III

**Definitions:**
- New Treatment Episode: See the “Key Definitions” document
- Antipsychotic treatment: Defined as having at least one prescription filled within 30 days of the start of the new treatment episode using the following drug class codes,
while excluding patients who filled a prescription within 90 days before the new treatment episode (to identify patients newly started on the medication):
  o CN700, Antipsychotics
  o CN701, Phenothiazine/Related Antipsychotics
  o CN709, Antipsychotics, Other

- Side effects (SE): Presence or absence of side effects due to medication noted in the record 2-4 months following the start of a new treatment episode.
- Weight or BMI: Body Mass Index (BMI) is a number calculated from a person’s weight and height. BMI provides a reliable indicator of body fat for most people and is used to screen for weight categories that may lead to health problems.
- Akathisia: Akathisia is a common side effect associated with the use of anti-psychotic medications (neuroleptics). It is characterized by excessive, usually repetitive, movements such as pacing, foot tapping and rocking. It is often described as a ‘feeling that you are going to come out of your own skin’ if you don't move. Akathisia must be assessed by an authorized prescriber (i.e., MD, DO, NP, or PA).

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from the medical record data
- Measuring weight or BMI without further notation would count.
- A flag for patients on antipsychotics will be given to the abstractors.
Performance Measure Technical Documentation

Module: Schizophrenia

Indicator Statement: Annual assessment of weight/BMI, glycemic control, lipids

Indicator Number: 2

Executive Summary: This indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Psychoses. The VA guideline recommends that patients receive a clinical assessment of weight, lipids, and glycemic control every 6-12 months during long-term therapy. The guideline provides the following rationale for this recommendation:

Antipsychotic medications, in particular the second generation antipsychotic medications, may be associated with weight gain and possible dysregulation of blood glucose and lipids. Baseline and periodic monitoring of blood glucose, serum lipids, blood pressure and BMI would be prudent particularly in those persons identified as having diabetes, or who are at increased risk for developing diabetes, or those with other known risk factors for cardiovascular disease. These measures may help guide initial selection of antipsychotic medications, improve early detection of the need for medical intervention, and enhance ongoing reevaluation of the appropriateness of psychiatric medications. (Marder et al., in press) (17).

This indicator addresses the following IOM domains: Safety and Timeliness.

Numerator: All patients from the denominator with an assessment during the study period of:

1. weight or BMI
2. glycemic control
3. lipids
4. all of the above
5. at least one of the above (a, b, or c)

Denominator: This indicator will be evaluated for the following populations:

1. Patients with schizophrenia diagnosis
2. Patients with schizophrenia diagnosis who are taking antipsychotic medication

Patient cohorts: Patients with schizophrenia diagnosis

Strength of Evidence: Grade III

Definitions:

• Weight or BMI. Body Mass Index (BMI) is a number calculated from a person’s weight and height. BMI provides a reliable indicator of body fat for most people and is used to screen for weight categories that may lead to health problems.

• Glycemic control: Defined as a glucose (‘0010’, ‘0057’) or hemoglobin A1C (‘0017’) laboratory test in the DSS Clinical National Data Extracts. “Passing” this indicator requires only one or the other test for glycemic control during the study period, although all tests will be tracked from administrative data.

• Lipids: Defined as a LDLC (‘0027’), HDLC (‘0028’), total cholesterol (‘0029’), or tryglicerides (‘0030’) laboratory test in the DSS Clinical National Data Extracts. “Passing” this indicator requires only total cholesterol or LDL cholesterol during the study period, but all lab tests will be tracked from administrative data.
Feasibility/Data Collection Issues:
- Denominator from administrative data
- Numerator from the medical record (Weight/BMI) and administrative data (glycemic control and lipids).
- Measuring weight or BMI without further notation would count.
- We need to see that they did the laboratory work, but don’t need the results.
Executive Summary: This indicator is based on the established and growing body of empirical research literature supporting Social Skills Training (SST) as an effective psychosocial rehabilitation strategy for Schizophrenia (Bellack 2004; Mueser et al 1997). The Schizophrenia Patient Outcomes Research Team (PORT) Updated Treatment Recommendations (Lehman et al. 2003) provide the following rationale to support the effectiveness of skills training for people with schizophrenia:

Individuals with schizophrenia can learn a wide variety of social and independent living skills when provided with structured behavioral training; followup evaluations of up to 1 year show good retention of the skills that were taught earlier (Eckman et al. 1992; Wallace et al. 1992; Mueser et al. 1995; Liberman et al. 1998). The results of controlled trials indicate the benefit of skills training in improving patients' social and independent living skills when such training is offered in conjunction with adequate pharmacotherapy (Wallace and Liberman 1985; Eckman et al. 1992; Wirshing et al. 1992; Hayes et al. 1995; Kopelowicz et al. 1998; Liberman et al. 1998; Glynn et al. 2002). Evidence is strongest for the benefit of skills training in increasing skills assessed by situationally specific measures (Dilk and Bond 1996). There are several reports of controlled studies in which social skills training led to a reduction of symptom severity (Wallace and Liberman 1985; Wirshing et al. 1992; Dobson et al. 1995; Hayes et al. 1995).

Meta-analyses of studies of SST effectiveness have indicated that there is considerable variance among effect sizes and outcome measures across studies, indicating a need for future research (Dilk and Bond 1996; Pilling et al. 2002). Despite these reservations, SST remains a well-supported and broadly endorsed treatment for Schizophrenia. Furthermore, SST was specifically mentioned in Research Question 7 (RQ7) of the VA Statement of Work (June 2005) for the current program evaluation as a treatment approach of specific interest to VA: "The specific evidence-based care for each diagnosis will need to be identified, but for at least some of the diagnoses will include approaches such as cognitive behavioral therapy, social skills training, supported employment with individual assistance, intensive case management (MHICM or other), and family education in VA." This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

References:


Dilk MN, Bond GR. Meta-analytic evaluation of skills training research for individuals with severe mental illness. J Consult Clin Psychol. 1996 Dec; 64(6):1337-46


Numerator: All patients receiving during the study period:
(a) any social skills training visits during the study period; and
(b) how many social skills training visits.

Denominator: Patients with Schizophrenia diagnosis receiving any psychosocial rehabilitation during the study period.

Patient cohorts: Patients with schizophrenia diagnosis

Strength of Evidence: Grade I

Definitions:
• Social Skills Training: Social skills training visits may include evidence that the provider assisted with the following:
  1. Verbal instruction*
  2. Written instruction
  3. Modeling*
  4. Behavioral rehearsal*
  5. Corrective verbal feedback*
  6. Homework
  7. Videotape feedback
  8. Written feedback
  9. Relaxation training
  10. Self-reinforcement
  11. In vivo training

* Core Techniques
  To pass this indicator, there must be evidence of at least 3 of 4 core elements (1) verbal instruction, (2) modeling, (3) behavioral rehearsal, and (4) verbal feedback.

Social competence is based on a set of three component skills;
1) Social perception or receiving skills involves the ability to accurately read or decode social inputs. This includes accurate detection of affect cues, such as facial expressions and nuances of voice, gesture, and body posture, as well as verbal content (what the interpersonal partner says) and contextual information.
2) Social cognition or processing skills involves effective analysis of the social stimulus, integration of current information with historical information (e.g., what has the partner done in previous interactions? What is one’s experience in similar social situations?), and planning of an effective response. This domain is also referred to as social problem solving.
3) Behavioral response or expressive skills includes ability to generate effective verbal content, to speak with appropriate paralinguistic characteristics, and to use suitable nonverbal behaviors such as facial expression, gestures, and posture. Effective social behavior requires the smooth integration of these three component processes so as to meet the demands of the specific social situation.

The approach used by the provider can be employed in one-to-one interactions between clinician and client in informal, ad hoc interactions. Training is characteristically
conducted in small groups, which provides each individual with adequate opportunity to rehearse. The content of training programs is organized into curricula, such as job interview skills, medication management (how to communicate with health care providers), dating skills, and safe sex skills. Training duration can ranges from 4-8 sessions for a very circumscribed skill, to 6 months to 2 years for a comprehensive skills training program. Regardless of duration, training sessions are typically held 2-3 times per week. Training is structured so as to minimize demands on neurocognitive capacity (Bellack 2007).

- **Psychosocial rehabilitation**: Defined as one or more outpatient visits where Schizophrenia is the primary or secondary diagnosis using the following stop codes:
  - Psychosocial Rehabilitation – Individual: 532;
  - Psychosocial Rehabilitation – Telephone: 537;
  - MHICM – Telephone: 546;
  - Intensive Substance Abuse Treatment*: 547;
  - Substance Abuse – Group*: 550;
  - MHICM: 552;
  - Day Treatment – Group: 553;
  - Psychology – Group: 558;
  - Psychosocial Rehabilitation – Group: 559;
  - Substance Abuse – Group*: 560
  - MHICM – Group: 567
  - Day Treatment – Individual: 505
  - Day Hospital – Individual: 506
  - Substance Abuse Day Hospital*: 548
  - Day Treatment – Group: 553
  - Day Hospital – Group: 554
  - Post-Traumatic Stress Disorder Day Hospital: 580
  - Post-Traumatic Stress Disorder Day Treatment: 581
  - Psychosocial Rehabilitation Recovery Center – Individual: 582
  - Psychosocial Rehabilitation Recovery Center – Group: 583

* We include substance abuse treatment stop codes as it may be possible that people with dual diagnoses of schizophrenia and SUD may receive social skills training in these clinics.

**Feasibility/Data Collection Issues:**
- Denominator to come from administrative data
- Numerator to come from medical record.
Module: Schizophrenia
Indicator Statement: Percent of patients with a Global Assessment of Functioning (GAF) score less than or equal to 40 and four or more visits with a case manager during the study period
Indicator Number: 4

Executive Summary: This indicator is based on findings presented by Niv, Cohen, Sullivan, and Young (2007) regarding the "reliability and convergent, discriminant, and predictive validity" of the Global Assessment of Functioning (GAF) scale in a sample of patients with schizophrenia or schizoaffective disorder who received VHA care. Under the advisement of the VA Mental Health Program Evaluation Consultation Group, this indicator was developed to identify effective outreach and appropriate care for patients with diagnoses of Schizophrenia with significant physical and mental impairment by case management programs within the VA system. This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness, Timeliness, Patient-centeredness, and Efficiency.

Numerator: For patients in the denominator:
   a) those who have four or more visits with a case manager following their first eligible GAF score
   b) total number of visits with a case manager following the first eligible GAF score within 12 months of the first case manager visit.

Denominator: Patients with schizophrenia diagnosis with at least two Global Assessment of Functioning (GAF) scores 30 or more days apart from each other with scores of less than or equal to 40 during the study period.

Patient cohorts: Patients with schizophrenia diagnosis

Strength of Evidence: Grade III

Definitions:
- GAF: Global assessment of functioning, scale of 0-100
  - 91-100: Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms
  - 81-90: Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members)
  - 71-80: If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social occupational, or school functioning (e.g., temporarily falling behind in schoolwork)
  - 61-70: Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60: Moderate symptoms (e.g., flat affect and circumstential speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41-50: Severe symptoms (e.g., suicidal ideation, severe obsessionally rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

31-40: Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21-30: Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

11-20: Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1-10: Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death OR Inadequate information.

• Visits with a case manager: Any diagnosis-related visits (primary or secondary diagnosis) with mental health providers who do not have prescribing privileges (e.g., social workers, addiction therapists, psychologists, RNs, psychiatric technicians, etc.). These will be defined using the provider codes (PROV1-PROV10) available in the Medical SAS Outpatient Dataset:
  o Provider codes: 010000-010600, 070101, 070102, 070807, 070901, 070947, 070953

Feasibility/Data Collection Issues:
• Denominator will come from the medical record
• Numerator will come from administrative data
• This indicator will be used for descriptive purposes.
• We can present data on case managers for the patients with a GAF less than or equal to 40, greater than 40, as well as for those who have no recorded GAF during the study period.
Performance Measure Technical Documentation

Module: Schizophrenia
Indicator Statement: Depot Antipsychotic Medication for Schizophrenia
Indicator Number: 5

Executive Summary: This indicator is based on an indicator developed by Lehman et al. (1998) as documented in the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) database, which assigned to it an evidence level of AHRQ Level B ("Fair research evidence & supporting clinical consensus/opinion"). The original indicator assessed only patients with Schizophrenia who receive depot antipsychotic medication. This indicator has been modified and expanded under the advisement of the VA Mental Health Evaluation Consultation Group to also address patients with documentation that they receive case management, family involvement, or patient-provider conversations about changing medications. Lehman et al. provide the following rationale for measuring depot medication for noncompliant patients:

Non-compliance with antipsychotic medication is common and increases the likelihood of relapse and hospitalization of patients with schizophrenia. Practice guidelines, including those from the Schizophrenia PORT, recommend that individuals with relapse secondary to non-compliance be treated with depot antipsychotic drugs, long-acting agents requiring intramuscular administration 1-2 times per month. Research comparing oral and depot formulations shows better compliance with depot formulations, but no clear advantage in relapse rates.

The "family involvement" component of this indicator is based on an indicator developed by Young et al. (1998), also documented in the CQAIMH database with an evidence level of AHRQ Level C ("Little research evidence, principally based on clinical consensus/opinion"). Young et al. provide the following rationale for assessing recent family involvement on an annual basis:

Randomized controlled trials have shown that interventions directed at family members of individuals with schizophrenia can improve outcomes for both patients and families. These interventions include educating families about schizophrenia, providing support, and training families in problem solving and intervening during crisis situations. Less is known about the association between less-intensive family involvement in treatment and patient outcomes.

This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness, Timeliness, Patient-centeredness, and Efficiency.

Numerator: Patients in the denominator who are receiving depot antipsychotics during the study year.

Denominator: Patients with schizophrenia diagnosis with episodic treatment using antipsychotic medication in the study period with a previous history of treatment.

Patient cohorts: Patients with schizophrenia diagnosis

Strength of Evidence: Grade I

Definitions:

- Episodic Treatment: Defined as patients who received at least two filled prescriptions for any length but no more than 180 days (six 30-day prescriptions...
or two 90-day prescriptions) of an antipsychotic during the study period using the following drug class codes:
  o CN700, Antipsychotics
  o CN701, Phenothiazine/Related Antipsychotics
  o CN709, Antipsychotics, Other

• Previous History of Treatment: Defined as having at least one outpatient visit in the 12-months prior to the study period where schizophrenia is the primary diagnosis
• Depot: Injecting patients w/ medication for extended release (e.g., 2wks, 6wks, etc.)

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record
• A flag will be provided from administrative data to identify those who meet the definition of the denominator for chart abstraction.
Module: Schizophrenia

Indicator Statement: Proportion of patients with schizophrenia who are in each of the following categories:

1) In continuous treatment with antipsychotic medication
2) In intermittent treatment with antipsychotic medication
3) Not on antipsychotic medication but having mental health provider visits with a documented relapse monitoring plan,
4) Not on antipsychotic medication but having mental health provider visits without a documented relapse monitoring plan
5) Lost to follow-up or leave treatment against medical advice

Indicator Number: 6

Executive Summary: This indicator is based on an indicator developed by the American Psychiatric Association (APA) as documented in the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) database, which assigned to it an evidence level of AHRQ Level C ("Little research evidence, principally based on clinical consensus/opinion"). The original APA indicator applied to patients with schizophrenia diagnoses who are in the stable phase and have been discontinued from antipsychotic medications during a specified period; the indicator assessed those patients whose medical record contains a written relapse-monitoring plan designed for use in recognizing and responding to early signs of new episodes. Under the advisement of the VA Mental Health Evaluation Consultation Group, the denominator and the numerator for this indicator have both been modified and expanded to more broadly describe the full complement of patients with Schizophrenia who are not taking medication, as well as those who are, including those in continuous or intermittent treatment and those who are lost to follow-up or leave treatment against medical advice. This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness, Timeliness, and Efficiency.

Numerator: Patients from the denominator who are:

1) In continuous treatment with antipsychotic medication during the study period;
2) In intermittent treatment with antipsychotic medication during the study period;
3) Not on medication but having mental health provider visits with a documented relapse monitoring plan during the study period;
4) Not on medication but having mental health provider visits without a documented relapse monitoring plan during the study period; or
5) Lost to follow-up or leave treatment against medical advice during the study period.

Denominator: All patients with schizophrenia diagnosis

Patient cohorts: Patients with schizophrenia diagnosis

Strength of Evidence: Grade III

Definitions:
- Continuous treatment: Defined as having 300 or more days supplied of an antipsychotic during the study period
  - CN700, Antipsychotics
• Intermittent treatment: Defined as having less than 300 days but more than 60 days supplied of an antipsychotic during the study period and have at least 2 prescriptions (e.g., one 90-day prescription doesn’t count).
  o CN700, Antipsychotics
  o CN701, Phenothiazine/Related Antipsychotics
  o CN709, Antipsychotics, Other
• Not on medication: Defined as having less than 60 days supplied of an antipsychotic during the study period
  o CN700, Antipsychotics
  o CN701, Phenothiazine/Related Antipsychotics
  o CN709, Antipsychotics, Other
• Relapse monitoring plan: Evidence of a plan designed for use in recognizing and responding to incipient signs of decompensation and/or new episodes and educating the patient on what to do if they were to emerge. This might be in the form of a list of prodromal symptoms or early warning signs and a list of strategies available to the patient to deal with them (e.g., taking prn medications or instructions to call for help or report to the ER if symptoms persist). This would need to be documented quarterly.
• Lost to follow-up: More than 3 months without a visit for people not on medication (NOTE: This will come from admin data)
• Leave treatment against medical advice: A note in the medical record documenting that the patient was leaving treatment against medical advice. For inpatient, a note in the chart or standard form.

Feasibility/Data Collection Issues:
• Denominator from administrative data
• Numerator from administrative data and medical record.
• Numerator categories are mutually exclusive
• Numerators #3 and #4 are collapsed into a single numerator due to medical record abstraction issues.
**BIPOLAR DISORDER**

Performance Measure Technical Documentation

**Module:** Bipolar Disorder  
**Indicator Statement:** Percent of patients with bipolar disorder diagnosis with evidence of an initial assessment that includes appraisal for alcohol and chemical substance use in a new treatment episode  
**Indicator Number:** 1

**Executive Summary:** This indicator is based directly on Measure 4 of the evidence-based measures developed by the STABLE Project (Specifications for Bipolar Disorder Performance Measures, updated November 2006) to specifically assess quality of care for patients with Bipolar diagnoses. The following research-supported statements and related references constitute STABLE’s clinical rationale for this indicator:

- Between 40-70% of people with bipolar disorder have a history of substance use disorder  
- A current or past comorbid substance use disorder may lead to worse outcomes for bipolar disorders, including more symptoms, more suicide attempts, longer episodes and lower quality of life  
- Substance abuse may obscure or exacerbate mood swings that have no other apparent external cause  
- Substance abuse may also precipitate mood episodes or be used by patients to self-treat in an attempt to improve the symptoms of episodes

This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness and Timeliness.

**References:**
Ostacher, MJ; Sachs, GS, Update on Bipolar Disorder and Substance Abuse: Recent Findings and Treatment Strategies, J Clin Psychiatry 2006; 67[9]:e10  
American Psychiatric Association, Practice Guideline for the Treatment of Patients with Bipolar Disorder, Am J Psychiatry 159: 4, April 2002 Supplement

**Numerator:** Patients from the denominator who receive an initial assessment for bipolar disorder that includes assessment of alcohol and chemical substance use within 30 days after the start of a new treatment episode.

**Denominator:** Patients with bipolar disorder in a new treatment episode

**Patient cohorts:** Patients with bipolar disorder

**Strength of Evidence:** Grade III

**Definitions:**
- New Treatment Episode: See the Key Definitions Document  
- Initial assessment that includes appraisal for alcohol and chemical substance use: Documented assessment to include at least one of the following:
Clinician documentation regarding presence or absence of alcohol and chemical substance use

Patient completed history/assessment form that addresses alcohol and chemical substance use that is documented as being noted/acknowledged by clinician performing the assessment

Use of screening tools that address alcohol and chemical substance use including AUDIT-C and CAGE-AID

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from medical record data
Module: Bipolar Disorder

Indicator Statement: Annual assessment of weight or BMI, glycemic control, and lipids

Indicator Number: 2

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guidelines for Management of Psychoses. The VA guideline recommends that patients receive a clinical assessment every 6-12 months during long-term therapy that includes assessment of weight, lipids, and glycemic control. The guideline provides the following rationale for this recommendation:

Antipsychotic medications, in particular the second generation antipsychotic medications, may be associated with weight gain and possible dysregulation of blood glucose and lipids. Baseline and periodic monitoring of blood glucose, serum lipids, blood pressure and BMI would be prudent particularly in those persons identified as having diabetes, or who are at increased risk for developing diabetes, or those with other known risk factors for cardiovascular disease. These measures may help guide initial selection of antipsychotic medications, improve early detection of the need for medical intervention, and enhance ongoing reevaluation of the appropriateness of psychiatric medications.

This indicator is supported by a number of related evidence-based measures specific to patients with bipolar disorder developed by the STABLE (STAndards for BipoLar Excellence) Project (Specifications for Bipolar Disorder Performance Measures, updated November 2006), A.M. Kilbourne et al. (Journal of Affective Disorders, 2007), and by Marcus et al. (1999) as documented in the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) database. A short list of these related measures follows:

• STABLE (Endorsed by National Quality Forum (NQF)): Percentage of patients with bipolar diagnosis with evidence of screening for hyperglycemia within 16 weeks / 6 months after initiating treatment with an atypical antipsychotic agent.
• STABLE (Future NQF submission): Percentage of patients with bipolar diagnosis with evidence of assessment for hyperlipidemia within 16 weeks after initiating treatment with an atypical antipsychotic agent.
• Marcus et al: Blood level monitoring with mood stabilizers for bipolar disorder
• AM Kilbourne et al: Percent of patients with bipolar diagnosis receiving lipid tests on or within 6 months after receiving atypical antipsychotic medication (Cardiovascular disease risk monitoring)
• AM Kilbourne et al: Percent of patients with bipolar diagnosis receiving serum glucose level test on or within 6 months after receiving atypical antipsychotic medication (Cardiovascular disease risk monitoring)

This indicator addresses the following Institute of Medicine (IOM) domains: Safety and Timeliness.

Numerator: Patients from denominator who have had an assessment of weight/BMI, glycemic control, and lipids during the study period

Denominator: This indicator will be evaluated for the following populations:

1. Patients with bipolar disorder
2. Patient with bipolar disorder who are taking a mood stabilizer or antipsychotic
**Patient cohorts:** Patients with bipolar disorder

**Strength of Evidence:** Grade II

**Definitions:**
- **Weight/BMI:** Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.
- **Glycemic control:** Defined as a glucose (‘0010’, ‘0057’) or hemoglobin A1C (‘0017’) laboratory test in the DSS Clinical National Data Extracts. “Passing” this indicator requires only one or the other test for glycemic control during the study period although all tests will be tracked from administrative data.
- **Lipids:** Defined as a LDL (‘0027’), HDL (‘0028’), total cholesterol (‘0029’), or triglycerides (‘0030’) laboratory test in the DSS Clinical National Data Extracts. “Passing” this indicator requires only total cholesterol or LDL cholesterol during the study period but all lab tests will be tracked from administrative data.

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from administrative data (lipids and glycemic control) and medical record data (weight/BMI)
Module: Bipolar Disorder

Indicator Statement: Assess medication side effects between the second and fourth month after the initiation of an antipsychotic or mood stabilizer

Indicator Number: 3

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guidelines for Management of Psychoses. The VA guideline recommends that clinicians should assess patients after 6-8 weeks of pharmacology, and that the assessment should "consider a range of antipsychotic drug side effects in assessing clinical response." The VA guideline recommendation has been modified in the current indicator insofar as the time period has been extended to 2-4 months after initiation of psychopharmacology to encompass the related VA guideline recommendation to reassess side-effects "to determine if treatment may need to be modified," which has no specific time period stated in the VA guideline or in the related American Psychiatric Association (APA) guideline (2002 and 2005 update); this was determined by the VA Mental Health Program Evaluation Consultation Group to be a reasonable and valid time period for assessment.

The VA guideline recommends assessing a number of relevant side effects in patients with bipolar diagnoses, and provides the following rationale:

Antipsychotic medications, in particular the second generation antipsychotic medications, may be associated with weight gain and possible dysregulation of blood glucose and lipids.

Both sedation and weight gain are listed elsewhere in the same VA guideline as "Side Effects of Conventional and Second Generation Antipsychotics."

After reviewing the VA guideline recommendations, the VA Mental Health Program Evaluation Consultation Group, in concert with non-VA clinical experts in bipolar disorder, determined that the current indicator should focus on weight/BMI and excessive sedation as the two highest priority side effects for the bipolar patient population, both in terms of prevalence and of importance in providing safe and effective care. Still, we will evaluate assessment of other side effects, if noted. This indicator addresses the following IOM domains: Effectiveness, Patient-centeredness, Timeliness, and Safety.

Numerator: Patients from the denominator whose medication side effects (SE) have been assessed in the two to four months after the initiation of an antipsychotic or mood stabilizer, including:

1) Excessive Sedation
2) Other side effects

Denominator: Patients with bipolar disorder diagnosis in a new treatment episode who have been started on an antipsychotic or mood stabilizer

Patient cohorts: Patients with bipolar disorder diagnosis

Strength of Evidence: Grade II
Definitions:

- New Treatment Episode: See the Key Definitions Document
- Antipsychotic or Mood Stabilizer treatment: Defined as having at least one prescription filled within 30 days of the index visit following the start of a new treatment episode using the following drug class codes, while excluding patients who filled a prescription within 90 days before the new treatment episode (to identify patients newly started on the medication):
  - CN400, Anticonvulsants
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
  - CN750, Lithium Salts
- Excessive Sedation: Patient looks or reports being sleepy, tired, drowsy, takes too many naps, can't stay awake, lethargic, etc
- Other side effects: This may include akathisia, tremor, acne, nausea, diarrhea, polyuria (increased urine production), polydipsia (increased thirst), hypothyroidism, polycystic ovary syndrome (PCOS), drying/thinning of hair, skin rash, headache, cognitive dulling
  - Note: If documentation notes no side effects, this is also acceptable.

Feasibility/Data Collection Issues:

- Denominator will come from administrative data
- Numerator will come from medical record data
- Weight/BMI collected from the first date when it is recorded in the study period rather than 2 to 4 months after the initiation of a mood stabilizer or antipsychotic medication.
Performance Measure Technical Documentation

Module: Bipolar Disorder

Indicator Statement: Percent of patients with a Global Assessment of Functioning (GAF) score less than or equal to 40 and 4 or more visits with a case manager during a year

Indicator Number: 4

Executive Summary: This indicator is based on an indicator developed by Young et al. (1998), as documented in the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) database, which assigned to it an evidence level of AHRQ Level C ("Little research evidence, principally based on clinical consensus/opinion). The indicator is supported by findings presented by Niv, Cohen, Sullivan, and Young (2007) regarding the "reliability and convergent, discriminant, and predictive validity" of the Global Assessment of Functioning (GAF) scale in a sample of patients with schizophrenia or schizoaffective disorder who received VHA care.
Young et al. provide the following rationale:

Case management services may be provided to individuals with schizophrenia to assist in coordinating mental health care, medical care, and community-based services such as housing benefits and rehabilitative care. Three recent, comprehensive reviews have been conducted on the effectiveness of case management. One examined case management models collectively, including intensive programs such as Assertive Community Treatment (ACT), and found strong evidence for effectiveness. The other two reviews looked separately at case management programs other than ACT, finding a lack of conclusive evidence supporting effectiveness for these programs.

The majority of this evidence was generated for people with severe mental illness, a term that although variably defined, is interpreted here (as elsewhere) as inclusive of severely impaired people with schizophrenia or bipolar diagnoses. This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness, Efficiency, Timeliness, and Safety.

Numerator: For patients in the denominator:
   c) those who have four or more visits with a case manager following their first eligible GAF score
   d) total number of visits with a case manager following the first eligible GAF score for 12 months following the first visit with a case manager.

Denominator: Patients with bipolar diagnosis with at least two Global Assessment of Functioning (GAF) scores 30 or more days apart from each other with scores of less than or equal to 40 during the study period.

Patient cohorts: Patients with bipolar disorder

Strength of Evidence: Grade III

Definitions:
   • Global Assessment of Functioning (GAF): (scale of 0-100)
     o 91-100: Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms
81-90: Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).

71-80: If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social occupational, or school functioning (e.g., temporarily falling behind in schoolwork).

61-70: Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social occupational, or school functioning (e.g., occasional truancy or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.

51-60: Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41-50: Severe symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

31-40: Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).

21-30: Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).

11-20: Some danger of hurting self or others (e.g., suicidal attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).

1-10: Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death OR Inadequate information.

Visits with a case manager: Any diagnosis-related visits (primary or secondary diagnosis) with mental health providers who do not have prescribing privileges (e.g., social workers, addiction therapists, psychologists, RNs, psychiatric technicians, etc.). These will be defined using the provider codes (PROV1-PROV10) available in the Medical SAS Outpatient Dataset:

Provider codes: 010000-010600, 070101, 070102, 070807, 070901, 070947, 070953

Feasibility/Data Collection Issues:
- Denominator will come from medical record data
- Numerator will come from administrative data
• We can evaluate this indicator for those who have a GAF of 40 or less, for those with a GAF greater than 40, and for those with no GAF or where the GAF is documented but a score is not recorded.
Performance Measure Technical Documentation

Module: Bipolar Disorder

Indicator Statement: Proportion of patients with bipolar disorder who are in each of the following categories during the study period:

- 6) In continuous treatment with mood stabilizer medication
- 7) In intermittent treatment with mood stabilizer medication
- 8) Not on mood stabilizer medication but having mental health provider visits with a documented relapse monitoring plan,
- 9) Not on mood stabilizer medication but having mental health provider visits without a documented relapse monitoring plan
- 10) Lost to follow-up or leave treatment against medical advice

Indicator Number: 5

Executive Summary: This indicator is based on two separate indicators developed by the British Medical Association’s (BMA) Quality and Outcomes Framework (QOF; February 2006) and the American Psychiatric Association (APA) as documented in the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) database. The original BMA measure assessed “the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance.” BMA provided the following rationale:

For many patients with mental health problems, the most important indicators relate to the inter-personal skills of the doctor, the time given in consultations and the opportunity to discuss a range of management options. Within the 'patient experience' section of the quality framework (see the original measure documentation), there exists the opportunity to focus patient surveys on particular groups of patients. This would be one way in which a practice could look in more detail at the quality of care experienced by people with mental health problems. ... Poor compliance with medication is well recognised [sic], and it is estimated that around 50% of people with schizophrenia do not always take their medication regularly. This may lead to relapse, hospitalization and poorer outcome (Cserransky and Schuchart, 2002). There is also evidence to suggest that non-attendance at appointments may be interpreted by some practices as "irrationality," as part of having a serious mental illness, rather than recognising that not turning up for an appointment may be a sign of relapse (Lester et al., 2005).

The VA Mental Health Program Evaluation Consultation Group determined that the object of the BMA measure might be more effectively achieved by modifying a similar APA indicator for patients with schizophrenia diagnoses. The original APA indicator assessed those patients whose medical record contains a written relapse-monitoring plan designed for use in recognizing and responding to early signs of new episodes. Under the advisement of the VA Mental Health Program Evaluation Consultation Group, the denominator and the numerator for the APA indicator were modified and expanded to more broadly describe the complement of patients with who are not taking medication, as well as those who are. On the strength of the original BMA measure, the VA Mental Health Program Evaluation Consultation Group also determined that this indicator could reasonably apply to patients with bipolar diagnoses. This indicator addresses the
following Institute of Medicine (IOM) domains: Effectiveness, Efficiency, Timeliness, and Safety.

**Numerator:** Patients from the denominator who are:
6) In continuous treatment with mood stabilizer medication during the study period;
7) In intermittent treatment with mood stabilizer medication during the study period;
8) Not on medication but having mental health provider visits with a documented relapse monitoring plan during the study period;
9) Not on medication but having mental health provider visits without a documented relapse monitoring plan during the study period; or
10) Lost to follow-up or leave treatment against medical advice during the study period.

**Denominator:** Patients with bipolar disorder

**Patient cohorts:** Patients with bipolar disorder

**Strength of Evidence:** Grade I

**Definitions:**
- **Continuous treatment:** Defined as having 300 or more days supplied of a mood stabilizer during the study period
  - CN400, Anticonvulsants;
  - CN750, Lithium Salts;
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
- **Intermittent treatment:** Defined as having less than 300 days but more than 60 days supplied of mood stabilizer during the study period and have at least 2 prescriptions (e.g., one 90-day prescription doesn’t count).
  - CN400, Anticonvulsants;
  - CN750, Lithium Salts;
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
- **Not on medication:** Defined as having less than 60 days supplied of a mood stabilizer during the study period
  - CN400, Anticonvulsants;
  - CN750, Lithium Salts;
  - CN700, Antipsychotics
  - CN701, Phenothiazine/Related Antipsychotics
  - CN709, Antipsychotics, Other
- **Relapse monitoring plan:** Evidence of a plan designed for use in recognizing and responding to incipient signs of decompensation and/or new episodes and educating the patient on what to do if they were to emerge. This might be in the form of a list of prodromal symptoms or early warning signs and a list of strategies available to the patient to deal with them (e.g., taking prn medications or instructions to call for help or report to the ER if symptoms persist). This would need to be documented quarterly.
- **Lost to follow-up:** More than 3 months without a visit for people not on medication (this information will come from the administrative data).
• Leave treatment against medical advice: A note in the medical record documenting that the patient was leaving treatment against medical advice. For inpatient, a note in the chart or standard form.
• Licensed mental health provider: See the Key Definitions Document

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from administrative data and medical record data
• Numerator categories are mutually exclusive
POST TRAUMATIC STRESS DISORDER (PTSD)

Performance Measure Technical Documentation

**Module:** Post Traumatic Stress Disorder (PTSD)

**Indicator Statement:** Assess PTSD symptoms with a standardized measure/instrument

**Indicator Number:** 1

**Executive Summary:** The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress and on the findings of Greenberg, Rosenheck, & Fontana (2003), which have shown that the assessment of PTSD Symptoms (using the Short Form of Mississippi Scale for Combat-related PTSD & NEPEC PTSD scale) is related to outcomes of primary interest in PTSD treatment. Elsewhere, Fontana and Rosenheck (1994) addressed the importance of using standardized instruments to assess PTSD symptoms across “multiple domains of functioning, while at the same time minimizing the overall length of the data collection protocols.” The VA Mental Health Program Evaluation Consultation Group endorsed this finding, and recommended that the use of standardized PTSD symptom assessment instruments be used more frequently and consistently across all VHA care services for patients with PTSD diagnoses.

The VA clinical guideline for PTSD does recommend and provide evidence supporting a thorough assessment of PTSD symptoms for patients in both primary and mental health specialty care settings (Lagomasino et al., 1999; Williams & Shepherd, 2000), but does not specifically recommend that standardized assessment instrument be used in all cases. The VA Mental Health Program Evaluation Consultation Group has found that the current use of standardized instruments is generally confined to formal PTSD programs and that medical record chart data is unreliable for tracking PTSD symptoms and outcomes, and therefore recommended that this indicator be developed and implemented to address this issue. This indicator addresses the following IOM domains: Effectiveness and patient-centeredness.

**References:**

**Numerator:** Patients in the denominator who have an assessment of PTSD symptoms within the first 30 days of a new treatment episode.

**Denominator:**
   a) PTSD patients with a new treatment episode
b) PTSD patients with a new treatment episode that begins in specialty mental health care.

Patient cohorts: Patients with PTSD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Specialty mental health: See the “Key Definitions” document; defined as one or more visits to eligible specialty mental health providers within the first 30 days following the start of a new treatment episode.
• Assessment of PTSD symptoms: This may be done by standardized measure/instrument or by interview. Most commonly used assessment instruments may be the PCL and CAPS.

Adult PTSD Self Reports:
  • Posttraumatic Diagnostic Scale (PDS)
  • PTSD Checklist (PCL)
  • Revised Civilian Mississippi Scale for PTSD (R-CMS)
  • Screen for Posttraumatic Stress Symptoms (SPTSS)
  • Trauma Symptom Checklist – 40 (TSC-40)
  • Trauma Symptom Inventory (TSI)
  • Purdue PTSD Scale – Revised (PPTSD-R)
  • Davidson Trauma Scale (DTS)
  • Distressing Events Questionnaire (DEQ)
  • Impact of Events Scale – Revised (IES-R)
  • Los Angeles Symptom Checklist (LASC)
  • Mississippi Scale for Combat-Related PTSD (M-PTSD, M-PTSD-DS)
  • Modified PTSD Symptom Scale (MPSS-SR)
  • Penn Inventory for Posttraumatic Stress Disorder (Penn Inventory)

Adult PTSD Interviews:
  • PTSD Symptom Scale – Interview (PSS-I)
  • Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID PTSD Module)
  • Structured Interview for PTSD (SI-PTSD)
  • Clinician-Administered PTSD Scale (CAPS)

Assessment of PTSD symptoms by interview; includes an assessment of presence or absence of each the following:
  • Re-experiencing of event – Intrusive thoughts, nightmares, flashbacks, intense psychological distress or physiological reactivity at internal or external cues, etc.
  • Avoidance/social disengagement – Efforts to avoid related thoughts, places, or people, diminished interest in significant activities, feeling of detachment or estrangement from others, restricted range of affect, sense of foreshortened future, etc.
  • Symptoms of increased arousal – Difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response, etc.
This indicator is NOT satisfied with use of a standardized PTSD screening instrument [e.g., Primary Care PTSD (PC-PTSD), Trauma Screening Questionnaire (TSQ)] or a trauma exposure measure [Potential Stressful Events Interview (PSEI), Evaluation of Lifetime Stressors (ELS)].

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from medical record data
- We will collect data about the specific tools used and the scores on those tools.
- We will document whether assessment was done by standardized assessment measure/instrument or by interview. In analysis, we will evaluate whether those in specialty mental health received a standardized assessment measure/instrument. For those in a new treatment episode without qualification (denominator a), we will evaluate whether they received any assessment as well as whether assessment was from interview or a standardized assessment.
Performance Measure Technical Documentation

Module: Post Traumatic Stress Disorder (PTSD)
Indicator Statement: Complicated PTSD with a new treatment episode of PTSD with no care by a licensed mental health provider
Indicator Number: 2

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress. This indicator will be used for descriptive purposes. The VA Clinical Practice Guideline for PTSD recommends the following:

1. Primary care patients with complex PTSD should be referred to mental health specialty care for treatment.
2. Primary care patients with severe PTSD should be offered initiation of therapy or referred to mental health specialty care for treatment.
3. Primary care patients with PTSD with functional impairment because of acute physiological symptoms (e.g. arousal) should be offered initiation of therapy or referred to mental health specialty care for treatment.

This indicator was developed to assess the extent to which these recommendations are implemented in VHA primary care settings. In doing so, the definition of applicable patients was modified insofar as patients with "complex" or "severe" PTSD, or with "functional impairment because of acute physiological symptoms" has been operationally defined as "PTSD patients with SUD or mental health comorbidity," under the advisement of the VA Mental Health Program Evaluation Consultation Group. This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

References:

Numerator: Patients in the denominator with no care by a licensed mental health provider within 30 days of the start of the new treatment episode

Denominator: PTSD patients with a new treatment episode who also have any mental health comorbidity (MDD, SUD, Bipolar Disorder, or Schizophrenia) or risk behaviors

- MDD
- SUD
- Bipolar disorder
- Schizophrenia (includes other psychotic disorders, as per table 1B)
- Active suicidal ideation/Suicidal behavior (Suicide module)
- Recent assaultive behavior (e.g., last week)

Patient cohorts: Patients with PTSD diagnosis

Strength of Evidence: Grade III

Definitions:
- New Treatment Episode: See the “Key Definitions” document
• Licensed mental health provider: See the “Key Definitions” document, defined as any diagnosis-related visit (primary or secondary diagnosis using Table 1B from the Key Definitions Document) with a licensed mental health provider
  o Any notation of patient refusal for a referral constitutes a pass on this indicator
• Denominator is populated with those veterans who have one or more of the bulleted characteristics as defined below:
  o Mental health comorbidity: Defined as two or more diagnosis-related encounters for MDD, bipolar disorder, schizophrenia, or SUD (primary or secondary diagnosis using Table 1B of the Key Definitions Document) in the six months prior to the start of the new treatment episode
  o Risk Behaviors: Defined as documentation of positive assessment within 14 days of the start of the new treatment episode
    ▪ Recent assaultive behavior: Notation in the chart within 14 days of the start of the new treatment episode on whether the patient exhibited recent assaultive behavior
    ▪ Active Suicidal Ideation or suicidal behavior: Notation in the chart on whether the patient is actively considering or fantasizing about taking his own life. This may range from vague urges to detailed plans about the act. Only those who exhibit these behaviors within 30 days of the NTE should be included. [NOTE: This comes from the Suicide Module and reflects the first instance in the study period, and is not indexed to the NTE]

Feasibility/Data Collection Issues:
• Denominator will come from administrative and medical record data
• Numerator will come from medical record (refusal, referral) and administrative data (mental health provider visit)
• Refusals: Data will be collected separately about patient refusals of specialty mental health care referrals.
• Not completed referrals: Data will be collected separately about referrals to mental health specialty care that were made but not completed during the study period.
• Denominator data can be collected with suicide module, but as the first time it is seen in the study period; if the patient had more than one episode of suicidal ideation or suicidal behavior, we will only know about the first instance in the study period.
Performance Measure Technical Documentation

Module: Post Traumatic Stress Disorder (PTSD)
Indicator Statement: Proportion of all patients with a new PTSD episode who are assessed for depression
Indicator Number: 3

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress. The VA Clinical Practice Guideline for PTSD recommends that all patients with ASD/PTSD be assessed for "historical patterns of risk for psychiatric comorbidities" and provides evidence to support this recommendation (Davidson et al., 1991 Farrell et al., 1995 Weisberg et al., 2002) (B-5,B-7). The guideline further recommends that providers "recognize that ...mental disorders, and psychosocial problems commonly coexist with PTSD and should screen for them during the evaluation treatment of PTSD" and that primary care providers in particular should "consider the existence of comorbid conditions when deciding whether to treat patients in the primary care setting or refer them for specialty mental health care." According to the guideline:

Comorbid psychiatric conditions are important to recognize, because they can modify clinical determinations of prognosis, patient or provider treatment priorities, and setting where PTSD care will be provided. ...Providers should also expect that 50 to 80 percent of patients with PTSD have one or more coexisting mental disorders. Some comorbid medical or psychiatric conditions may require early specialist consultation, in order to assist in determining treatment priorities. In some cases, these disorders may require stabilization before (or in concert with) initiating PTSD treatment.

Specifically regarding depression, the guideline further states that, "while many mild to moderate illnesses may not necessarily present situations mandating immediate attention, the presence of severe depressive symptoms may represent a medical emergency, even in the absence of suicidal ideation." Although the guideline does recommend assessing a range of psychiatric comorbidities, this indicator has been developed to address only depression because it is the most prevalent psychiatric comorbidity found in populations with diagnoses of PTSD, and because standardized instruments for assessing depression are available to facilitate reliable and valid assessments. This indicator addresses the following IOM domain: Effectiveness.

References:

Numerator: Patients in the denominator who are assessed for presence or absence of comorbid depression within 30 days after the start of the new treatment episode
Denominator: PTSD patients with a new treatment episode

Patient cohorts: Patients with PTSD diagnosis

Strength of Evidence: Grade III

Definitions:
- New Treatment Episode: See the “Key Definitions” document
- Assessed for depression: Any documentation of the presence or absence of depression, or any assessment of mood, either by formal assessment (standardized tool) or by interview. Standardized tools for screening and/or assessment include:
  - PRIME-MD: 2-question screen
  - PHQ-2: 2-question Patient Health Questionnaire
  - PHQ-9: 9-question Patient Health Questionnaire
  - BDI: Beck Depression Inventory
  - BDI-S: (13-item version)
  - CEB-D: 5-item brief version developed for patients ≥ 60 years old
  - CES-D: Center for Epidemiologic Studies-Depression Scale (5, 10, or 20-item version)
  - MOS Depression Questionnaire: Medical Outcomes Study Depression Questionnaire
  - IDS-SR_30: Inventory of Depressive Symptomatology 30 item screener
  - QIDS-SR_16: Quick Inventory of Depressive Symptomatology 16 item screener
  - HRSD_{17}: Hamilton Rating Scale for Depression 17 item screener
  - HRSD_{21}: Hamilton Rating Scale for Depression 21 item screener
  - HRSD_{24}: Hamilton Rating Scale for Depression 24 item screener
  - MADRS: Montgomery Asberg Depression Rating Scale
  - Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID MDD Module)
  - SSDS-PC
  - SIGECAPS mnemonic may also be used. This collects the symptoms of depression from the DSMIV.
    - S: sleep disturbance
    - I: Interest/pleasure reduction
    - G: Guilt feelings or thoughts of worthlessness
    - E: Energy changes/fatigue
    - C: Concentration/attention impairment
    - A: Appetite/weight changes
    - P: Psychomotor disturbances
    - S: Suicidal thoughts
- Informal assessment includes documentation of the presence or absence of depressive symptoms (e.g., sad mood, suicidal thoughts, hopelessness, etc.).

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record
Performance Measure Technical Documentation

Module: Post Traumatic Stress Disorder (PTSD)
Indicator Statement: Cognitive Behavioral Therapy (CBT) for PTSD
Indicator Number: 4

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress and on the strong evidence base supporting the use of Cognitive Behavioral Therapy (CBT) as an effective evidence-based therapy for PTSD. This indicator addresses the following IOM domain: Effectiveness. The 2004 VA Clinical Practice Guideline for PTSD identifies Cognitive Therapy as a psychotherapy intervention that is of "significant benefit" in the pursuit of reducing symptoms severity and improving the global functioning of patients with PTSD (I-17). The guideline advises that Cognitive Therapy is "strongly recommended for treatment of PTSD in military & non-military populations" (I-18). The guideline provides substantial evidence in support of the claim that "Randomized controlled trials (RCTs) have shown that CT is an effective intervention for patients with PTSD" (I-20).

CBT combines elements of cognitive and behavioral approaches, emphasizing both behavioral changes and changes in negatively biased patterns of cognition. CBT is structured and time-limited and is typically at least 12 sessions in duration, but can be as short as 9 sessions for certain manualized treatment approaches (e.g., CBT for PTSD, Foa & Rothbaum, 1998) and significantly longer when treating personality disorders (e.g., Cognitive-Behavioral Treatment of Borderline personality disorder, Linehan, 1993). CBT has instructional components and makes use of homework assignments. Cognitive behavioral therapy is based on the concept that thoughts, feelings, and behaviors, are interrelated and each influences the other. CBT is a collaborative effort between the therapist and the client. Cognitive behavioral therapists try to understand the functional relationship between thoughts, feelings, and behaviors. They also encourage their clients to treat thoughts as hypotheses about the world, question their negative thinking, and develop more helpful thinking patterns. Cognitive behavioral therapists have a specific agenda for each session. Specific techniques / concepts are taught during each session. CBT focuses on helping the client achieve the goals they have set and training skills that can help to prevent recurrence of problems in the future.

References:

Numerator: Patients in the denominator who receive:
   a) Any Cognitive Behavioral Therapy (CBT) visits (including behavioral therapy and cognitive therapy) in the study period, and
b) The number of CBT visits received in the year after the first CBT visit from the same CBT provider

**Denominator:** Patients with PTSD diagnosis who are receiving psychotherapy

**Patient cohorts:** Patients with PTSD diagnosis

**Strength of Evidence:** Grade I

**Definitions:**
- Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
- Cognitive Behavioral Therapy: For PTSD, techniques used in CBT include:
  - *Discussion of thoughts related to the traumatic event(s) and cognitive restructuring* (e.g., discussing the connection between thoughts and feelings, treating thoughts as hypotheses about the world, evaluating the evidence supporting or disproving a certain thought, finding cognitive distortions in thoughts, creating rational/helpful alternative thoughts for a negative thought, Socratic questioning).
  - *Education about PTSD symptoms and diagnosis* (e.g., discussion of common reactions to traumatic events, discussion of the role of avoidance in maintaining PTSD symptoms, discussion of the role of thoughts in maintaining PTSD symptoms, discussion of relationship between trauma and patient's specific symptoms).
  - *Anxiety management techniques* (e.g., relaxation training, breathing training).
  - *Conducted exposure to reduce anxiety related to trauma reminders* (e.g., in vivo, imaginal, flooding, prolonged, directed, interoceptive, EMDR) during the session or discussion of exposure conducted as homework.
  - *Emotion regulation* (e.g., acceptance of negative emotions, tolerating the present moment, developing a non-judgmental stance).
  - *Collaboratively determined homework* for veteran to practice skills learned in session
  - *Help with activity monitoring and scheduling* (e.g., having patient monitor his/her activities for a specific period of time, discussing the connection between rewarding activities and mood, determining activities patient finds pleasurable and/or provide him/her with sense of mastery, scheduling these activities as homework).
  - *Training in coping skills*, such as assertiveness and problem solving
  - *Relapse prevention* (e.g., discussion about how to deal with symptom recurrence, anniversaries of the trauma, traumas that may occur in the future).
  - *Education about CBT* for PTSD (e.g., providing patient with a rationale for treatment, i.e., why a certain CBT technique works to reduce PTSD symptoms).
  - *Discussion of homework* assigned during previous session and problem-solving regarding homework non-compliance.

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from the medical record
Performance Measure Technical Documentation

Module: Post Traumatic Stress Disorder (PTSD)

Indicator Statement: Proportion of patients with PTSD diagnosis who are monitored regarding symptom severity

Indicator Number: 5

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress. The VA guideline recommends "regular follow-up with monitoring and documentation of symptom status" in the treatment of PTSD in both primary care and specialty mental health settings. In discussing the regularity of monitoring, the guideline recommends that patients be assessed “every three months after initiating treatment for PTSD, in order to monitor changes in clinical status and revise the intervention plan accordingly. The interval of three months is suggested because many controlled trials of first line therapies for PTSD recommended in this guideline demonstrate clinically significant changes during this time frame.” This indicator reflects these recommendations as applied to PTSD-diagnosed patients in a new treatment episode.

The VA Clinical Practice guideline recommendations were modified slightly under the advisement of the VA Mental Health Program Evaluation Consultation Group. Although the VA Consultation Group was doubtful that standardized measures/ instruments to monitor PTSD symptoms are used broadly across VA settings, they nevertheless endorsed the importance of recommending the widespread VA implementation of such tools in the future. Currently, VA Clinical Experts believe that such standardized PTSD measures/instruments are used only in PTSD-specific treatment settings. The 2004 VA Clinical Practice Guideline for PTSD supports this by recommending that "The use of a pencil-paper measure of PTSD symptom severity such as the PTSD Checklist should be considered. Scores on the PCL may be serially over time to create a longitudinal record of symptom severity and may be helpful for recognizing environmental or seasonal precipitants of PTSD symptoms." This indicator addresses the following IOM domains: Safety, Timeliness, and Effectiveness.

References:

Numerator: Patients in the denominator who have an assessment of PTSD symptom severity by standardized instrument
  a) New Treatment Episode: At least every 3 months for the first year, and

Denominator: a) PTSD patients with a new treatment episode
  b) All PTSD patients

Patient cohorts: Patients with PTSD diagnosis

Strength of Evidence: Grade III
Definitions:

- New Treatment Episode: See the “Key Definitions” document
- Assess PTSD symptom severity: Must use a standardized tool. The most commonly used instruments may be the PCL and CAPS. Standardized tools for assessing PTSD symptoms include:
  - Adult PTSD Self Reports:
    - Posttraumatic Diagnostic Scale (PDS)
    - PTSD Checklist (PCL)
    - Revised Civilian Mississippi Scale for PTSD (R-CMS)
    - Screen for Posttraumatic Stress Symptoms (SPTSS)
    - Trauma Symptom Checklist – 40 (TSC-40)
    - Trauma Symptom Inventory (TSI)
    - Purdue PTSD Scale – Revised (PPTSD-R)
    - Davidson Trauma Scale (DTS)
    - Distressing Events Questionnaire (DEQ)
    - Impact of Events Scale – Revised (IES-R)
    - Los Angeles Symptom Checklist (LASC)
    - Mississippi Scale for Combat-Related PTSD (M-PTSD, M-PTSD-DS)
    - Modified PTSD Symptom Scale (MPSS-SR)
    - Penn Inventory for Posttraumatic Stress Disorder (Penn Inventory)
  - Adult PTSD Interviews:
    - PTSD Symptom Scale – Interview (PSS-I)
    - Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID PTSD Module)
    - Structured Interview for PTSD (SI-PTSD)
    - Clinician-Administered PTSD Scale (CAPS)

This indicator is NOT satisfied with use of a standardized PTSD screening instrument [e.g., Primary Care PTSD (PC-PTSD), Trauma Screening Questionnaire (TSQ)] or a trauma exposure measure [Potential Stressful Events Interview (PSEI), Evaluation of Lifetime Stressors (ELS)]. This indicator is NOT satisfied by non-standardized assessment.

Feasibility/Data Collection Issues:

- Denominator will come from administrative data
- Numerator will come from medical record data
- In analysis, we will separate out by:
  - All PTSD patients, and
  - Those PTSD patients in specialty mental health
- Medical record abstractors will collect the dates of the first 5 assessments after the PTSD new treatment episode.
Performance Measure Technical Documentation

Module:  Post Traumatic Stress Disorder (PTSD)

Indicator Statement: Proportion of patients with PTSD diagnosis who receive an adequate trial of selective serotonin reuptake inhibitors (SSRIs)

Indicator Number:  6

Executive Summary: This indicator is based on recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress. The guideline "strongly recommend[s] selective serotonin reuptake inhibitors (SSRIs)" as monotherapy for the treatment of PTSD, and assigns this recommendation an "A" grade, defined as "a strong recommendation that the intervention is always indicated and acceptable" based on "high grade evidence directly linked to health outcome" and "more than a small relative impact on a frequent condition with a substantial burden of suffering; or a large impact on an infrequent condition with a significant impact on the individual patient level" (AA-3, AA-4). The guideline provides extensive rationale and evidence supporting the use of SSRIs, including but not limited to the following excerpt:

Antidepressants, particularly serotonergic reuptake inhibitors, have proved effective in treating PTSD, and have been recommended as first-line agents in treatment guidelines (Davidson et al., 2001; Brady et al., 2000; Foa et al., 2000; Foa et al., 1999). Sertraline is the best-studied of the SSRIs, with four studies of over 100 participants each showing a significant response to the drug (Brady et al., 2000;).

This indicator addresses the following IOM domains: Effectiveness, Efficiency, and Timeliness.

References

Numerator: Patients in the denominator who receive a trial of SSRIs for ≥ 60 days or have a documented reason for discontinuing SSRI treatment in < 60 days of the start of
the SSRI trial (patient refusal, discontinued for medical reasons, not an appropriate candidate).

**Denominator:** Patients with PTSD with a new treatment episode who are in:
- a. Specialty mental health care and who are not receiving psychotherapy
- b. Any type of care and who are not receiving psychotherapy
- c. Any care

**Patient cohorts:** Patients with PTSD diagnosis

**Strength of Evidence:** Grade I

**Definitions:**
- New Treatment Episode: See the “Key Definitions” document
- Specialty mental health: See the “Key Definitions” document – two or more visits within 90 days of the start of the new treatment episode.
- Patients who are not receiving psychotherapy:
  - Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
  - Patients with fewer than 4 diagnosis-related psychotherapy visits within 60 days of the start of the SSRI trial defines a patient not receiving psychotherapy
- SSRI trial: Two or more consecutive 30-day prescriptions or one 90-day prescription for an SSRI/SNRI (associated NDC codes can be found in the Key Definitions Document):
  - SSRIs:
    - Citalopram
    - Escitalopram
    - Fluoxetine
    - Fluvoxamine
    -Paroxetine
    -Sertraline
  - SNRIs:
    - Duloxetine
    - Venlafaxine
- Date of start of SSRI trial: Defined as the date of the first prescription filled for an SSRI as defined above

**Feasibility/Data Collection Issues:**
- Numerator will come from administrative (SSRI treatment) and medical record data (Initial SSRI refusal, reason for early SSRI discontinuation – side effects, notation that patient is not a candidate for SSRI treatment – rule out bipolar or concerns about serotonin syndrome). Collect each type separately.
- Denominator will come from administrative data (new treatment episode, no psychotherapy).
- SSRI for 6 consecutive weeks within a calendar year will be counted for the numerator
- In analysis, compare PTSD cohort with cohort that has PTSD and MDD.
- Dosage of SSRI considered not as important as the duration of treatment.
Performance Measure Technical Documentation

Module: Post Traumatic Stress Disorder (PTSD)
Indicator Statement: Reduction in target symptoms during the new treatment episode
Indicator Number: 7

Executive Summary: This indicator is based on an indicator proposed by VA in the PTSD Appendix A to support PTSD Program Outcome #5 (“VA patients should attain reduction or remission of target symptoms”), and has been modified and developed with the VA Mental Health Program Evaluation Consultation Group (February - August 2007). In the PTSD Appendix A, VA proposed measuring "reduction in target symptoms, e.g., hyper-arousal, trauma re-experiencing, avoidance of associated stimuli, reduction in suicide risk, documented GAF scores, side effects " with the following data sources: "medical record, GAF scores, SF-36 data, SHEP." There do not appear to be any previously developed performance indicators that support the use of these measurements in evaluating quality of care. However, clinical experts in PTSD and in general mental health care, both internal and external to VA, endorsed the currently developed indicator as being high-priority, relevant, useful, and meaningful within the VA system. There are, however, caveats associated with utilizing this indicator. It is likely that this indicator can only be reliably and validly recorded if a standardized instrument is used, yet it is unlikely that such standardized instruments are currently in use in most applicable VA care settings for patients with PTSD diagnoses. This indicator addresses the following IOM domains: Effectiveness, Timeliness, and Efficiency.

Numerator: Patients in the denominator who within the 3-months following a new treatment episode have a documented reduction in score from a standardized measure/instrument

Denominator: PTSD patients with a new treatment episode and at least two standardized assessments using the same tool within 90 days of the start of the new treatment episode

Patient cohorts: Patients with PTSD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Standardized measure/instrument: Collect all for 90 days after start of new treatment episode (up to a maximum of 5 per NTE). The most commonly used instruments may be the PCL and CAPS. Standardized tools for assessing PTSD symptoms include:
  • Adult PTSD Self Reports:
    • Posttraumatic Diagnostic Scale (PDS)
      o Total severity score: 0-51 (may be documented as scores in each of 4 parts of the scale which will total no more than 51)
      o Can also be scored with an algorithm as PTSD =yes/no
    • PTSD Checklist (PCL)
      o Total score: 17-85, based on a 17-item instrument. (NOTE: If some of the 17 items are not answered, score will be <17)
Can also be scored with the DSM-IV criteria, or a combination of DSM-IV and total score
Separate scores can also be obtained for Criteria B, C, and D

- Revised Civilian Mississippi Scale for PTSD (R-CMS)
  - Total score: 30-150, based on a 30-item instrument (see note for PCL).
- Screen for Posttraumatic Stress Symptoms (SPTSS)
  - Score: 0-10, based on average of 17 items rated from 0-10
- Trauma Symptom Checklist – 40 (TSC-40)
  - Total score: 0-120
- Trauma Symptom Inventory (TSI)
  - Uses a proprietary scoring algorithm, not based on a total score. Assessment with this instrument should include a score report. Recommend coding this as PTSD diagnosis = Yes/No, or score report = present/absent for simplicity.
- Purdue PTSD Scale – Revised (PPTSD-R)
  - Total score: 17-85 (see note for PCL)
  - Can also be scored with an algorithm as PTSD =yes/no
- Davidson Trauma Scale (DTS)
  - Frequency score: 0-68
  - Severity score: 0-68
  - Total score: 0-136
- Distressing Events Questionnaire (DEQ)
  - Renamed the PTSD Screening and Diagnostic Scale (PSDS) according to a 2000 study
  - Total score: 0-68
  - Can also be scored with DSM-IV symptom criteria and documented as PTSD =yes/no
- Impact of Events Scale – Revised (IES-R)
  - Total score: 0-88
- Los Angeles Symptom Checklist (LASC)
  - Total score: 0-172
  - Can also be scored with an algorithm as PTSD =yes/no
- Mississippi Scale for Combat-Related PTSD (M-PTSD, M-PTSD-DS)
  - Total score: 35-175
- Modified PTSD Symptom Scale (MPSS-SR)
  - Total score: 0-51, or severity: A-D
- Penn Inventory for Posttraumatic Stress Disorder (Penn Inventory)
  - Total score: 0-78

Adult PTSD Interviews:
- PTSD Symptom Scale – Interview (PSS-I)
  - Total score: 0-51
  - Can also be scored with an algorithm as PTSD =yes/no
- Structured Clinical Interview for the DSM-IV Axis I Disorders (SCID PTSD Module)
  - No total score, diagnosis is made using an algorithm; see comments for TSI. Assessment with this instrument should include a score report.
- Structured Interview for PTSD (SI-PTSD)
  - Total score: 0-68
Can also be scored with an algorithm as PTSD =yes/no
  • Clinician-Administered PTSD Scale (CAPS)
    • Several scoring methods are in use, including a total score and an algorithm.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data (standardized tool scores)
• In analysis, decision will have to be made on what reduction in score will count.
• For analysis, we may want to look at this by specialty care vs. all care.
MAJOR DEPRESSIVE DISORDER (MDD)

Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)
Indicator Statement: Percentage of patients whose severity of MDD was classified during the initial assessment period using a reasonable instrument
Indicator Number: 1

Executive Summary: The following indicator comes from the Physician Consortium for Performance Improvement Major Depressive Disorder Physician Performance Measurement Set, released by American Medical Association on behalf of the Physician Consortium for Performance Improvement in October 2003 and revised August 2005. The original specifications do not provide any description of the instruments or other means through which patient severity of MDD disorder should be assessed. Therefore, this indicator has been revised to include specific mention of “reasonable instruments” for this purpose. The Physician Consortium for Performance Improvement provides primarily general rationale for this indicator, but does indicate that “Despite potential risks and established clinical guidelines, recent data suggest that some patients are not being managed optimally for this disease.” This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

Numerator: Patients from the denominator whose severity of major depressive disorder was classified within 30 days of a new treatment episode using a reasonable instrument

Denominator: Patients with MDD diagnosis in a new treatment episode

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Classification: The following instruments would count for classification:
  o PHQ-9: 9 question Patient Health Questionnaire
  o BDI: Beck Depression Inventory
  o CES-D: Center for Epidemiologic Studies-Depression Scale
  o MOS Depression Questionnaire: Medical Outcomes Study Depression Questionnaire
  o IDS-SR30: Inventory of Depressive Symptomology 30 item screener
  o QIDS-SR16: Quick Inventory of Depressive Symptomology 16 item screener
  o HRSD17: Hamilton Rating Scale for Depression 17 item screener
  o HRSD21: Hamilton Rating Scale for Depression 21 item screener
  o HRSD24: Hamilton Rating Scale for Depression 24 item screener
  o MADRS: Montgomery Asberg Depression Rating Scale
  o SCID: Structural Clinical Interview for DSM IV (MDD module)
  o In addition, notation in the record as to degree of severity (i.e., “moderate severity,” “severe depression”) would count
SIGECAPS mnemonic may also be used. This collects the symptoms of depression from the DSMIV.

- S: Sleep disturbance
- I: Interest/pleasure reduction
- G: Guilt feelings or thoughts of worthlessness
- E: Energy changes/fatigue
- C: Concentration/attention impairment
- A: Appetite/weight changes
- P: Psychomotor disturbances
- S: Suicidal thoughts.

**Feasibility/Data Collection Issues:**

- Denominator will come from administrative data
- Numerator will come from medical record data
- For data collection, we will collect the type of screener used as well as whether degree of severity comes from a note in the record without an instrument. This will allow us to see if there are differences when an instrument is used
- We will represent the numerator two ways: 1) Patients from the denominator with a quantitative symptom assessment and 2) Patients from the denominator with a qualitative symptom assessment.
Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)
Indicator Statement: Proportion of MDD patients with a new treatment episode who have an initial and follow-up quantitative symptom assessment.
Indicator Number: 2

Executive Summary: The following indicator comes from the 2005 Health Resources and Services Administration (HRSA) Health Disparities Collaborative (HDC) Depression Collaborative Measures set. This measure is one of 8 additional recommended measures in the HRSA Health Disparities Collaborative for Depression, and is based on AHRQ guidelines, which suggest that if there is no response at 6 weeks treatment needs to be changed or augmented. HRSA HDC provides the following rationale:

Depression care in the United States is even more fragmented than care of other chronic illnesses, creating a major gap between the recommended guidelines for care and actual care. It is estimated that only 19 percent—fewer than 1 in 5—of people with depression who see their primary care provider receive appropriate, guideline-based care. Improving depression care is not only a matter of meeting the typical challenges of providing good chronic illness care—following people over time rather than responding to acute episodes, providing systematic follow-up to ensure that patients adhere to treatment plans, and so on. In addition, depression care brings its own complex set of challenges, ranging from underdiagnosis to financial disincentives for providers to special treatment requirements because the underlying nature of the illness frequently undercuts patients' ability to be effective managers of their own care.

The title of the original HRSA HDC indicator was: “Depression: percent of clinically significant depression patients who have a documented Current Patient Health Questionnaire (PHQ) reassessment between 4 to 8 weeks after their last New Episode PHQ.” This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

Numerator: Patients from the denominator with a documented quantitative symptom assessment:
1) Initial: Within 30 days following the start of the new treatment episode; AND
2) At follow-up: Between the second and fourth month after new episode assessment

Denominator: Patients with MDD diagnosis in a new treatment episode

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See Key Definitions document
• Quantitative symptom assessment may include:
  o PHQ: Patient Health Questionnaire
  o BDI: Beck Depression Inventory
  o CES-D: Center for Epidemiologic Studies-Depression Scale
  o MOS Depression Questionnaire: Medical Outcomes Study Depression Questionnaire
  o IDS-SR30: Inventory of Depressive Symptomology 30 item screener
o QIDS-SR16: Quick Inventory of Depressive Symptomology 16 item screener
o HRSD17: Hamilton Rating Scale for Depression 17 item screener
o HRSD21: Hamilton Rating Scale for Depression 21 item screener
o HRSD24: Hamilton Rating Scale for Depression 24 item screener
o MADRS: Montgomery Asberg Depression Rating Scale
o SIGECAPS mnemonic may also be used. This collects the symptoms of depression from the DSMIV.
  • S: Sleep disturbance
  • I: Interest/pleasure reduction
  • G: Guilt feelings or thoughts of worthlessness
  • E: Energy changes/fatigue
  • C: Concentration/attention impairment
  • A: Appetite/weight changes
  • P: Psychomotor disturbances
  • S: Suicidal thoughts.

Feasibility/Data Collection Issues:
• The denominator will come from administrative data
• The numerator will come from medical record data
• Realistically, nurses will see only the PHQ, BDI and CES-D, so we will give them copies of these three. However, all would count towards the indicator if seen.
• SIGECAPS is not a quantitative assessment. This will be grouped with other qualitative notations.
Module: Major Depressive Disorder (MDD)
Indicator Statement: If a new diagnosis of depression is made, specific comorbidities should be elicited and documented in the record, including presence or absence of:

   a) Alcohol or other drug use;
   b) Medication use; and
   c) History of bipolar symptoms

Indicator Number: 3

Executive Summary: The primary source for this indicator is Kerr & Clarke 1997 #2 (Depression Guideline Panel, 1993a & 1993b). This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness. Kerr & Clarke’s rationale for the original indicator is as follows:

   Practitioners need to consider the presence of other co-morbidities prior to making a diagnosis of major depression. Other factors that may contribute to the patient's mental health and which the clinician may want to treat first include: substance abuse, medications that cause depression, general medical disorder, causal, non-mood psychiatric disorder and/or grief reaction (AHCPR, 1993a). The clinician should also consider alternative diagnoses by eliciting a proper patient history. Examples of alternative diagnoses include: bipolar disorder (if the patient manifests prior manic episodes) (4).

The original Kerr & Clarke indicator has been modified by the addition of 2 comorbidities identified by the 2002 VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder as important. The guideline recommends that initial patient assessments "differentiate unipolar from bipolar depression" because "A past history of mania or hypomania excludes a patient from a diagnosis of MDD. These patients may require referral to a mental health professional. These patients often need specialist’s treatment and follow-up, since initiating or titrating routine antidepressant medication can precipitate a manic episode" (36). Similarly, the guideline also recommends that initial assessments identify patients who may be experiencing depressed symptoms as a result of an underlying medical condition such as trauma, for the following reasons:

   "Simultaneous treatment is often required for both the medical problem and psychiatric symptoms. Additionally, there is often a strong association between the level of disability from the medical condition and the depressive symptom requiring treatment" (51).

Numerator: Patients from the denominator who are assessed for presence or absence of the following comorbidities:

   a) Alcohol or other drug use within 30 days following the start of either the MDDNTE or SUDNTE, whichever happens second;
   b) Medication use within 30 days on or after the MDD NTE; and
   c) History of bipolar symptoms within 30 days before or after the MDD NTE.

Denominator: Patients with MDD diagnosis in a new treatment episode

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade III
Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Alcohol and drug use: Documentation of no recent alcohol and no recent drug use
  OR information about recent alcohol and drug use including type, quantity, and
  frequency for all substances used. (COLLECTED IN CROSS CUTTING MODULE IN
  ABSTRACTION)
• Type: Specifically ask about alcohol, marijuana, cocaine, heroin/narcotics,
  methamphetamine/stimulants, intravenous drug use; or note about denying all other
  drug use
• Quantity (only needed for alcohol): May include note in chart on any of the following:
  Number of drinks per day, number of drinks per week, any note about binge drinking
  (>5 drinks per day), any evidence of quantity
• Frequency: Note about daily, monthly, weekly, or occasional use
• Medication use: List of medication that the patient is currently taking. Notation in the
  record that the patient is not on any medications would count
• Bipolar symptoms: Presence or absence of signs of mania and depression.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• For medication use, we may want to consider validating any notes that say there is
  not medication use with pharmacy data.
• We are making the assumption that the treating provider read all related notes within
  the 30 day window. Therefore, we are allowing a look back period of 30 days prior to
  the NTE for those questions pertaining to historical information.
Performance Measure Technical Documentation

Module:  Major Depressive Disorder (MDD)
Indicator Statement:  Past psychiatric history of MDD
Indicator Number:  4

Executive Summary:  The following indicator comes from Wells et al., 1993, as cataloged in the National Inventory of Mental Health Quality Measures developed by the Center for Quality Assessment & Improvement in Mental Health. Wells et al., 1993 provided the following rationale for this indicator:

A psychiatric history is an important part of an inpatient admission assessment, with implications for diagnosis, treatment, and discharge planning. Clinical practice guidelines recommend that this assessment include previous episodes of psychiatric illness (including symptoms, functioning and duration) and previous treatment (including dose, duration & response).

The title of the original indicator was “Assessment of Psychiatric History in Treating Depression,” and was restricted to inpatients ages 65 years and older. The original indicator has been modified to include assessment of family psychiatric history and has been extended to all new patients with a diagnosis of major depression, regardless of age. This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

Numerator:  Patients from the denominator who received assessment of lifetime psychiatric history of MDD within 30 days of the new treatment episode (before, after or on).

Denominator:  Patients with MDD diagnosis in a new treatment episode

Patient cohorts:  Patients with MDD diagnosis

Strength of Evidence:  Grade III

Definitions:
- New Treatment Episode:  See the “Key Definitions” document
- Assessment of psychiatric history of MDD:  only includes personal history of MDD (indication of recurrence and treatment response history); should be found in the progress notes; only seeing history of other psychiatric comorbidities without notes on MDD history would not count. Should also think about ways to capture treatment history, especially to see if there is an adequate medication history in the chart.

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data
- The documentation of past history must be included in the new assessment to count.
Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)
Indicator Statement: Proportion of patients with MDD diagnosis that received Cognitive Behavioral Therapy (CBT)
Indicator Number: 5

Executive Summary: This indicator has been developed based on the strength of the evidence bases supporting Cognitive Behavioral Therapy (CBT) and Interpersonal Psychotherapy as effective therapies for major depression. CBT combines elements of cognitive and behavioral approaches, emphasizing both behavioral activation and changes in negatively biased patterns of cognition. This approach has the most research supporting its effectiveness for immediate gains during current episode and long term benefit in preventing future episodes of illness. CBT is structured and time-limited, and is at least 12 sessions in duration. The evidence base for CBT is strongest for major depression but robust evidence also exists for schizophrenia. Interpersonal Psychotherapy focuses on clarification and resolution of difficulties in relationships, exploring losses, role disputes and transitions, and social skills deficits. Supporting documentation and rationale for these two therapies is cited in the 2002 VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder, as well as in a number of other sources, including but not limited to the following:


This indicator addresses the following IOM domains: Effectiveness.

Numerator: Patients from the denominator:
a) Receiving any Cognitive Behavioral Therapy (CBT) visits (including Behavioral Therapy and Cognitive Therapy) in the study period, and
b) The number of CBT visits received

Denominator: Patients with MDD diagnosis receiving any psychotherapy

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade I - Although there is substantial robust evidence that CBT is effective for MDD, we must also remain aware that evidence is still unclear regarding the optimal dose/duration of this treatment.

Definitions:
• Any Psychotherapy Visits (for defining the denominator population): See the Key Definitions Document
• Cognitive Behavioral Therapy (CBT): CBT for Major Depressive Disorder (MDD) is typically at least 12 sessions in duration
  o Discussion of thoughts and feelings that may contribute to depression
  o Discussion of behaviors that may contribute to depression
  o Discussion of cognitive model of depression
  o Teach skills to manage depression, such as reattribution, increasing participation in enjoyable activities
  o Education about diagnosis of depression
  o Collaboratively determine homework for veteran to practice skills learned in session.
    • Helped veteran with activity monitoring and scheduling (e.g., completing an activity monitoring chart, recording activity pleasure ratings, developing an activity schedule)
    • Asked veteran to do things that he/she enjoyed doing between sessions
    • Practice skills learned in session, write down daily activities, write down thoughts, behavioral experiments, behavioral activation, etc.
  o Assist veteran in questioning negative thoughts and developing new more adaptive thoughts; help veteran create statements that he/she could use to respond to negative thoughts (e.g., practicing rational responses using reattribution or alternative reasoning)
  o Help veteran understand the beliefs or assumptions behind his/her thinking (e.g., core beliefs, cognitive schemas, patterns in thinking).

CBT combines elements of cognitive and behavioral approaches, emphasizing both behavioral activation and changes in negatively biased patterns of cognition. CBT is structured and time-limited and is typically at least 12 sessions in duration. CBT has instructional components and makes use of homework assignments. Cognitive behavioral therapy is based on the concept that thoughts, feelings, and behaviors, are interrelated and each influences the other. CBT is a collaborative effort between the therapist and the client. Cognitive behavioral therapists want to gain a very good understanding of their clients’ concerns, and they typically ask questions to obtain understanding of the client’s experience and perspectives. They also encourage their clients to ask questions of themselves. Cognitive behavioral therapists have a specific agenda for each session. Specific techniques / concepts are taught during each session. CBT focuses on helping the client achieve the goals they have set and training skills that can help to prevent recurrence of problems in the future.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• The definition of CBT above is provided to help abstractors identify the dates of CBT sessions. For data collection, we will not require that all components of the description be present.
• This is a descriptive measure about the number of CBT visits. While CBT is typically 12 visits, the indicator does not require that there be exactly 12 visits identified.
• In analysis, we will stratify primary care and mental health to look at the number of visits in each.
• Those patients with NTE will have these questions re-abstracted using revised study period dates. We will rely on administrative data to pick up number of visits for CBT by the same provider, looking backward and forward one year.
Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)

Indicator Statement: Assessment of degree of response/remission, side effects and adherence/compliance of medication

Indicator Number: 6

Executive Summary: The primary source for this indicator is Kerr and Clarke 1997 #13 (Depression Guideline Panel, 1993a & 1993b). Kerr and Clarke's justification includes the following:

The Depression Guideline Panel recommended follow-up visits at 12-week intervals, but did not have any evidence about optimal timing. At each visit during which depression is discussed, the degree of response/remission and side effects of medication should be assessed and documented during the first year of treatment (AHCPR, 1993a).

Kerr and Clarke further commented that "Even effectively treated patients may relapse or develop toxicities to medications. While most persons will be off of medications after one year, the optimal time to remove medications is still not well established." The benefits associated with this indicator were described as: "Alleviate symptoms of depression. Reduce toxicities of medication. Reduce remission." The original indicator title, as follows, was worded almost identically to the title as it currently stands: "At each visit during which depression is discussed, degree of response/remission and side effects of medication should be assessed and documented during the first year of treatment." This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

Numerator: Patients from the denominator for which there is documentation describing assessment of degree of response/remission, side effects of and adherence/compliance to medication in the period two to four months following the start of the new treatment episode

Denominator: Patients with MDD in a new treatment episode on medication

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade III

Definitions:
- Depression diagnosis: See Table 1B in the Key Definitions Document
- New Treatment Episode: See the "Key Definitions" document
- Patients on Medication: Defined as patients with one or more 30-day prescriptions filled for an antidepressant in the three months after the start of the new treatment episode using the following VA Drug Class Codes:
  - CN600, Antidepressants
  - CN601, Tricyclic Antidepressants
  - CN602, Monamine Oxidase Inhibitor Antidepressants
  - CN609, Antidepressants, Other
  - CN750, Lithium Salts.
• Degree of response/remission and adherence/compliance:
  o Progress note that indicates patient is doing better or feels okay or is not doing better or doesn’t feel okay.
• Side effects of medication: presence or absence of side effects noted in the record.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• A list of side effects for the abstractors will be developed in case providers name them without calling them side effects
• Abstractors are collecting additional information; first date of each month, allowing up to 12 dates. We will analyze the additional information descriptively.
Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)

Indicator Statement: Documentation that the follow-up visit between the second and fourth month includes assessment of response

Indicator Number: 7

Executive Summary: The following indicator is based on clinical care recommendations in the 2002 VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder. The VA guideline for recommends frequent assessments of side effects/adherence every 1-2 weeks; this indicator reflects a less stringent timeframe of 2-4 months. This indicator addresses the following IOM domains: Safety, Timeliness, and Effectiveness.

Numerator: Patients from the denominator with a licensed mental health provider at which MDD is the primary or secondary diagnosis and during which there was assessment and documentation of response to outpatient group and/or individual MDD psychotherapy in the period two to four months following the start of the new treatment episode

Denominator: Patients with MDD in new treatment episode who are in psychotherapy

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade III

Definitions:
- New Treatment Episode: See the “Key Definitions” document
- Licensed Mental Health Provider: See the “Key Definitions” document
- Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document in the two months following the start of the new treatment episode
- Response: Note in the chart about effectiveness or lack thereof of medication or treatment.

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data
- Abstractors are collecting additional information; first date of each month, allowing up to 12 dates. We will analyze the additional information descriptively
- For analysis, look at:
  - Whether person had 12-week follow up (can happen between 8-20 weeks)
  - Whether there was assessment and documentation of response, side effects, and adherence.
Performance Measure Technical Documentation

Module: Major Depressive Disorder (MDD)

Indicator Statement: Rates of Inappropriate Level of Care: Complicated MDD with no care by a licensed mental health provider

Indicator Number: 8

Executive Summary: The following indicator is based on clinical care recommendations in the 2002 VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder. The VA guideline recommends that patients in Primary Health Care should be referred to and treated by a mental health provider if there is any evidence of psychosis, history of mania, active suicidal ideation, suicidal behavior, or psychiatric comorbidity. The VA guideline provides extensive guidance to support this recommendation. This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

Numerator:
 a) Patients from the denominator with no care by a licensed mental health provider within 3 months of the start of the new treatment episode
 b) Patients from the denominator with no care by a licensed mental health provider within 30 days of the notation of positive suicidal ideation or suicidal behavior

Denominator:
 a) Patients with MDD diagnosis in a new treatment episode for whom there is evidence of any of these categories in the thirty days on, after, or before the start of the new treatment episode:
   • Psychosis
   • Mania
 b) Patients with MDD who have positive suicidal ideation or suicidal behavior

Patient cohorts: Patients with MDD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Licensed mental health provider: See the “Key Definitions” document
• Psychosis: Notation in the record of psychosis/psychotic symptoms, hallucinations, delusions, or paranoia
• Mania: Notation about history of mania or current mania, including extremely elevated mood, energy and unusual thought patterns
• Active Suicidal Ideation or suicidal behavior: Notation in the chart on whether the patient is actively considering or fantasizing about taking his own life. This may range from vague urges to detailed plans about the act. (This information is abstracted from the medical records in the suicide module for the first instance of suicidal behavior or ideation recorded within the study period).

Feasibility/Data Collection Issues:
• Numerator comes from administrative data
• Denominator comes from the medical record and administrative data.
Module: Substance Use Disorder (SUD)
Indicator Statement: Comprehensive SUD Assessment: Recovery environment
Indicator Number: 1
Executive Summary: The following indicator comes from the 2001 VA/DoD Clinical Practice Guidelines for SUD. The VA Clinical Practice Guideline recommends that a comprehensive SUD Assessment and an assessment of goals should address each of the following 10 general categories for patients beginning a new treatment episode (ASAM, 1996; Senay, 1997; Strauss, 1995):
1. Patient's demographics and identifying information, including housing, legal, and occupational status
2. Patient's chief complaint and history of the presenting complaint
3. Recent substance use and severity of substance-related problems
4. Lifetime and family history of substance use
5. Co-morbid psychiatric conditions and psychiatric history
6. Social and family context
7. Developmental and military history
8. Current medical status and medical history, including risk for HIV or hepatitis C
9. Mental status and physical examinations
10. Patient's perspective on current problems and treatment goals or preferences
This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness and patient-centeredness.

References:

Numerator: Patients from the denominator who have their recovery environment assessed within 30 days of the start of the new treatment episode

Denominator: Patients with SUD diagnosis with a new treatment episode in specialty mental health care

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade III
Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Specialty mental health: Defined as one or more diagnosis-related visits within 30 days of the start of the new treatment episode (see the “Key Definitions” document for the provider codes associated with specialty mental health)
• Assessment of recovery environment includes assessing
  1) who lives with the patient or provides social support
  2) Whether or not their social supports/people they live with are alcohol or drug users
  3) Whether these people support their recovery (if they are noted to be users themselves, this would count as assessment)

If the provider documents that the patient is/is not motivated, this does NOT qualify.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• Chart abstractors will look forward 30 days into the record from the start of the new treatment episode for relevant information
• Limiting sample to those in specialty mental health care will be done during the analysis phase
• The date of the first diagnosis-related visit (primary or secondary diagnosis) at the start of each new treatment episode will be provided from administrative data for chart abstraction.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Assessment for PTSD in specialty care
Indicator Number: 2

Executive Summary: The following indicator is based on recommendations regarding comprehensive SUD assessment in the 2001 VA/DoD Clinical Practice Guidelines for SUD. These recommendations have been expanded here to include a specific screening for PTSD as part of the comprehensive SUD assessment. The rationale for screening for PTSD is due to the high comorbidity of both disorders among a veteran population. This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness and patient-centeredness.

Numerator: Patients from the denominator who have assessment for PTSD within 30 days of the start of the new treatment episode

Denominator: Patients with SUD diagnosis with a new treatment episode in specialty mental health

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Speciality mental health: Defined as one or more diagnosis-related visits within 30 days of the start of the new treatment episode (see the “Key Definitions” document for the provider codes associated with specialty mental health)
• Assessment for PTSD symptoms:
  A. Includes assessment of presence or absence of each the following (This does not require a standardized measure/instrument.):
    o Re-experiencing of event – Intrusive thoughts, nightmares, flashbacks, intense psychological distress or physiological reactivity at internal or external cues, etc.
    o Avoidance/social disengagement – Efforts to avoid related thoughts, places, or people, diminished interest in significant activities, feeling of detachment or estrangement from others, restricted range of affect, sense of foreshortened future, etc.
    o Symptoms of increased arousal – Difficulty falling or staying asleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, exaggerated startle response, etc.

*OR*

B. Screen for symptoms consistent with PTSD using a standardized screen such as the PCL/PC-PTSD

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• PC-PTSD recently implemented in the VA as of October 2007
• Chart abstractors will look forward 30 days into the record from the start of the new treatment episode for relevant information
• Limiting sample to those in specialty mental health care will be done during the analysis phase
• Chart abstractors are instructed to consider documentation of no history of trauma or traumatic event as evidence that the patient was evaluated for PTSD.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Conduct brief intervention at initial visits for patients with alcohol abuse or dependence
Indicator Number: 3

Executive Summary: The following indicator is based on recommendations in the 2001 VA/DoD Clinical Practice Guidelines for SUD. The Clinical Practice Guideline recommends the use of brief interventions to "promote reduced hazardous use of alcohol and other drugs and prevent future complications or dependence" and cites multiple sources of evidence to support this recommendation (e.g., Kaner, 2007). The guideline provides the following rationale:

Multiple randomized clinical trials have demonstrated the efficacy of brief interventions by physicians in primary care settings. Training in brief provider intervention has been demonstrated to increase rates of alcohol counseling in primary care when accompanied by real-time cues for screening and facilitative clinic support services (Adams et al., 1998; Buchsbaum et al., 1993). The guideline qualifies this recommendation in specialty care by acknowledging the following:

Considerable evidence shows that even brief interventions (i.e., one to four brief sessions) can be effective for many patients with alcohol dependence, particularly as early interventions for those with mild to moderate dependence severity (Finney & Moos, 1998 Wilk et al., 1997). Comparable findings have not been reported for brief intervention with other substance dependence (e.g., opioid and cocaine dependence), which typically require intensive treatment early in recovery (Crits-Cristoph & Siqueland, 1996).

This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

References:

Numerator for 1: Proportion of patients that have medical records documenting:
(a) Provider advice to drink less or abstain from alcohol and feedback was provided about risks of alcohol use to health condition or to general health during the study period.
OR
(b) Completed referral to specialty mental health during the study period.
OR
(c) Already in specialty care
OR
(d) All other patients

**Numerator for 2:** Proportion of patients that have medical records documenting:
(e) Within 30 days of the new treatment episode; provider advice to drink less or abstain from alcohol and feedback was provided about risks of alcohol use to health condition or to general health
OR
(f) Within 30 days of the new treatment episode; completed referral to specialty mental health
OR
(g) Started the new treatment episode in specialty care
OR
(h) All other patients

**Denominator:** This indicator is evaluated for the following populations:
1. All SUD patients with alcohol abuse or dependence within the study period;
2. All SUD patients with alcohol abuse or dependence in a new treatment episode

**Patient cohorts:** Patients with SUD diagnosis

**Strength of Evidence:** Grade I

**Definitions:**
- Alcohol Dependence and Alcohol Abuse: Defined as one or more encounters where relevant diagnoses (ICD-9 codes for 303.9 and 305.00) are the primary or secondary diagnosis
- Completed referral to specialty mental health: A diagnosis-related visit with a specialty mental health provider within 60 days of the first diagnosis-related visit (primary or secondary) during the study period
- Already in specialty mental health (Numerator 1): Defined as two or more outpatient encounters with a specialty mental health provider (see the Key Definitions Document for definition) in 90 days prior to the first diagnosis-related visit (primary or secondary diagnosis of 303.9 or 305.00) of any kind in the study period
- Provider advice to drink less or abstain from alcohol: Note in medical record that states that the provider and patient discussed the pros and cons of drinking less or abstaining, or note from provider stating that s/he recommended to the patient to drink less or abstain (e.g., recommendation may be documented in the treatment planning note), or referral to specialty SUD care or to the community (e.g., 12 step)
- Feedback was provided about risks of alcohol use to health condition or to general health: Note in medical record that states that the provider and patient discussed the risks associated with alcohol and the patient’s current medical condition and/or the provider referred the patient to primary care or a specialty medical clinic for health risks associated with alcohol use
Feasibility/Data Collection Issues:
- Denominator will come from administrative data.
- Numerator will come from medical record for part (a), administrative data for parts (b), (c), and (d).
- For people who had a new treatment episode in the last thirty days of the study period and who were abstracted before WVMI changed their abstraction method to follow them out a full year, the data are censored.
- Numerator 1a will be abstracted by medical record abstractors using an “or”, rather than an “and”, meaning that a pass is coded if the provider gives advice about drinking or provides feedback about risks.
**Module:** Substance Use Disorder (SUD)

**Indicator Statement:** Pharmacotherapy for alcohol dependence (a) offered, (b) filled, (c) refused, or (d) contraindicated

**Indicator Number:** 4

**Executive Summary:** The following indicator is based on recommendations in the 2001 VA/DoD Clinical Practice Guidelines for SUD. The Clinical Practice Guideline recommends identifying patients with alcohol dependence who should be considered for addiction-focused pharmacotherapy. The guideline states that there "are two medications currently approved for the treatment of alcohol dependence: naltrexone and disulfiram," and provisionally endorses acamprosate, which has since received more substantial empirical support and approval. In discussing this recommendation, the guideline provides the following background and rationale:

There are several factors to consider regarding what, if any, pharmacotherapy to use for alcohol dependence. First, there must be some motivation on the part of the patient to achieve and maintain abstinence. Pharmacotherapy is unlikely to work if patients are not willing to make a commitment to recovery. Second, patients should generally be in some kind of counseling or psychotherapy. There are exceptions to this, for example, a patient who has been abstinent for some time and is involved in self-help groups, but requires pharmacotherapy to help maintain abstinence. Third, compliance-enhancing procedures must be integrated into the treatment plan (Volpicelli et al., 1997; Pettinati et al., 2000).

Of the two medications currently available, naltrexone has stronger evidence of efficacy, especially in the first three months of abstinence. It should be routinely considered for patients beginning alcoholism treatment. Naltrexone should also be considered whenever a patient is able to maintain some abstinence, but is having difficulty with slips or cravings. Disulfiram should be considered more selectively. Monitored administration significantly improves compliance. Disulfiram should be considered whenever a patient requests it or when some form of monitoring is available. In clinical practice, it is sometimes used to provide additional support during periods of high risk of relapse. Evidence for its efficacy in combined cocaine and alcohol dependence is relatively strong (Carroll et al., 1998; McCance-Katz et al., 1998; George et al., 2000; Petrakis et al., 2000).

This indicator addresses the following Institute of Medicine (IOM) domains: Safety and effectiveness.

**References:**


**Numerator:** Patients from the denominator who were:
- a) offered a prescription for naltrexone, Antabuse (disulfiram) or acamprosate but did not fill within 30 days on or after the start of the new treatment episode OR
- b) offered a prescription and filled within 30 days of the start of the new treatment episode OR
- c) offered a prescription for naltrexone, Antabuse (disulfiram) or acamprosate but refused medication within 30 days on or after the start of the new treatment episode OR
- d) found to have documentation that prescription is contraindicated within 30 days on or after start of new treatment episode OR
- e) found to have no documentation of offer or refusal and no record of prescription being filled

**Denominator:** Patients with:
- a) alcohol dependence with a new treatment episode
- b) alcohol dependence in a new treatment episode and a comorbid mental health diagnosis (MDD, BP, Schiz, PTSD)

**Patient cohorts:** Patients with SUD diagnosis

**Strength of Evidence:** Grade I

**Definitions:**
- Alcohol Dependence: Defined as the primary diagnosis (ICD-9 code: 303.90) on the first outpatient visit following the start of the new treatment episode
- New Treatment Episode: See the "Key Definitions" document
- Comorbid mental health diagnosis: Use co-occurring disorder definition from Key Definitions Document
- Pharmacotherapy: Naltrexone or Antabuse (Disulfiram) or acamprosate (See Appendix A in Key Definitions Document for associated NDC codes)
- Filled prescription: One or more prescriptions filled within 30 days of start of new treatment episode
- Contraindications to naltrexone (ReVia): Currently receiving opioid analgesics, currently dependent on opioids including maintenance on opiate agonists (e.g., methadone); patient has failed the naloxone challenge test or has a positive urine screen for opioids; acute hepatitis or liver failure; history of sensitivity to naltrexone or its components; documentation that patient is not a candidate for this drug
- Contraindications to Antabuse (disulfiram): Severe myocardial disease or coronary occlusion; psychoses, hypersensitivity to disulfiram or its derivatives; patients receiving or have recently received metronidazole, paraldehyde, alcohol, or alcohol-containing preparations (e.g., cough syrup); documentation that patient is not a candidate for this drug
- Contraindications to acamprosate (Campral): Previously demonstrated hypersensitivity to acamprosate or it is compounds; severe renal impairment (Creatinine clearance ≤ 30 mL/min); documentation that patient is not a candidate for this drug
- Offered: Prescription written or notation in the chart that provider discussed using the medication with the patient
• Refused: Notation in the chart that the patient refused medication

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Filled prescriptions from the numerator will come from administrative data; offered or refused prescriptions will come from medical record data.
- We will collect refusals separately in order to assess the number of people offered treatment who did not accept it.
- A flag for patients with alcohol dependence (ICD-9 code: 303.90-303.92) as primary or secondary diagnosis will be provided from administrative data for chart abstraction.
- Remove those with alcohol abuse (ALAB) and only score this for those with alcohol dependence (ALDEP).
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Maintenance pharmacotherapy for opiate dependence at empirically based dosages (a) offered, (b) filled, (c) refused medication, or (d) contraindicated
Indicator Number: 5

Executive Summary: The following indicator is based on a recommendation in the 2001 VA/DoD Clinical Practice Guidelines for SUD to conduct pharmacotherapy management with patients with opioid dependence. Further, it differentiates the rates of offered medication and actual utilization. Information on empirically-based dosages and contraindications to Methadone are detailed in the Clinical Practice Guidelines; “Providers should adjust opioid agonist doses to maintain a therapeutic range between signs/symptoms of overmedication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability).” One anticipated sensitivity of this indicator is that a large number of opioid dependence diagnoses may be made inappropriately by primary care due to physical dependence as a function of pain management. This indicator addresses the following Institute of Medicine (IOM) domains: Safety and effectiveness.

Numerator: Patients from the denominator who were:
  a) offered Methadone or a prescription for buprenorphine at the empirically based dose but did not fill within 30 days on or after the start of the new treatment episode OR
  b) offered Methadone or a prescription for buprenorphine at the empirically based dose and filled within 30 days on or after the start of the new treatment episode OR
  c) offered Methadone or a prescription for buprenorphine at the empirically based dose but refused medication within 30 days on or after the start of the new treatment episode OR
  d) found to have documentation that prescription is contraindicated within 30 days on or after start of new treatment episode OR
  e) found to have no documentation of offer or refusal and no record of prescription being filled

Denominator: Patients with SUD diagnosis with opiate dependence with a new treatment episode

Patient cohorts: Patients with SUD diagnosis with opiate dependence

Strength of Evidence: Grade I

Definitions:
• Opiate Dependence: Defined as the primary diagnosis (ICD-9 code: 304.00-304.02, 304.7) on the first outpatient visit following the start of the new treatment episode
• New Treatment Episode: See the “Key Definitions” document
• Pharmacotherapy: Methadone or buprenorphine (including buprenorphine/ naloxene)
  o Methadone: Defined by one or more stop codes for opioid substitution (stop code: 523) within 90 days of the start of the new treatment episode
- Buprenorphine: SUBOXONE (CIII) is (buprenorphine HCl and naloxone HCl dihydrate sublingual tablets). SUBUTEX (CIII) is (buprenorphine HCl sublingual tablets). Buprenorphine is generic name and Subetex and Suboxone are trade names. Refer to Appendix A in the Key Definitions Document for the NDC codes associated with Buprenorphine.

- Filled prescription: One or more prescriptions filled within 30 days of start of new treatment episode
- Patient preference: For (c) above indication that patient preferred an alternative to long-term maintenance pharmacotherapy and was offered naltrexone as an opioid antagonist
- Contraindications to Methadone (from VA SUD CPGs): Allergy to agent, concurrent enrollment in another OAT, significant liver failure, and/or use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone) OR a note in chart that patient is not a candidate for this treatment
- Contraindications to Buprenorphine: SUBOXONE and SUBUTEX should not be administered to patients who have been shown to be hypersensitive to buprenorphine, and SUBOXONE should not be administered to patients who have been shown to be hypersensitive to naloxone. Also accept wording in the chart that patient is not a candidate for this treatment
- Empirically based dose:
  - Buprenorphine: Dose should reach 12 mg within first week OR chart should document justification for lower dose OR reason for discontinuation of buprenorphine
  - Methadone: Dose should reach 60 mg within the first month OR chart should document justification for lower dose (no evidence of relapse by urinalysis or self-report) OR reason for discontinuation of methadone
- Refused: Notation in the chart that the patient refused medication:

Feasibility/Data Collection Issues:
- Denominator will come from administrative data.
- Numerator: Filled prescriptions from the numerator will come from administrative data for buprenorphine; offered or refused prescriptions will come from the medical record. Methadone dosage and offered or refused or justification for lower dose, and discontinuation will all come from the medical record.
- We will collect refusals separately in order to assess the number of people offered treatment who did not accept it.
- A flag for patients where opiate dependence (ICD-9 code: 304.00-304.02, 304.70-304.72) as the primary or secondary diagnosis from administrative data for chart abstraction.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Opiate Agonist Therapy (OAT) as first line of defense for at least 90 days of treatment at beginning of a new treatment episode
Indicator Number: 6
Executive Summary: The following indicator comes from 2001 VA/DoD Clinical Practice Guidelines for SUD. The Clinical Practice Guideline recommends determining if "Opioid Agonist Therapy (OAT) is appropriate for and acceptable to the patient" with the objective of "careful consideration of OAT as the first line treatment for opioid dependence." The guideline provides the following discussion for this recommendation:

OAT is inaccurately considered by some providers to be a treatment of last recourse; however, evidence consistently shows that patients have better outcomes when maintained with an agonist than a placebo (Newman and Whitehall, 1979; Strain et al., 1993a; Strain et al., 1993b) or than when provided long-term detoxification (Sees et al., 2000). Discharge from OAT programs is generally followed by relapse and other adverse outcomes (Gerstein et al., 1994). Unless there are legal or other extenuating circumstances (such as active duty in DoD), OAT should be considered for any patient with a diagnosis of opioid dependence. For patients who previously relapsed, re-treatment should be a consideration. As part of the decision process, it is important to determine if appropriate agonist dosing was utilized and whether there were psychosocial barriers that could be better addressed upon re-attempting OAT.

This indicator addresses the following Institute of Medicine (IOM) domains: Safety and effectiveness.

References:
**Numerator:** Patients from denominator receiving 90 doses of OAT in the 90 days following the first dose

**Denominator:** Patients with opiate dependence who are initiating OAT within 30 days on or after the start of a new treatment episode

**Patient cohorts:** Patients with SUD diagnosis

**Strength of Evidence:** Grade I

**Definitions:**
- **New Treatment Episode:** See the “Key Definitions” document
- **Opiate Dependence:** Defined as the primary diagnosis (ICD-9 code: 304.00-304.02, 304.70-304.72) on the first outpatient visit following the start of the new treatment episode
- **Opiate Agonist Therapy (OAT):** Methadone, Buprenorphine; maintenance/duration of treatment should be indicated on the original order in the medical record; exclude people who are receiving opiate assisted detoxification or short-term taper.
- **Initiating OAT:** One or more methadone stop codes or 1+ prescriptions for buprenorphine within 30 days of start of a new treatment episode
  - Methadone treatment defined by stop code: 523
  - Buprenorphine: See Appendix A for related NDC codes

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator can come from medical record data or administrative data (we will pilot this indicator)
- Count number of Methadone visits in a 90 day period for data collection
- A flag for patients with opiate dependence (ICD-9 code: 304.00-304.02, 304.70-304.72) will be provided from administrative data for chart abstraction.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Proportion of patients in SUD that have a continuous SUD treatment involvement for at least:

1) Three months,
2) Six months, or
3) One year or longer at time of discharge

And rates of:
4) Program completion

Indicator Number: 7

Executive Summary: The following indicator comes from the Office of Quality Performance for 90-day treatment retention and has been revised to include multiple days in treatment. The Office of Quality Performance provides the following rationale:
Research has shown unequivocally that good addiction treatment outcomes are contingent on adequate lengths of treatment. There is no predetermined length of addiction treatment that assures success, but duration of treatment is the factor most consistently associated with successful addiction treatment outcome. Many patients drop out during the initial 90 days of treatment with limited clinical benefit and high rates of relapse. While two contacts per month for three months would rarely be sufficient, most patients require ongoing treatment for at least this duration to establish early remission. The initial intensity of treatment should be considered primarily as a means to promote treatment retention, e.g., severely dependent patients typically may require multiple treatment contacts per week in order to stabilize early remission. However, for many patients following initial stabilization, it may be appropriate to provide a lower intensity of addiction-focused treatment extending over a longer duration with superior remission rates for those who remain engaged in treatment for 6-12 months. Many individuals continue to benefit from treatment (e.g., methadone maintenance) over a period of years.

This indicator addresses the following Institute of Medicine (IOM) domains: Effective and efficiency.

Numerator: Number of patients in the denominator who EITHER completed the program OR had a continuous length-of-stay in the SUD specialty care of one visit beyond each time period:

1) Three months,
2) Six months, or
3) One year

And rates of:
4) Program completion

Denominator: Patients with SUD diagnosis in a new treatment episode in SUD specialty care

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade II
Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Specialty SUD care: Defined as a visit within 30 days of the start of the new
treatment episode where SUD is the primary diagnosis (Table 1B) and care takes
place in one of the following outpatient or inpatient settings:
  o Any specialty SUD care outpatient clinic visits as documented in the Key
    Definitions Document (with primary or secondary SUD diagnosis):
  o Any inpatient/residential treatment admission with the following bed
    section codes (with primary or secondary SUD diagnosis):
      ▪ 27 – Substance Abuse Residence Rehabilitation
      ▪ 29 – Substance Abuse Compensated Work Therapy/Transition
      ▪ 72 – Alcohol Dependence – High Intensity
      ▪ 73 – Drug Dependence – High Intensity
      ▪ 74 – Substance Abuse – High Intensity
      ▪ 84 – Psychiatric Substance Abuse (Intermediate Care)
      ▪ 86 – Domiciliary Substance Abuse
      ▪ 90 – Substance Abuse STAR I, II, and III
• Length of Stay:
  o Three months – 7+ SUD specialty visits or SUD-related inpatient
    admissions with a combined LOS of 7+ days
  o Six months – 13+ SUD specialty visits or SUD-related inpatient
    admissions with a combined LOS of 13+ days (1+ visits per quarter)
  o One year – 25+ SUD specialty visits (2+ visits per quarter) or SUD-related
    inpatient admissions with a combined LOS of 25+ days
• Completed the program: Note in the chart stating that patient completed program,
  including discharge summary or notation of graduation ceremony

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data and administrative data
• Program completion: Discharge or interim note (e.g., a note for patients transferring
  from inpatient to outpatient). Minimum frequency of visits is 2 times per month.
  Includes phone sessions. Date of program completion should follow start of new
  treatment episode. Any dates of completion that occur before the start of the new
  treatment episode will be ignored.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Proportion of patients with SUD diagnosis that received evidence-based cognitive behavioral Relapse Prevention Therapy (RPT) by the first provider of RPT.
Indicator Number: 8

Executive Summary: This indicator is based on the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Substance Use Disorders, which identifies cognitive behavioral relapse prevention therapy as an evidence-based psychosocial treatment for treatment of patients with SUD and provides descriptive evidence supporting its efficacy. According to the APA guideline, “psychosocial treatments are essential components of a comprehensive treatment program” (5). The guideline provides evidence supporting the efficacy of cognitive behavioral Relapse Prevention Therapy, including the following:

Relapse prevention is a treatment approach in which CBT techniques are used to help patients develop greater self-control to avoid relapse (Marlatt & Gordon, 1985; Annis & Davis, 1989). Specific relapse prevention strategies include discussing the patient’s ambivalence about the substance use disorder, identifying emotional and environmental triggers of craving and substance use, developing and reviewing specific coping strategies to deal with internal or external stressors, exploring the decision chain leading to reinitiation of substance use, learning from brief episodes of relapse (slips) about triggers leading to relapse, and developing effective techniques for early intervention ([Marlatt & Gordon, 1985], [Annis, 1986]). In more recent clinical trials ([Project MATCH, 1997], [O’Malley et al., 1992]), techniques drawn from cognitive therapy and relapse prevention have been combined with the aims of initiating abstinence and preventing relapse.

This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

References:

Numerator: Patients from the denominator who received:
a) Any evidence-based cognitive behavioral Relapse Prevention Therapy (RPT) in the study period
b) The number of RPT visits received in the year following the first RPT encounter by the same provider in (a)

**Denominator:** Patients with SUD diagnosis who have at least one psychotherapy visit in the study period

**Strength of Evidence:** Grade I

**Patient cohorts:** Patients with SUD diagnosis

**Definitions:**
- Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
- Relapse Prevention Therapy (RPT): Discussion of the following topics:
  1. Assessment of environmental and/or emotional characteristics that may be associated with relapse (help veteran identify triggers [emotions, thoughts] for use)
  2. Identify and discuss high risk situations that veteran encountered in past; explore actions he/she took to avoid or cope with this situation
  3. Coping skills training to prevent relapse (discuss, teach, show, or rehearse how to cope with difficult situations without using alcohol or drugs)
    a. Help veteran prepare for possible triggers or situations that might lead to use
    b. Encourage veteran to anticipate future high risk situations and to formulate appropriate ways to manage these situations
    c. Role play different situations that veteran may encounter
  4. Lifestyle modification strategies: discussion about alternative activities to learn to cope, such as meditation, exercise, spiritual practices

RPT intervention strategies can be grouped into three categories: coping skills training, cognitive therapy, and lifestyle modification. Coping skills training strategies include both behavioral and cognitive techniques. Cognitive therapy procedures are designed to provide clients with ways to reframe the habit change process as a learning experience, with errors and setbacks expected as mastery develops. Finally, lifestyle modification strategies such as meditation, exercise, and spiritual practices are designed to strengthen a client's overall coping capacity.

In clinical practice, coping skills training forms the cornerstone of RPT, teaching clients strategies to:
- Understand relapse as a process
- Identify and cope effectively with high-risk situations
- Cope with urges and cravings
- Implement damage control procedures during a lapse to minimize its negative consequences
- Stay engaged in treatment even after a relapse, and
- Learn how to create a more balanced lifestyle
Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data
- First date of psychotherapy from administrative data will be provided for chart review.
  - Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
- For people who had a new treatment episode in the last thirty days of the study period and who were abstracted before WVMI changed their abstraction method to follow them out a full year, additional data will come from the administrative data files.
Module: Substance Use Disorder (SUD)

Indicator Statement: Proportion of patients with SUD diagnosis that received evidence-based Contingency Management (CM) or Contingency Contracting

Indicator Number: 9

Executive Summary: This indicator is based on the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Substance Use Disorders, which identifies contingency management as an evidence-based psychosocial treatment for treatment of patients with SUD. According to the APA guideline, “psychosocial treatments are essential components of a comprehensive treatment program” (5). The guideline provides evidence supporting the efficacy of contingency management therapy, including the following:

“As an adjunctive treatment, contingency management has been used with a variety of substances of abuse, including cocaine (Higgins et al., 2000, Silverman et al., 2004), opiates (Stitzer et al., 1992, Silverman et al., 1996), and marijuana (Budney et al., 2000). ... Although most studies have centered on abstinence from substance use, contingency management procedures are potentially applicable to a wide range of target behaviors and problems” (27).

This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

References:

Numerator: Patients from the denominator who received:
   a) Any evidence-based Contingency Management (CM) or Contingency Contracting in the study period
   b) The number of Contingency Management (CM) or Contingency Contracting visits received in the study period by the same provider in (a).

Denominator: Patients with SUD diagnosis who have at least one psychotherapy visit in the study period
Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade I

Definitions:
- Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
- Contingency Management (CM) and Contingency Contracting:
  1. Contract for behavior change that indicates the rewards for achieving specific treatment goals such as appointment attendance or abstinence based on urine drug screen monitoring
  2. Vouchers and/or other positive reinforcement for meeting treatment goals
     a. Use a pre-planned system to provide increasingly more valuable rewards for increasingly longer periods of uninterrupted abstinence
  3. Withdrawal of vouchers or other negative reinforcement for not meeting treatment goals (e.g., non compliance with therapy or medication regimen)

CM is a strategy used in alcohol and other substance abuse treatment to encourage positive behavior change (e.g., abstinence, attending therapy sessions) by providing reinforcing consequences when patients meet treatment goals and by withholding those consequences or providing punitive measures when patients engage in the undesired behavior (e.g., drinking, failure to adhere to clinic rules). For example, positive consequences for abstinence may include receipt of vouchers that are exchanged for retail goods, whereas negative consequences for drinking may include withholding of vouchers. The reinforcing or punishing consequences may be contingent on objective evidence of recent alcohol and/or drug use or on another behavior important in the treatment process, such as compliance with a medication regimen or regular clinic attendance. Often CM procedures may involve contingency contracting, which is tailored for each patient and may be implemented through explicit written contracts that detail the desired behavior change, duration of intervention, frequency of monitoring, and potential consequences of a patient's success or failure.

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data
- Dates for psychotherapy visits from administrative data will be provided for chart review. Dates for all visits (up to 50 visits) that meet the definition below (different from the definition used to define the denominator) will be provided for chart abstraction.
  - Psychotherapy: Defined as one or more diagnosis-related psychotherapy encounter (primary or secondary from Table 1B in the Key Definitions Document) with one of the CPT codes listed in the relevant section of the Key Definitions Document
- For people who had a new treatment episode in the last thirty days of the study period and who were abstracted before WVMI changed their abstraction method to follow them out a full year, additional data will come from the administrative data files.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)

Indicator Statement: Proportion of patients abstinent from drugs OR alcohol in the 30 days prior to their last visit for outpatient specialty care treatment

Indicator Number: 10

Executive Summary: This indicator comes from the Substance Abuse and Mental Health Services Administration (SAMHSA)’s National Outcomes Measures (NOMs). It has been revised to include collateral support for abstinence including provider and family report. NOMs defines abstinence as an important outcome, “The first and foremost domain is abstinence from drug use and alcohol abuse or decreased symptoms of mental illness with improved functioning.” This indicator addresses the following Institute of Medicine (IOM) domains: Effective and efficiency.

Numerator: Patients from the denominator who were abstinent from drugs OR alcohol in the 30 days prior to their last visit for outpatient specialty care treatment during the study period

Denominator: Patients with SUD diagnosis in specialty mental health care

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade III

Definitions:

• Specialty mental health: Denominator defined as one or more specialty mental health visits in the 30 days before the last specialty mental health visit of the study period. See the “Key Definitions” document for the definition of specialty mental health.
• Abstinent from drugs: Absence of drugs from urinalysis (UA); provider, family or self report of being abstinent un-contradicted by other source. Any evidence of drug use would indicate that the patient was not abstinent. Also make note if no information provided on abstinence
• Abstinent from alcohol: Breathalyzer indicating no alcohol on breath; provider, family or self report of being abstinent un-contradicted by other source. Also make note if no information provided on abstinence.
• Last follow up visit: Last documented visit for specialty care.

Feasibility/Data Collection Issues:

• Denominator will come from administrative data
• Numerator will come from medical record data
• Drugs include any drug, not just drug of dependence
• In data collection, if no information provided on abstinence make note of it
• To make this consistent with results from SAMHSA NOMS, assessment of abstinence from alcohol is based on all relevant information in the chart.
• For people who were abstracted before WVMI changed their abstraction method to follow them out a full year, additional data will be censored.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Patients diagnosed with SUD in primary care were given a referral to specialty SUD care
Indicator Number: 11

Executive Summary: This indicator comes from 2001 VA/DoD Clinical Practice Guidelines for SUD. The Clinical Practice Guideline states that "When acceptable to the patient, a specialty care rehabilitation plan is generally indicated" and provides evidence (Gerstein & Harwood, 1990; Institute of Medicine, 1990) for this recommendation (A-11, A-12). The guideline provides the following discussion and rationale:

Substance use disorders often follow a chronic, relapsing course, making individualized treatment more complicated (McLellan et al., 1996; O'Brien & McLellan, 1996). Treatment has not yet been well-conceptualized for many patients who either have responded with minimal improvement to repeated rehabilitative treatments or are unable or unwilling to engage in rehabilitation efforts, but who desire other services. Even when patients are unable and/or unwilling to participate in rehabilitation or show minimal benefit, there are opportunities to address SUDs in other care settings.

Care management approaches for SUDs are similar to management of other severe and persistent disorders for which no cure has been identified, such as bipolar disorder or diabetes mellitus (McLellan et al., 2000). Recent evidence suggests that approaches emphasizing engagement with the patient over long periods of time, case management, and integration of substance abuse treatment interventions with treatment for the coexisting conditions result in reduced substance use and associated complications (Drake & Mueser, 2000; Osher & Drake, 1996; U.S. DHHS, 1994; Willenbring et al., 1995; Willenbring et al., 1999). In the absence of serious co-morbidity or with appropriate specialist consultation, care management can be provided within some addiction treatment clinics.

Even when patients refuse referral or are unable to participate in specialized addiction treatment, many are accepting of general medical or psychiatric care. Clinicians in multiple settings can deliver care management for patients with SUDs. The chronic illness approach is consistent with management approaches for many other disorders treated in medical and psychiatric settings (Drake & Mueser, 2000; McLellan et al., 2000; Willenbring et al., 1999).

This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness and patient-centeredness.

References:


Numerator:
(1) Patients from the denominator who were already in Specialty SUD care
OR
(2) Patients from the denominator not already in Specialty SUD care who were offered a referral to Specialty SUD care and who
   a) Refused referral to Specialty SUD care;
   b) Did not complete a referral to Specialty SUD care or
   c) Completed at least one visit to Specialty SUD care

Denominator: Patients with SUD diagnosis

Patient cohorts: Patients with SUD diagnosis

Strength of Evidence: Grade II

Definitions:
• Patients already in specialty SUD care (numerator 1): Patients are considered already in specialty SUD care if their first diagnosis-related (primary or secondary) visit of the study period is in specialty SUD care (based on definition in Key Definitions Document)
• Patients with referral (numerator 2): Patients not already in specialty SUD care who receive a referral to specialty SUD care within 30 days either before or after the first diagnosis-related (primary or secondary) visit of the study period.
• Completed referral: Making and showing up to an appointment within 30 days of the referral
• Not completing a referral: Note in the chart that patient was referred and did not follow up with the specialty SUD provider

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from both administrative and medical record data
• Time frames for completing referral will be made later on in analysis
• We will collect refusals separately in order to assess the number of people offered treatment who did not accept it.
• In analysis, stratify to look at results for everyone and for those specifically diagnosed with dependence.
• For people who were abstracted before WVMI changed their abstraction method to follow them out a full year, additional data will be censored.
Performance Measure Technical Documentation

Module: Substance Use Disorder (SUD)
Indicator Statement: Assess for current psychiatric symptoms and/or psychiatric history for patients with SUD in specialty mental health
Indicator Number: 12

Executive Summary: The following indicator is based on the 2001 VA/DoD Clinical Practice Guidelines for Management of SUD stating that assessment of co-morbid psychiatric conditions and psychiatric history is important in a SUD comprehensive biopsychosocial assessment. This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

Numerator: Patients from the denominator who, within 30 days on, after or before the start of the new treatment episode, had their current co-morbid psychiatric symptoms and/or past psychiatric history assessed.

Denominator: Patients with a new treatment episode of SUD in specialty mental health

Patient cohorts: Patients with SUD

Strength of Evidence: Grade III

Definitions:
• SUD new treatment episode: See the “Key Definitions” document
• Specialty mental health: See the “Key Definitions” document; one or more diagnosis-related visits (SUD – primary diagnosis only, Table 1B) in the 30 days following the start of the new treatment episode.
• Assessment for co-morbid psychiatric symptoms (numerator) which includes documentation of:
  o Current signs, symptoms or patient complaints of psychosis (includes hallucinations, delusions, and bizarre behavior), depression (includes depressed mood, trouble getting out of bed, change in appetite, losing interest in activities, and suicidal thoughts) or mania (includes expansive or irritable mood, inflated sense of self importance, decreased need for sleep, increased talkativeness, and racing thoughts)
  o Notation of no current mental health symptoms is satisfactory.
• Past psychiatric history: Includes past history of bipolar disorder, major depression or psychosis/schizophrenia, could include a note about previous hospitalizations or treatments for one of these conditions
  o Notation of no past psychiatric history is satisfactory.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• This indicator is identical to Co-Occurring Disorders Indicator #1.
• Chart abstractors are instructed to look for documentation of an assessment and for documentation of the presence or absence of at least one symptom for one disorder or two disorders.
• Documentation that the patient has no previous treatment for his all of his diagnoses is accepted as evidence of a psychiatric treatment history assessment.
CO-OCCURRING DISORDERS

Performance Measure Technical Documentation

Module: Co-Occurring Disorders
Indicator Statement: Assess for current symptoms and history for patients with COD in specialty mental health
Indicator Number: 1

Executive Summary: The following indicator is based on the 2001 VA/DoD Clinical Practice Guidelines for Management of SUD stating that assessment of co-morbid psychiatric conditions and psychiatric history is important in a SUD comprehensive biopsychosocial assessment. This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

Numerator: Patients from the denominator who:
   a) Within 30 days after the start of a co-occurring disorder new treatment episode had their symptoms of comorbid mental health diagnosis assessed by a licensed mental health provider; and
   b) Within 30 days before, on, or after the start of a co-occurring disorder new treatment episode had their psychiatric history assessed (X-Cutting module)

Denominator: Patients with a new treatment episode for a co-occurring disorder in specialty mental health care

Patient cohorts: Patients with SUD and a comorbid diagnosis of MDD, BP, SZ, or PTSD

Strength of Evidence: Grade III

Definitions:
- Comorbid MDD, BP, SZ, or PTSD diagnosis (denominator): See the Key Definitions Document for definition of comorbid condition.Co-Occurring Disorder Index Visit: See the Key Definitions Document
- Specialty mental health: See the Key Definitions Document; one or more diagnosis-related visits (where mental health condition or SUD is primary diagnosis, Table 1B in the Key Definitions Document) in the 30 days following the start of the new treatment episode.
- Assessment for psychiatric symptoms for the co-morbid mental health condition (numerator) which includes documentation of:
  o Current signs, symptoms or patient complaints of psychosis (includes hallucinations, delusions, and bizarre behavior), depression (includes depressed mood, trouble getting out of bed, change in appetite, losing interest in activities, and suicidal thoughts), mania (includes expansive or irritable mood, inflated sense of self importance, decreased need for sleep, increased talkativeness, and racing thoughts) or PTSD (exposure to a traumatic event with recurrent and intrusive recollections)
  o Notation of no current mental health symptoms is satisfactory.
• Past psychiatric history: Includes past history of bipolar disorder, major depression, psychosis/schizophrenia or PTSD could include a note about previous hospitalizations or treatments for one of these conditions
  o Notation of no past psychiatric history is satisfactory.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• This indicator is also present in the SUD technical manual.
• Numerator b is collected in SUD module in WVMI abstraction.
• For co-occurring disorders, the new treatment episode date is the second validated new treatment episode date. If there is no second validated new treatment episode, the first will be used.
• Psychiatric history comes from the Cross-Cutting module.
Performance Measure Technical Documentation

Module: Co-Occurring Disorders
Indicator Statement: All patients diagnosed with COD who are in a new treatment episode for COD should receive appropriate treatment for both their substance use disorder and mental health disorder
Indicator Number: 2

Executive Summary: The following indicator is based on the VA/DoD Clinical Practice Guidelines for Management of SUD (2001) and PTSD (2000) and applies across all diagnoses relevant to this evaluation. For example, the guidelines for SUD state that:

Patients appropriate for care management may have a range of medical and psychiatric co-morbid conditions that require integrated care, with concurrent attention to their substance dependence or abuse. These patients may require substantial emergency care and stabilization and may repeatedly present in crisis, but are unwilling to return for outpatient visits or engage in alcohol and/or drug treatment. Patients who are willing to engage in ongoing medical or psychiatric care have not refused all help. Such patients may also receive integrated care management from addiction treatment providers in some settings (e.g., Opioid Agonist Therapy [OAT], dual disorders programs, or programs for chronic SUDs) (Willenbring et al., 1995).

This indicator is also based on empirical support for integrating mental health and substance abuse treatments into a combined service (Drake, Mueser, Brunette, & McHugo, 2004) and was created based on elements of the Integrated Treatment for Dual Disorders (IDDT; Mueser, Noordsky, Drake, & Fox, 2003). According to SAMHSA (2006):

Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. As such, integrated treatment reflects the longstanding concern within substance abuse treatment programs for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems.

Treatment for people with co-occurring disorders must address both their mental health and substance abuse needs (Center for Substance Abuse Treatment, 2005; Mee-Lee et al. 2001; Burnam & Watkins, 2006), regardless of the level of severity of each problem. This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

References:
COSIG Program, 2006 (SAMHSA Action Plan); Center for Substance Abuse Treatment. Substance abuse treatment for persons with co-occurring disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. (Treatment improvement protocol [TIP]; no. 42).


**Numerator:** Patients from the denominator who had (1) any visits within three months of the start of the co-occurring disorder new treatment episode or (2) 2 visits every month for the first three months following the start of the co-occurring disorder new treatment episode that:
   a) Addressed SUD
   b) Addressed mental illness by a qualified provider
   c) Addressed BOTH
   d) Addressed NEITHER

**Denominator:** Patients with a new treatment episode for a co-occurring disorder

**Patient cohorts:** Patients with a cohort diagnosis of SUD and comorbid MDD, BP, SZ, or PTSD

**Strength of Evidence:** Grade II

**Definitions:**
- Co-Occurring Disorder Index Visit: See the Key Definitions Document
- Comorbid MDD, BP, SZ, or PTSD diagnosis (denominator): See the Key Definitions Document for definition of comorbid condition.
- Addressed SUD: Documentation in the medical record of group or individual or family treatment for SUD; medication for SUD; a note by the provider that says the person doesn’t need SUD treatment or a note from provider that says the person is in sustained remission/has been sober for > 1 year.
- Addressed mental health: Documentation in the medical record of group or individual (includes psychotherapy) or family treatment; medication for mental health; or a note by the provider that says the person doesn’t need mental health treatment
- Qualified provider: Licensed independent provider (includes MD, DO, physician’s assistant, nurse practitioner/clinical nurse specialist, licensed clinical social worker, psychologist or a trainee with a co-signature)

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from the medical record data
- Patients can “pass” by either (1) or (2) in the numerator
- For some individuals, the appropriate treatment may be no treatment at all if comorbid condition is not active. This should still be noted in the chart.
**Performance Measure Technical Documentation**

**Module:** Co-Occurring Disorders  
**Indicator Statement:** Proportion of patients with COD and severe functional impairment that receive integrated substance abuse and mental health treatment  
**Indicator Number:** 3

**Executive Summary:** The following indicator is based on the VA/DoD Clinical Practice Guidelines for Management of SUD (2001) and PTSD (2000) and applies across all diagnoses relevant to this evaluation. For example, the guidelines for SUD state that:

Patients appropriate for care management may have a range of medical and psychiatric co-morbid conditions that require integrated care, with concurrent attention to their substance dependence or abuse. These patients may require substantial emergency care and stabilization and may repeatedly present in crisis, but are unwilling to return for outpatient visits or engage in alcohol and/or drug treatment. Patients who are willing to engage in ongoing medical or psychiatric care have not refused all help. Such patients may also receive integrated care management from addiction treatment providers in some settings (e.g., Opioid Agonist Therapy [OAT], dual disorders programs, or programs for chronic SUDs) (Willenbring et al., 1995).

The following indicator is based on empirical support for integrating mental health and substance abuse treatments into a combined service (Drake, Mueser, Brunette, & McHugo, 2004) and was created based on elements of the Integrated Treatment for Dual Disorders (IDDT; Mueser, Noordsky, Drake, & Fox, 2003). According to SAMHSA (2006):

Integrated treatment coordinates substance abuse and mental health interventions to treat the whole person more effectively; the term refers broadly to any mechanism by which treatment interventions for COD are combined within a primary treatment relationship or service setting. As such, integrated treatment reflects the longstanding concern within substance abuse treatment programs for treating the whole person, and recognizes the importance of ensuring that entry into any one system can provide access to all needed systems.

In addition, integrated treatment is recommended for patients with severe and persistent mental illness (Drake et al., 2004). This indicator addresses the following Institute of Medicine (IOM) domain: Effectiveness.

**Reference:**
COSIG Program, 2006 (SAMHSA Action Plan); Center for Substance Abuse Treatment. Substance abuse treatment for persons with co-occurring disorders. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. (Treatment improvement protocol [TIP]; no. 42).

**Numerator:** Patients from the denominator who received treatment for both their mental health and substance use disorder during the study period from:
(a) One clinic team or clinician cross-trained in both mental health and SUD issues (e.g., IDDT); or
(b) Separate clinic teams that are well coordinated (e.g., notes indicated active communication or knowledge that separate clinics were working with patient); or
(c) Separate clinic teams not well coordinated (e.g., no communication between the two clinic teams or only a referral); or
(d) Only received treatment for one condition

Denominator:
  a) Patients, with a co-occurring disorder and who have GAF score ≤40, who had at least two diagnosis-related visits during the study period
  b) Patients, with a co-occurring disorder and who have GAF score >40, who had at least two diagnosis-related visits during the study period
  c) Patients, with a co-occurring disorder and who have no reported GAF, who had at least two diagnosis-related visits during the study period

Patient cohorts: Patients with cohort diagnosis of SUD and MDD, BP, SZ, or PTSD

Strength of Evidence: Grade I

Definitions:
• Comorbid MDD, BP, SZ, or PTSD diagnosis: See the Key Definitions Document
• Global Assessment of Functioning (GAF): Scale of 0-100. Qualifying GAF score may be at any time during the study period. Collect first date on which a GAF ≤40 is noted in the record.
• Diagnosis-related visits: Defined as any encounters on separate days where either SUD or the patient’s mental health condition (Table 1B, Key Definitions Document) is the primary diagnosis. To qualify for the denominator, you may have two encounters for SUD or two encounters for a mental health condition, or one of each.
• One clinic team or cross-trained clinician: Notation in the chart that the patient is participating in dual diagnosis/integrated treatment groups specifically designed to address both mental health and substance abuse problems; groups could be family, persuasion, dual recovery, etc (IDDT).
• Separate clinic teams not well coordinated: Notation in the chart that two different teams are treating the two conditions, but no evidence that they are communicating with each other regarding the intersection of the treatment.
• Separate clinic teams that are well coordinated: Notation in the chart that two different teams are treating the two conditions, but there is evidence that they are communicating with each other regarding the intersection of the treatment.
• Treatment for only one condition: NO evidence in the chart that both conditions were treated and NO note that treatment of one of the conditions is not necessary because the condition is under control.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data and medical record data
• Numerator will come from medical record data
• Numerator may be difficult to operationalize and define well.
• For data collection purposes, nurse abstractors will assess the whole study period and will determine which category best describes the care that was provided. We will not be collecting information on a visit-by-visit basis.

• Data for the numerator will be collected on everyone. We will be able to evaluate this indicator for those with GAF scores ≤40, >40, and with no GAF reported. Denominators (b) and (c) will be used descriptively.
Performance Measure Technical Documentation

Module: Co-Occurring Disorders
Indicator Statement: Proportion of patients with COD in a new treatment episode for COD with an administrative discharge
Indicator Number: 4

Executive Summary: A review of the addiction treatment literature done by WL White, et. al. reveals a number of key findings related to current administrative discharge practices.

• Definitional Problems: Discharge categories and their definitions differ across programs, but there is evidence that discharge rates by type of discharge vary across community-based and prison-based treatment programs (Pelissier, et al., 2003) and vary from therapist to therapist within the same treatment program (Najavits & Weiss, 1994).

• Discharge Status and Clinical Outcomes: In adult populations, addiction treatment retention and completion are predictive of positive outcomes, and failure to complete treatment (including those administratively discharged) is predictive of worse outcomes (Price, 1997; Grella, et al., 1999; Wallace & Weeks, 2004).

• Administrative Discharge Profiles: Adult and adolescent noncompleters are more likely to have clinical profiles marked by younger age, greater problem severity (although some studies report a positive link between severity and retention) psychiatric impairment (i.e., depression, conduct disorder, antisocial personality disorder, schizophrenia), history of perpetration of violence, less motivation for recovery, and less recovery supports in their family and social network (Godley, et al., 2001; Hser, et al., 1998; DeLeon & Jainchill, 1986; Agosti, et al., 1996; DeLeon, et al., 2000; Pelissier, et al., 2003).

• Administrative Discharge Prevalence and Level of Care Patterns: At the present time, 18 percent (288,000 thousand) of the 1.6 million people admitted to publicly funded addiction treatment in the United States are administratively discharged (compared to 49 percent who complete treatment, 24 percent who leave against staff advice; and 9 percent who are transferred) (Substance Abuse and Mental Health Services Administration, 2002).

• Rates of AD are not uniform across levels of care. The highest to lowest rates of AD are found in methadone maintenance (30.7 percent), long-term residential (24.8 percent), outpatient (23.7 percent), intensive outpatient (19.8 percent), detoxification (9.4 percent), short-term residential (9 percent), and inpatient hospital treatment (4.6 percent) (SAMHSA, 2002).

Common objectives for treatment programs to use AD include:
• To protect the integrity of the treatment milieu.
• To assure the best utilization of limited treatment resource.
• To protect the reputation of the treatment program.
• To prevent the treatment organization and its staff from enabling clients.
• To fulfill the ethical obligation of terminating and (at least nominally) referring clients who fail to respond to program services.

Reference:
Numerator:  
- a) Proportion of patients with an administrative discharge on or after the start of the new treatment episode
- b) Patients with an administrative discharge within 90 days of the start of a new treatment episode
- c) Patients with an administrative discharge more than 90 days of the start of a new treatment episode
- d) Patients with no documentation of an administrative discharge
- e) For descriptive purposes, note reasons for discharge

Denominator:  Patients with a new treatment episode for a co-occurring disorder

Patient cohorts:  Patients with cohort diagnosis of SUD and MDD, BP, SZ, or PTSD

Strength of Evidence:  Grade III

Definitions:
- Co-Occurring Disorder Index Visit: See the Key Definitions Document
- Comorbid MDD, BP, SZ, or PTSD diagnosis: See the Key Definitions Document for a definition of a comorbid condition.
- Administrative discharge:  the adversarial termination of services due to a client’s failure to comply with program rules and expectations, also referred to as “disciplinary discharge,” “discharge for cause,” or “discharge upon staff request.” The reasons for AD vary by modality but generally include:
  - Failing to participate in service activities, e.g., missing counseling sessions.
  - Threatening, or appearing to threaten, the physical or psychological safety of others.
  - Breaking rules regarding relationship boundaries, e.g., having phone or face-to-face contact with family members or friends during a “blackout” period, verbal abuse (profanity, racial slurs), or “fraternization” (sexual or other inappropriate activity with another client).
  - Refusing to live within rules established for communal living (e.g., hygiene, assigned chores, disruptiveness, quiet hours, and punctuality for treatment activities).
  - Failing to pay service fees.
  - Possessing contraband in the treatment facility (e.g., illicit drugs, cigarettes, prohibited food items).
  - Using alcohol or unprescribed drugs.
  - Failing to secure medication for a psychiatric condition.
  - The AD status is distinct from successful treatment completion (sometimes referred to as “planned discharge” or “graduation”), client termination of service participation against staff advice (also referred to as “against medical advice,” “absent without leave” or “drop-outs”), or referrals to another treatment resource (also referred to as “transfers”).
  - Or, “unable to determine” why administrative discharge.

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data
• The team will pilot this indicator to see if discharge is appropriate. It is possible that patient was referred to another program to get the level of care they need and therefore administrative discharge would be appropriate and good care.
• It is possible to have more than one reason for discharge.
• We will evaluate the reasons for discharge based on good and poor quality separately. For example, those who receive an administrative discharge and are referred to another program would be considered having good care. Those who receive another type of administrative discharge would be categorized as having poor care.
• We can present the indicator as any administrative discharge as well as presenting it with its three components: any within 90 days, any after 90 days in the study period, and those with no administrative discharge.
CROSS-CUTTING: PSYCHOSOCIAL NEEDS INDICATORS

Performance Measure Technical Documentation

Module: Psychosocial Indicators
Indicator Statement: Patients receive Mental Status Exam (MSE) including assessment of:
- Appearance (Personal hygiene/appropriate dress [Schiz])
- General Behavior (Schiz, Bipolar, MDD, SUD & PTSD)

Indicator Number: 1

Executive Summary: The following indicator is based on clinical care recommendations in the VA/DoD Clinical Practice Guidelines for Management of Post-Traumatic Stress (2004), Major Depressive Disorder (2000), Substance Use Disorders (2001), and Psychoses (2004), and applies across all diagnoses relevant to this evaluation. For example, the VA guideline for major depressive disorder directs providers to "Perform Mental Status Examination (MSE)" in primary care, outpatient mental health specialty and inpatient mental health care settings in order to "develop an appropriate clinical understanding of the patient that will inform subsequent provider decisions" (7-8). Assessing Axes IV and V of DSM-IV is part of the mental status examination conducted in psychiatry and has been recommended as part of standard practice (APA, 2006). Furthermore, the VA guideline for psychoses recommends that clinicians assess patients' "Functionality and Psychosocial Support System," defined as follows:

This assessment has to do with immediate needs for housing, transportation and access, life skills, work and/or employment, education, financial, social skills, health awareness, family, legal, cultural and/or spiritual help. Essentially this is a full evaluation of the issues relevant to Axes IV and V of DSM-IV

After reviewing a comprehensive list of issues relevant to Axis V of DSM-IV, the VA Mental Health Program Evaluation Consultation Group identified "Personal hygiene/appropriate dress" and "Appropriate behavior" as being the most relevant assessment domains to patients with Schizophrenia (both domains) and Bipolar, MDD, SUD, or PTSD (second domain only). This indicator addresses the following Institute of Medicine (IOM) domains: Efficiency, Effectiveness, and Timeliness.

Reference:

Numerator: Patients who received a Mental Status Exam (MSE) including assessment of:
- Appearance (Personal hygiene/appropriate dress [Schiz]) AND
- General Behavior (Schiz, Bipolar; MDD, SUD & PTSD)

a) Baseline assessment for all patients with a new treatment episode: within 30 days after the start of the new treatment episode
b) Annual assessment for all patients: within study year

Denominator:
a) All patients with a new treatment episode
b) All patients

**Patient cohorts:** All diagnoses

**Strength of Evidence:** Grade III

**Definitions:**
- New Treatment Episode: See the “Key Definitions” document
- Mental Health or SUD Diagnoses: See Table 1A in the “Key Definitions” document
- Personal hygiene/appropriate dress (Schiz) MSE core element 1b: Basic grooming and hygiene, dress and whether it was appropriate attire for the occasion (e.g. like a heavy coat in hot summer weather) and personal hygiene (e.g. foul odor, being unkempt, dirty clothes, evidence of not bathing)
- Appropriate behavior (All diagnoses in specialty care): MSE core element 2: The patient’s general behavior which may include: Level of distress, degree of eye contact, attitude toward the interviewer (e.g., aggressive, hostile, disconnected, or uncooperative during the session).

**Feasibility/Data Collection Issues:**
- Numerator will come from medical record data (same data gathered for Cross-Cutting Indicator #6).
- Denominator will come from administrative data
- Analyses of appropriate behavior for those in specialty care will be conducted post hoc. Specialty care will be defined per the Key Definitions Document as one or more specialty care encounters in the 30 days following the start of the new treatment episode.
- Numerator is collected in the cross-cutting module in WVMI abstraction.
Performance Measure Technical Documentation

Module: Psychosocial Indicators

Indicator Statement: Patients with a new treatment episode in specialty care receive baseline assessment of Psychosocial Needs or Deficits (Axis IV) across the following domains:
- Housing
- Social supports
- Employment

Indicator Number: 2

Executive Summary: This indicator is based on an indicator developed by the American Psychiatric Association (APA), as documented in the Center for Quality Assessment and Improvement in Mental Health (CQAIMH) database, which assigned it an evidence level of AHRQ Level C ("Little research evidence, principally based on clinical consensus/opinion."). The original indicator was entitled "Assessment for Psychosocial Issues of Psychiatric Patients" and assessed the number of patients who undergo a psychiatric evaluation during a specified period whose medical record documents an evaluation of the patient's psychosocial deficits. The APA provided the following rationale in support of this indicator:

Clinical practice guidelines recommend that a psychiatric evaluation of a newly presenting patient include an assessment of the individual's psychosocial and developmental history. Such an assessment typically includes information about developmental milestones, family and social relationships, educational and work history, and major life events including a history of trauma. This assessment can inform diagnosis and treatment as well as provide information about patient strengths, vulnerabilities, and potential sources of support.

This indicator is also supported by the 2004 VA/DoD Clinical Practice Guidelines for Management of Psychoses, which recommends that clinicians assess patients' "Functionality and Psychosocial Support System," defined as follows:

This assessment has to do with immediate needs for housing, transportation and access, life skills, work and/or employment, education, financial, social skills, health awareness, family, legal, cultural and/or spiritual help. Essentially this is a full evaluation of the issues relevant to Axes IV and V of DSM-IV.

After reviewing a comprehensive list of issues relevant to Axis IV of DSM-IV, the VA Mental Health Program Evaluation Consultation Group identified the three domains of Housing, Social Supports, and Employment as the most relevant for patients with the diagnoses included in this program evaluation, the most measurable using VA data, and the most actionable using VA services. This indicator addresses the following Institute of Medicine (IOM) domains: Efficiency, Effectiveness, Timeliness, and Patient-Centeredness.

Numerator: Patients from the denominator who receive a baseline assessment of the presence or absence of psychosocial needs or deficits (Axis IV) across the following domains within: one month of the start of the new treatment episode
- Housing
- Social supports
- Employment status (work or other meaningful daily activity)

Denominator: All patients with a new treatment episode

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Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Mental Health or SUD Diagnoses: See Table 1A in the “Key Definitions” document
• Assessment of the presence or absence of psychosocial needs or deficits across each domain. Any documentation that indicates the provider assessed for the presence or absence of psychosocial need/deficits across each domain. This could be revealed by subjective statements from the patient or objective observations documented by the provider. For example:
  o Housing- Assessment of physical shelter. Documenting the patient “lives alone” would not be sufficient unless the type of shelter was assessed. Acceptable documentation could include statements such as:
    ▪ Patient has safe and secure living situation
    ▪ Currently homeless, needs immediate housing
    ▪ Wife recently kicked patient out of the house, doesn’t have a place to stay lined up yet.
    ▪ Completed patient profile or needs assessment that allows the patient to describe their shelter/housing.
  o Social Supports- Documenting the patient is “married” would not be sufficient unless the element of need/deficit was addressed. Acceptable documentation could include statements such as:
    ▪ Patient is lonely
    ▪ Complains about having no friends
    ▪ States husband is non-supportive
    ▪ Completed patient profile or needs assessment that addresses social supports need/deficit
    ▪ Patient feels she can’t stop drinking until her stressful living situation changes.
  o Employment status-Purposeful daily activity. This could include anything from paid employment to volunteering or attending classes. The intent is to know if the patient is currently engaged in purposeful activity, regardless of being paid. Documenting the patient is “trained as a beautician” or “likes to volunteer” would not be sufficient unless the element of current activity is assessed. Acceptable evidence of assessment could include statements such as,
    ▪ Trained as a beautician and is currently employed
    ▪ Currently volunteering at the church
    ▪ Just lost job
    ▪ Student, taking classes, etc.
    ▪ Homemaker takes care of their children/relatives, etc.
    ▪ Retired, but has daily purposeful activity (e.g., hobbies) documented.
    ▪ On disability, but provider notes how patient spends the day.
    ▪ Enrolled in a day treatment facility (i.e., 8-hour day treatment)
    ▪ Completed patient profile or needs assessment that addresses current employment activity
Feasibility/Data Collection Issues:

- Denominator will come from administrative data
- Numerator will come from medical record data
- Not clear yet whether this will be descriptive or evaluative
- Analyses of appropriate behavior for those in specialty care will be conducted post hoc. Specialty care will be defined per the Key Definitions Document as one or more specialty care encounters in the 30 days following the start of the new treatment episode.
Module: Psychosocial Indicators

Indicator Statement: Patients with identified need should be offered services for:
- Social supports
- Housing
- Employment status (work or other purposeful daily activity)

Indicator Number: 3

Executive Summary: This indicator was developed to support the evaluation of Program Outcomes proposed by VA in all diagnosis-specific Appendices A under the domain of "Rehabilitation," the title of which has since been modified to address "Rehabilitation and Recovery Support". In each Appendix A, VA proposed addressing the following Rehabilitation-related “program outcomes” and “proposed performance measures” (termed as such in the Appendices A):
- VA patients should demonstrate improved functioning in life activities.
- VA patients should receive assistance in obtaining full or part time employment that is appropriate to their interests and abilities.
- VA patients should receive housing assistance and be appropriately housed.

Effectively assessing these VA-proposed Outcomes required defining key terms like "improved," "appropriate(ly)," and "assistance," as well as creating a related set of assessment-focused performance indicators to identify patients' baseline "functioning in life activities" and needs for employment and housing. This indicator was developed to identify those patients who received services appropriate to their level of need, as identified in the related psychosocial assessment indicator(s).

Consultation with the VA Mental Health Program Evaluation Consultation Group and other VA experts knowledgeable in the system-wide provision of VA services revealed that there is no clear documentation of VA expectations regarding which specific services should be provided to patients with areas of need identified in the domains of Social Supports, Housing, or Employment. Despite this lack of explicit VA expectations, the Statement of Work (SOW) for the current program evaluation clearly sets some expectations via the Appendices A. Namely, both the VA-proposed goal for the Rehabilitation domain ("Improve ability to function in society") and VA-proposed Program Outcome #11 (#12 in MDD Appendix A; "VA patients should demonstrate improved functioning in life activities") require that services aim not only to diminish symptoms but to improve functional adaptation as well. Therefore, although this indicator is currently only descriptive, further and ongoing consideration will be made as to potential evaluative framework(s). This indicator addresses the following Institute of Medicine (IOM) domains: Efficiency, Effectiveness, Timeliness, and Patient-Centeredness.

Numerator: Patients from the denominator who are offered services across the following domains during the study period:
- Housing
- Social supports
- Employment status

Denominator: All patients with a new treatment episode AND have evidence of need/deficit across social supports, housing or employment status
Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Mental Health or SUD Diagnoses: See Table 1A in the “Key Definitions” document
• Evidence of need/deficit across all domains could come from subjective evidence as stated by the patient (regardless of the lack of any objective evidence from the provider), the provider or administrative data. Some examples could include:
  o Patient writes, “homeless” on profile or needs assessment but provider doesn’t comment on housing issue.
  o Patient is severely depressed and can’t care for herself in current living situation.
  o Patient needs to increase socialization skills
  o Patient needs to change to an environment more conducive to recovery.
  o Patient is psychotic and needs immediate care/housing
• Evidence that services were offered across domains:
  o Social Support (medical record): Any documentation that indicates the provider attempted to help patient with social supports. For example, some comments would be sufficient evidence,
    o Provider encourages depressed patient to increase social situations despite the fact that the patient doesn’t agree.
    o Provider provides suggestions for alternative living situation to promote recovery.
    o Encouraged patient to arrange a social outing with a friend.
    o Helped patient establish a strategy for dealing with unsupportive husband.
  o Housing (medical record): Any documentation that indicates the provider attempted to help patient with social supports. For example, some comments would be sufficient evidence,
    ▪ Provider intervenes to find safe housing for patient who is psychotic and unaware of his/her need for shelter.
    ▪ Discussed alternative living situations that would be a more appropriate recovery environment.
    ▪ Encouraged patient to apply for housing assistance
  o Employment (medical record)
    ▪ Patient works at a bar. Discussed strategies for seeking employment opportunities that would be more conducive to recovery.
    ▪ Discussed communication strategies that will help patient maintain employment status.
  o Social Support Services (administrative data): Defined as two or more outpatient visits with the following stop codes in the study period:
    ▪ 505, Day Treatment – Individual
    ▪ 506, Day Hospital – Individual
    ▪ 520, Long Term Enhancement – Individual
    ▪ 521, Long Term Enhancement – Group
    ▪ 527, Mental Health Telephone
    ▪ 532, Psychosocial Rehabilitation – Individual
- 537, Telephone – Psychosocial Rehabilitation
- 546, Telephone – MHICM
- 547, SUD Intensive Outpatient
- 552, Mental Health Intensive Case Management (MHICM)
- 553, Day Treatment – Group
- 554, Day Hospital – Group
- 559, Psychosocial Rehabilitation – Group
- 560, SUD Group
- 564, Mental Health Team Case Management
- 567, Mental Health Intensive Case Management (MHICM) Group

Housing Services (administrative data): Defined as two or more outpatient visits with the following stop codes in the study period or an inpatient or residential facility admission using the following bed section codes during the study period (based on BEDSECN in the Medical SAS Inpatient Dataset):

Stop codes
- 522, HUD-VASH
- 528, Telephone – Homeless Mentally Ill
- 529, Health Care for Homeless Veterans/Homeless Chronically Mentally Ill (HCHV/HCM)
- 530, Telephone – HUD-VASH
- 590, Community Outreach to Homeless Veterans by Staff Other Than HCHV and RRTP Programs
- 725, Residential Rehabilitation Treatment Program (RRTP) Outreach Services
- 726, RRTP Aftercare – Community
- 727, RRTP Aftercare – VA
- 728, RRTP Admission Screening Services
- 729, Telephone – RRTP

Bed Sections (NOTE: if admission date is within study period, include in measure even if discharge occurs after the end of the study period.)
- 25, Psychiatric Residence Rehabilitation Treatment
- 26, PTSD Residence Rehabilitation
- 27, Substance Abuse Residence Rehabilitation
- 37, Domiciliary Care for Homeless Veterans
- 77, Psychiatric Residence Rehabilitation
- 84, Psychiatric Substance Abuse (Intermediate Care)
- 85, Domiciliary
- 86, Domiciliary Substance Abuse
- 88, Domiciliary PTSD
- 89, Sustained Treatment and Rehabilitation (STAR) I, II, and III
- 90, Substance Abuse STAR I, II, and III

Employment Services (administrative data): Defined as two or more outpatient visits with the following stop codes in the study period (based on CL1-CL15 from the Medical SAS Outpatient Dataset):
- 568: Mental Health Compensated Work Therapy/Supported Employment (CWT/SE), Face-to-Face
- 569: Mental Health Compensated Work Therapy/Supported Employment (CWT/SE), Not Face-to-Face
- 570: Mental Health Compensated Work Therapy/Transitional Work Experience (CWT/TWE), Not Face-to-Face
- 574: Mental Health Compensated Work Therapy/Transitional Work Experience (CWT/TWE), Face-to-Face
- 575: Mental Health Vocational Assistance Group

Feasibility/Data Collection Issues:
- Denominator will come from both medical record and administrative data
- Numerator will come from both medical record and administrative data
- Provider intervention alone is considered a service.
- If we see a note that patient refused services, we will collect it separately for analysis.
- Analyses of appropriate behavior for those in specialty care will be conducted post hoc. Specialty care will be defined per the Key Definitions Document as one or more specialty care encounters in the 30 days following the start of the new treatment episode.
- The VA considers the veteran to have a housing need if he is not independently housed or in a residential treatment facility. This definition was applied for chart abstraction. Living in a shelter or in a semi-permanent housing arrangement constitutes housing need.
Performance Measure Technical Documentation

Module: Psychosocial Indicators
Indicator Statement: Proportion of patients admitted to psychiatric inpatient unit or residential treatment unit with >= 24 hour stay who received housing services
Indicator Number: 4

Executive Summary: This indicator is based on clinical care recommendations in the VA/DoD Clinical Practice Guidelines for Management of Post-Traumatic Stress (2004), Major Depressive Disorder (2000), Substance Use Disorders (2001), and Psychoses (2004), and applies across all diagnoses relevant to this evaluation. For example, the VA guideline for psychoses recommends that "if housing assessment indicates that patient is not currently housed, arrange immediate shelter." This indicator was developed to support Program Outcome #13 (MDD #14) proposed by VA in all diagnosis-specific Appendices A: "VA patients should receive housing assistance and be appropriately housed." VA proposed measuring this using documented evidence of housing. The development of this indicator was complicated by the discovery that there is no clear VA definition of "appropriately housed" or documentation of VA expectations regarding which specific service(s) should be provided to inpatients with housing needs, as indicated by the VA Mental Health Program Evaluation Consultation Group (February - August 2007) and other VA experts knowledgeable in the system-wide provision of VA services. Despite this obstacle—and despite the apparent lack of suitable previously developed performance indicators supporting the use of this measurement in evaluating quality of care—helping to secure adequate housing for patients is an vital component of patient-centered care, and therefore this indicator is of high importance to VA as well as to veterans and policy-makers. VA experts recommended that VA housing assistance may be reasonably expected for those patients in psychiatric inpatient units or in residential treatment; this indicator does not include a threshold Global Assessment of Functioning (GAF) score requirement in the denominator on the assumption that inpatients have GAF scores below 50. This indicator addresses the following Institute of Medicine (IOM) domains: Efficiency, Effectiveness, Timeliness, and Patient-Centeredness.

Note: This is an evaluative performance indicator.

Numerator: Proportion of patients who received housing assistance

Denominator: All patients discharged from psychiatric inpatient unit or residential treatment unit with >= 24 hour stay and who were not appropriately housed prior to discharge

Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:
- Mental Health or SUD Diagnoses: See Table 1A in the “Key Definitions” document
- Psychiatric inpatient unit: Defined as any discharge to the community from an inpatient psychiatric facility where length of stay was greater than or equal to 24 hours and with the relevant mental health or SUD diagnosis as the primary diagnosis on the discharge (based on bed section code from final discharge from hospital – PLDISCH in the Medical SAS Inpatient Dataset):
- 70, Acute Psychiatry
- 72, Alcohol Dependence – High Intensity
- 73, Drug Dependence – High Intensity
- 74, Substance Abuse – High Intensity
- 79, Special Inpatient PTSD Unit
- 84, Psychiatric Substance Abuse (Intermediate Care)
- 91, Evaluation/Brief Treatment PTSD
- 92, Psychiatry – General Intervention
- 93, High Intensity General Psychiatry – Inpatient
  - Exclusion:
    - Patients admitted and discharged on the same day.
    - Patients who expired (where DISTO=-2 on Medical SAS Inpatient file)
    - Patients with an unplanned departure resulting in discharge due to failing to return from leave (where BOS=2 or 3 on Medical SAS Inpatient file)
  - Note: Keep inpatient discharges where admission date occurred during study period but discharge occurred after the end of the study period.
- Residential Treatment Program: Defined as any discharge to the community from a residential treatment program where length of stay was greater than or equal to 24 hours with the relevant mental health or SUD diagnosis as the primary diagnosis on the discharge (based on bed section code from final discharge from hospital – PLDISCH in the Medical SAS Inpatient Dataset):
  - 25, Psychiatric Residence Rehabilitation Treatment
  - 26, PTSD residential rehabilitation
  - 27, Substance Abuse Residence Rehabilitation
  - 37, Domiciliary Care for Homeless Veterans
  - 77, Psychiatric Residence Rehabilitation
  - 85, Domiciliary
  - 86, Domiciliary Substance Abuse
  - 88, Domiciliary PTSD
  - 89, Sustained Treatment and Rehabilitation (STAR) I, II, and III
  - 90, Substance Abuse STAR I, II, and III
    - Exclusion:
      - Patients admitted and discharged on the same day.
      - Patients who expired (where DISTO=-2 on Medical SAS Inpatient file)
      - Patients with an unplanned departure resulting in discharge due to failing to return from leave (where BOS=2 or 3 on Medical SAS Inpatient file)
    - Note: Keep inpatient discharges where admission date occurred during study period but discharge occurred after the end of the study period.
- Evidence of need/deficit across all domains could come from subjective evidence as stated by the patient (regardless of the lack of any objective evidence from the provider), the provider or administrative data. Some examples could include:
  - Patient writes, “homeless” on profile or needs assessment but provider doesn’t comment on housing issue.
  - Patient is severely depressed and can’t care for herself in current living situation.
- Patient needs to change to an environment more conducive to recovery.
- Patient is psychotic and needs immediate care/housing.

- Housing services: This is an indication in the medical record that the patient received counseling about housing services, was referred for housing services or a stop code indicative of housing services. It does not require that the patient actually be housed.

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from medical record data
- The date of relevant inpatient discharges will be provided from administrative data for chart abstraction.
- Abstractors look for evidence of a referral for housing services. Receiving list of housing options, for example, is considered housing service, as long as it is an improvement over the patient’s previous homelessness.
Performance Measure Technical Documentation

**Module:** Psychosocial Indicators  
**Indicator Statement:** Proportion of patients admitted to psychiatric inpatient unit or residential treatment unit with >= 24 hour stay who were appropriately housed at discharge from unit  
**Indicator Number:** 5

**Executive Summary:** This indicator is based on indicators proposed by VA in all diagnosis-specific Appendices A under Program Outcome #13 (MDD #14), "VA patients should receive housing assistance and be appropriately housed" and has been modified and developed with the VA Mental Health Program Evaluation Consultation Group (February - August 2007). Consultation with the VA Mental Health Program Evaluation Consultation Group and other VA experts knowledgeable in the system-wide provision of VA services revealed that there is no clear VA definition of "appropriately housed" or documentation of VA expectations regarding which specific service(s) should be provided to inpatients with housing needs. Therefore, this indicator is descriptive only. VA experts did recommend that VA housing assistance may be reasonably expected for those patients in psychiatric inpatient units or in residential treatment, and that for patients discharged from these facilities, the discharge plan may be reasonably expected to indicate where the patient is being discharged. This indicator addresses the following Institute of Medicine (IOM) domains: Efficiency, Effectiveness, Timeliness, and Patient-Centeredness.

**Numerator:** Proportion of patients whose discharge plan indicates that they were appropriately housed at discharge from unit

**Denominator:** All patients discharged from psychiatric inpatient unit or residential treatment unit with >= 24 hour stay

**Patient cohorts:** All diagnoses

**Strength of Evidence:** Grade III

**Definitions:**
- Psychiatric inpatient unit: Defined as any discharge to the community from an inpatient psychiatric facility where length of stay was greater than or equal to 24 hours and with the relevant mental health or SUD diagnosis as the primary diagnosis on the discharge (based on bed section code from final discharge from hospital – PLDISCH in the Medical SAS Inpatient Dataset):
  - 70, Acute Psychiatry
  - 72, Alcohol Dependence – High Intensity
  - 73, Drug Dependence – High Intensity
  - 74, Substance Abuse – High Intensity
  - 79, Special Inpatient PTSD Unit
  - 84, Psychiatric Substance Abuse (Intermediate Care)
  - 91, Evaluation/Brief Treatment PTSD
  - 92, Psychiatry – General Intervention
  - 93, High Intensity General Psychiatry – Inpatient
- Exclusion:
  - Patients admitted and discharged on the same day.
• Patients who expired (where DISTO=-2 on Medical SAS Inpatient file)
• Patients with an unplanned departure resulting in discharge due to failing to return from leave (where BOS=2 or 3 on Medical SAS Inpatient file)
  ▪ Note: Keep inpatient discharges where admission date occurred during study period but discharge occurred after the end of the study period.

□ Residential Treatment Program: Defined as any discharge to the community from a residential treatment program where length of stay was greater than or equal to 24 hours with the relevant mental health or SUD diagnosis as the primary diagnosis on the discharge (based on bed section code from final discharge from hospital – PLDISCH in the Medical SAS Inpatient Dataset):
  o 25, Psychiatric Residence Rehabilitation Treatment
  o 26, PTSD residential rehabilitation
  o 27, Substance Abuse Residence Rehabilitation
  o 37, Domiciliary Care for Homeless Veterans
  o 77, Psychiatric Residence Rehabilitation
  o 85, Domiciliary
  o 86, Domiciliary Substance Abuse
  o 88, Domiciliary PTSD
  o 89, Sustained Treatment and Rehabilitation (STAR) I, II, and III
  o 90, Substance Abuse STAR I, II, and III

□ Exclusion:
  • Patients admitted and discharged on the same day.
  • Patients who expired (where DISTO=-2 on Medical SAS Inpatient file)
  • Patients with an unplanned departure resulting in discharge due to failing to return from leave (where BOS=2 or 3 on Medical SAS Inpatient file)
  ▪ Note: Keep inpatient discharges where admission date occurred during study period but discharge occurred after the end of the study period.

□ Mental Health or SUD Diagnoses: See Table 1A in the “Key Definitions” document
□ Evidence of need/deficit across all domains could come from subjective evidence as stated by the patient (regardless of the lack of any objective evidence from the provider), the provider or administrative data. Some examples could include:
  o Patient writes, “homeless” on profile or needs assessment but provider doesn’t comment on housing issue.
  o Patient is severely depressed and can’t care for herself in current living situation.
  o Patient needs to change to an environment more conducive to recovery.
  o Patient is psychotic and needs immediate care/housing

□ Appropriately housed: For patients discharged from a residential facility or an inpatient psych facility, discharge plan should note where patient is being discharged to. These are the 2 acceptable settings for housing:
  o Patient is independently housed (in own room or house or SRO setting)
  o Patient is in a residential treatment facility.
  o Living in a shelter not considered appropriately housed.
Feasibility/Data Collection Issues:

- Numerator will come from medical record data ("appropriately housed")
- Denominator will come from administrative data
- The date of relevant inpatient discharges will be provided from administrative data for chart abstraction.
- We were not able to collect qualitative information about where patients were discharged to and thus will not evaluate “appropriateness” based on this qualitative information. Instead, medical record reviewers will abstract whether the patient was appropriately housed after discharge.
- We will have the ability to compute this indicator with three denominators: all discharges, discharges from a psychiatric inpatient unit, and discharges from a residential treatment facility.
CROSS-CUTTING: SUICIDALITY INDICATORS
Performance Measure Technical Documentation

Module: Suicide (All Modules)
Indicator Statement: Percentage of patient charts that document assessment for suicide ideation (SI)
Indicator Number: 1

Executive Summary: The following indicator is based on the VA/DoD Clinical Practice Guidelines for Management of SUD, PTSD, MDD, and Psychoses (applies to Schizophrenia and Bipolar Disorder). The assessment and management of suicidal patients is an essential component of standard clinical care (Bongar, 2002), yet there are no empirically-based performance indicators evaluating suicide risk. This indicator was created based on suicide expert consultation and has been approved by our VA Mental Health Program Evaluation Consultation Group. These professionals reached the consensus that suicide risk should be assessed more frequently for patients with Schizophrenia and Bipolar diagnoses, and for patients with higher depression and PTSD severity (i.e., GAF < 50). Diagnosis-specific thresholds were used based on the Key Definitions document of acute and new treatment episodes. Thresholds for global assessment of functioning (GAF) scores were determined under the advisement of the VA Mental Health Program Evaluation Consultation Group, based on previous research (Niv et al., 2007). Assessing suicide ideation is part of the mental status examination conducted in psychiatry and has been recommended as part of standard practice (APA, 2006). This indicator addresses the following Institute of Medicine (IOM) domains: Safety and Effectiveness.

References:


Numerator: Patients from the denominator with a documented assessment for current suicide ideation (SI) at least once during the study period

Denominator: All patients

Patient cohorts: Patients with a cohort diagnosis

Strength of Evidence: Grade III

Definitions:
• Assessment of suicide ideation (SI): Documentation of the presence or absence of suicide ideation. Using the PHQ-9 would count for assessment of SI, but a PHQ of
fewer items would not. Outpatients who are subsequently admitted to the hospital for elevated suicide risk still must be assessed for SI within 24 hours of that admission.

- The presence or endorsement of current SI includes any reference to the patient’s not wanting to live anymore, comments about killing oneself or doing oneself serious harm, overwhelming hopelessness, thoughts of death as a “solution,” or entertaining any similar thoughts.
- Absence of SI is documentation of specific denial of SI (e.g., “no suicidal thoughts,” “no thoughts of self harm,” etc.).

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from medical record data
- Data collectors will be made aware of any standardized tools that may be used (similar to the PHQ-9) that could potentially evaluate SI and follow up with help consultation as needed to determine if the use of the tool would suffice for this indicator.
- In analysis, we will separate results out by:
  - All patients, and
  - Those who are in specialty mental health care (defined as two or more encounters during the study period)
**Performance Measure Technical Documentation**

**Module:** Suicide (All Modules)

**Indicator Statement:** Percentage of outpatient charts with endorsement of suicide ideation, suicide intent or suicide behavior that receive appropriate follow-up

**Indicator Number:** 2

**Executive Summary:** The following indicator is based on the VA/DoD Clinical Practice Guidelines for Management of SUD, PTSD, MDD, and Psychoses (applies to Schizophrenia and Bipolar Disorder). The assessment and management of suicidal patients is an essential component of standard clinical care (Bongar, 2002), yet there are no empirically-based performance indicators evaluating suicide risk. This indicator was created based on suicide expert consultation and has been approved by our VA Mental Health Program Evaluation Consultation Group. Providing a follow-up assessment of suicidal ideation is the standard of care if the patient had a recent endorsement of suicidal ideation. This indicator addresses the following Institute of Medicine (IOM) domains: Safety and Effectiveness.

**Reference:**
Bongar B. *The Suicidal Patient Clinical and Legal Standards of Care* (2nd ed.)

**Numerator:** Documentation of appropriate follow up (per the definitions below) for the ideation, intent or behavior endorsed

**Denominator:** Outpatient visits/contacts where the patient endorsed suicide ideation, intent or behavior

**Patient cohorts:** Patients with a cohort diagnosis

**Strength of Evidence:** Grade III

**Definitions:**
- Presence or endorsement of current Suicidal Ideation includes any comments about killing oneself or doing oneself serious harm, overwhelming hopelessness, thoughts of death as a “solution,” or entertaining any similar thoughts.
- **Appropriate intervention for suicidal ideation:**
  - Provision of resource list (to outpatient): Patient given a list of resources to call or visit if in danger.
  - Appointment for follow up
  - Assessment for suicidal intent
- Presence or endorsement of suicidal intent: Documentation indicating imminent threat of suicide, patient has a specific plan for hurting or killing him/herself (e.g., location, how, when), or indication about chosen means to self-harm or suicide or access to lethal means (e.g., pills, firearms).
- **Appropriate intervention for suicidal intent:**
  - Family (of outpatient) intervention: Documented provider discussion with patient and family members regarding patient’s suicide intent and efforts for keeping the patient safe.
  - Patient was referred for admission to an inpatient unit.
• Suicidal behavior is characterized by a successful or unsuccessful attempt to kill oneself. It includes attempted suicide, suicidal gestures and completed suicide. An attempted suicide is a suicidal action that is not fatal. If an attempted suicide involves a suicidal action unlikely to have any potential of being fatal, it is called a suicide gesture. A person taking such an action (for example, ingesting six Tylenol tablets) may be making a plea for help or attention without having any intention of actually ending his/her life. A completed suicide is a suicidal action that results in death.

• **Appropriate intervention for suicidal behavior:**
  - Patient was admitted to an inpatient unit.
  - Inpatient admission includes documentation of Suicidal Protocol/Precautions/Standing Orders.
  - Inpatient suicide protocol: (e.g., removal of personal effects, close observation, safe environment, etc.)

**Feasibility/Data Collection Issues:**
• Denominator will come from medical record data
• Numerator will come from medical record data
• **NOTE:** Data collectors will have to be aware of any standardized tools that may be used (similar to the PHQ-9) that could potentially evaluate SI and follow up with help consultation as needed to determine if the use of the tool would suffice for this indicator.
• In analysis, we will separate results out by:
  - All patients, and
  - Those who are in specialty mental health care (defined as two or more encounters during the study period)
CROSS-CUTTING INDICATORS

Performance Measure Technical Documentation

Module: Cross Cutting Indicator (All Modules)
Indicator Statement: Medical Assessment (History)
Indicator Number: 1

Executive Summary: The following indicator is based on clinical care recommendations in the VA/DoD Clinical Practice Guidelines for Management Post-Traumatic Stress (2004), Major Depressive Disorder (2000), Substance Use Disorders (2001), and Psychoses (2004), and applies across all diagnoses relevant to this evaluation. In particular, the 2001 VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders (SUD) provides specific recommendations for the specific categories that a comprehensive SUD Assessment for patients beginning an acute treatment episode should address, including “current medical status and medical history” (ASAM, 1996; Senay, 1997; Strauss, 1995). This indicator addresses the following IOM domains: Effectiveness and patient-centeredness.

Numerator: Number of patients whose past medical history is assessed by a qualified provider
1) Within 30 days of the start of the new treatment episode
2) In the study period

Denominator:
1) All patients with a new treatment episode
2) All patients

Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Past medical history: The general medical history includes available information on known general medical illnesses (e.g., hospitalizations, procedures, treatments, and medications), allergies or drug sensitivities, and undiagnosed health problems that have caused the patient major distress or functional impairment. This includes history of any episodes of important physical injury or trauma; sexual and reproductive history; and any history of endocrinological, infectious (including but not limited to HIV, tuberculosis, and hepatitis C), neurological disorders, sleep disorders (including sleep apnea), and conditions causing pain and discomfort. Of particular importance is a specific history regarding diseases and symptoms of diseases that have a high prevalence among individuals with the patient’s demographic characteristics and background—for example, infectious diseases in users of intravenous drugs or pulmonary and cardiovascular disease in people who smoke. Information regarding all current and recent medications, including hormones (e.g., birth control pills, androgens), over-the-counter medications, herbal supplements, vitamins, complementary and alternative medical treatments, and medication side
effects, is part of the general medical history. With all aspects of the general medical history, obtaining corroborating information (e.g., from medical records, treating clinicians, family) can be helpful, since ordinary errors in comprehension, recall, and expression can lead to errors in patient reports.

- Qualified provider: Any physician (MD or DO), physician’s assistant, or nurse practitioner

**Feasibility/Data Collection Issues:**

- Denominator will come from administrative data
- Numerator will come from the medical record
**Performance Measure Technical Documentation**

**Module:** Cross Cutting Indicators  
**Indicator Statement:** Comprehensive Assessment: Co-morbid psychiatric conditions, psychiatric history, and response to treatment  
**Indicator Number:** 2

**Executive Summary:** The following indicator comes from the 2001 VA/DoD Clinical Practice Guidelines for SUD. The VA Clinical Practice Guideline recommends that a comprehensive SUD Assessment and an assessment of goals should address each of the following 10 general categories for patients beginning a new treatment episode (ASAM, 1996; Senay, 1997; Strauss, 1995):

1. Patient's demographics and identifying information, including housing, legal, and occupational status  
2. Patient's chief complaint and history of the presenting complaint  
3. Recent substance use and severity of substance-related problems  
4. Lifetime and family history of substance use  
5. Co-morbid psychiatric conditions and psychiatric history  
6. Social and family context  
7. Developmental and military history  
8. Current medical status and medical history, including risk for HIV or hepatitis C  
9. Mental status and physical examinations  
10. Patient's perspective on current problems and treatment goals or preferences

This indicator addresses the following Institute of Medicine (IOM) domains: Effectiveness and patient-centeredness.

**References:**


**Numerator:** Patients from the denominator who are assessed within 30 days before or after the start of the new treatment episode for:

a) co-morbid psychiatric conditions, and  
b) past psychiatric history  
c) response to previous treatment

**Denominator:** Patients with a new treatment episode

**Patient cohorts:** All diagnoses
**Strength of Evidence:** Grade III

**Definitions:**
- New Treatment Episode: See the “Key Definitions” document
- Co-morbid psychiatric condition: Includes documentation of presence or absence of any co-occurring mental health condition such as bipolar disorder, major depression or psychosis/schizophrenia, or PTSD.
- Past psychiatric history: This could include a note about previous hospitalizations or treatments for one of these conditions. We are looking for characteristics, frequency or length of previous episodes. Chart documentation that patient has no previous treatment of all of the patient's cohort diagnoses is considered evidence of a psychiatric treatment history assessment.
- Response to previous treatment: Notation of history of medication or psychotherapy trials in the past and response to those trials.

**Feasibility/Data Collection Issues:**
- Denominator will come from administrative data
- Numerator will come from medical record data
- Analyses of assessments for those in specialty care will be conducted post hoc. We defined specialty care per the Key Definitions Document, identifying those who have 1+ specialty care encounters in the 30 days following the start of the new treatment episode.
- The date of the first diagnosis-related visit (primary or secondary diagnosis) at the start of each new treatment episode (up to 5 episodes) will be provided from administrative data for chart abstraction.
Performance Measure Technical Documentation

Module: Cross Cutting Indicators
Indicator Statement: Assessment of recent substance use – type, quantity and frequency
Indicator Number: 3

Executive Summary: The following indicator is based on clinical care recommendations in the 2004 VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress. The Center for Substance Abuse Treatment Improvement Protocol # 42 recommends that all patients with mental health disorders be assessed for co-occurring substance use, as patients with mental illness and co-morbid drug or alcohol use experience greater impairment and worse treatment outcomes than people with only one of these disorders. In addition, alcohol use interacts negatively with medications prescribed for mental health conditions, including antidepressants (Schuckit, 1986; Dackis et al., 1986; Goodwin, 1983; Kofoed et al., 1988; Friedman et al., 1983). The 2001 VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders (SUD) recommends that this assessment include “recent substance use” (ASAM, 1996; Senay, 1997; Strauss, 1995). This indicator addresses the following IOM domains: Effectiveness and patient-centeredness.

Numerator: Patients in the denominator who have an assessment of recent substance abuse, including type, quantity, and frequency, within the first 30 days of the new treatment episode.

Denominator: Patients in a new treatment episode

Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:
• New treatment episode: See the “Key Definitions” document
• Recent substance abuse: Past 3 months
• Assessment: Documentation of no recent alcohol and no recent drug use OR documentation of recent alcohol and drug use including type, quantity, and frequency for all substances used.
  o Type: Specifically ask about alcohol, marijuana, cocaine, heroin/narcotics, methamphetamine/stimulants, intravenous drug use; or note about denying all other drug use
  o Quantity (only needed for alcohol): May include note in chart on any of the following: Number of drinks per day, number of drinks per week, any note about binge drinking (>5 drinks per day), any evidence of quantity
  o Frequency: Note about daily, monthly, weekly, or occasional use

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from medical record data
• The date of the first diagnosis-related visit (primary or secondary diagnosis) at the start of each new treatment episode (up to 5 episodes) will be provided from administrative data for chart abstraction.
Performance Measure Technical Documentation

Module:  Cross Cutting Indicator (All Modules)
Indicator Statement:  Physical Exam
Indicator Number:  4

Executive Summary:  The following indicator is based on clinical care recommendations in the VA/DoD Clinical Practice Guidelines for Management Post-Traumatic Stress (2004), Major Depressive Disorder (2000), Substance Use Disorders (2001), and Psychoses (2004), and applies across all diagnoses relevant to this evaluation. In particular, the 2001 VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders (SUD), which provides specific recommendations as to the specific categories that a comprehensive SUD Assessment for patients beginning an acute treatment episode should address a number of categories including “physical examinations” (ASAM, 1996; Senay, 1997; Strauss, 1995). This indicator addresses the following IOM domains: Effectiveness and patient-centeredness.

Numerator:  Number of patients who receive a physical exam by a qualified provider
1) Within 30 days of the start of the new treatment episode
2) In the study period

Denominator:
1) All patients with a new treatment episode
2) All patients

Patient cohorts:  All diagnoses

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode:  See the “Key Definitions” document
• Physical Exam:  A physical exam must include all 6 of the following to pass: vital signs, heart, lungs, abdomen, extremities and cognition/ neuropsychological status.
• Qualified provider: Non-mental health prescriber which includes an MD (not a psychiatrist unless dually board certified) or DO; physician’s assistant, nurse practitioner.

Feasibility/Data Collection Issues:
• Denominator will come from administrative data
• Numerator will come from the medical record
Performance Measure Technical Documentation

**Module:** Cross Cutting Indicator (All Modules)

**Indicator Statement:** Assessment of substance use disorder, and trauma and patient strengths completed

**Indicator Number:** 5

**Executive Summary:** The following indicator comes from the 2006 Hospital-Based Inpatient Psychiatric Services (HBIPS) measures developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This indicator addresses the following Institute of Medicine (IOM) domains: Patient-centeredness and effectiveness. JCAHO provides the following rationale:

There is substantial evidence that there is a high prevalence of co-occurring substance use disorders as well as history of trauma among persons admitted to acute psychiatric settings. Professional literature suggests that these factors are under identified yet integral to current psychiatric status and should be assessed in order to develop appropriate treatment (Ziedonis, 2004, NASMHPD, 2005). Similarly, persons admitted to inpatient settings require a careful assessment of risk for violence and the use of seclusion and restraint. Careful assessment of risk is critical to safety and treatment. Effective, individualized treatment relies on assessments that explicitly recognize patients’ strengths. These strengths may be characteristics of the individuals themselves, supports provided by families and others, or contributions made by the individuals’ community or cultural environment (Rapp, 1998). In the same way, inpatient environments require assessment for factors that lead to conflict or less than optimal outcomes.

**Numerator:** Patients whose records include documentation of initial assessment completed:

- Within 72 hours of admission:
  - Presence/absence of co-occurring substance use disorder in past 12 months
  - Presence/absence of history of psychological trauma and contribution of trauma to current presentation
  - Assessment of patient strengths

**Denominator:** All psychiatric inpatient discharges with at least a 72 hour stay

**Patient cohorts:** All diagnoses

**Strength of Evidence:** Grade III

**Definitions:**

- Psychiatric inpatient discharges where one of the cohort diagnoses is the primary diagnosis on the inpatient record responsible for the length of stay in the selected bed section (DXLSB) (see exclusion criteria below):
  - 70, Acute Psychiatry
  - 92, Psychiatry – General Intervention
  - 93, High Intensity General Psychiatry – Inpatient
  - 72, Alcohol dependence, high intensity
  - 73, Drug dependence, high intensity
74, Substance abuse, high intensity

Exclusion criteria:

- Patients who expired (where DISTO=-2 on Medical SAS Inpatient file) within 72 hours of admission to the specified bed section
- Patients transferred to a different bed section within 72 hours of admission to the specified bed section (based on date and time of admission to the selected bed section [BSINDAY, ADTIME] and date and time patient was discharged from the selected bed section [BSOUTDAY, BSOUTIME])
- Patients discharged from the hospital within 72 hours of admission to the specified bed section (where DISTO=-1, 0-35)

- Patient strengths: Documentation in the medical record that the initial assessment contained a screening for patient strengths which should include, but is not limited to two or more of the following: an appraisal of the patient's vocational interests (interests, hobbies, etc.), interpersonal relationships and supports (family, peers, etc.), cultural/spiritual/religious and community involvement, access to housing/residential stability.
- Co-occurring SUD: Documentation in the medical record that the initial assessment contained a screening for the use of alcohol or substance abuse over the past twelve (12) months. If there is a positive history of use over the past twelve (12) months, then an assessment for the negative effect on one or more of the following must be included: important relationships (e.g., family, friends, schoolmates, coworkers), work or school, daily functioning (e.g., personal hygiene, caring for self or others in your charge, attending to medical and emotional health, driving, shopping or paying bills) and sickness or physical withdrawals when quitting use of alcohol or substances.
- History of psychological trauma: Documentation in the medical record that the initial assessment contained a screening for psychological trauma which must address if the patient has ever experienced any psychological trauma (event) that was so frightening, horrible or upsetting that it is impacting current coping by one or more of the following: having nightmares about it, having thoughts about it when you did not want to, trying hard not to think about it (e.g., went out of your way to avoid situations reminding you of it), being excessively on guard, watchful or easily startled and feeling numb or detached from others, activities or surroundings. Documentation of military trauma alone would suffice for this, whether or not the patient shows symptoms.

Feasibility/Data Collection Issues:

- Denominator will come from administrative data
- Numerator will come from medical record data
- We will collect each numerator item separately in order to assess which area may have problems
- Regardless of what cohort a patient is assigned to, the numerator applies to everyone with a psychiatric inpatient discharge.
Module: Cross Cutting Indicator (All Modules)
Indicator Statement: (Comprehensive) Mental status examination conducted in patients with a new treatment episode
Indicator Number: 6

Executive Summary: The following indicator is based on clinical care recommendations in the VA/DoD Clinical Practice Guidelines for Management Post-Traumatic Stress (2004), Major Depressive Disorder (2000), Substance Use Disorders (2001), and Psychoses (2004), and applies across all diagnoses relevant to this evaluation. The VA guideline for major depressive disorder directs providers to "Perform Mental Status Examination (MSE)" in Primary care, Outpatient Mental Health Specialty and Inpatient Mental Health care settings in order to "develop an appropriate clinical understanding of the patient that will inform subsequent provider decisions" (7-8). The guideline further states:

Particularly in the elderly patient, a full Mental Status Examination (MSE) includes cognitive screening assessment that may consist of a standardized instrument such as the Folstein Mini-Mental State Examination (MMSE) (Crum RM, et al., 1993; Cummings JL, 1993; Folstein MF, et al., 1975) (See Psychoses Guideline). Other MSE findings of importance... include slow speech, sighing, psychomotor retardation or agitation, downcast eyes, and little or no smiling.

This indicator addresses the following IOM domains: Efficiency, Effectiveness, and Timeliness.

Numerator:
1) Patients who received a Mental Status Exam (MSE) within the first 30 days of a new treatment episode
2) Patients who received a Mental Status Exam (MSE) during the study period. (Report descriptively)

Denominator:
1) Patients in new treatment episode
2) All patients

Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:
• New Treatment Episode: See the “Key Definitions” document
• Mental Status Exam (MSE): The mental status examination contains the following core elements:
  o The patient's appearance which may include:
    ▪ Presenting appearance including sex, chronological and apparent age, ethnicity, apparent height and weight (average, stocky, healthy, petite), any physical deformities (hearing impaired, injured and bandaged right hand)
    ▪ Basic grooming and hygiene, dress and whether it was appropriate attire for the occasion (e.g. like a heavy coat in hot
summer weather) and personal hygiene (e.g. foul odor, being unkept, dirty clothes, evidence of not bathing)

○ The patient’s general behavior which may include: Level of distress, degree of eye contact, attitude toward the interviewer

○ The patient's expressions of mood and affect which may include:
  - Mood or how they feel most days (happy, sad, despondent, melancholic, euphoric, elevated, depressed, irritable, anxious, angry). Think of the climate in an area.
  - Affect or how they felt a given moment (comments can include range of emotions like broad, restricted, blunted, flat, inappropriate, labile, consistent with the content of the conversation and facial expressions, pessimistic, optimistic) as well as inappropriate signs (began dancing in the office, verbally threatened examiner, cried while discussing recent happy event and unable to explain why). Think of the weather, which varies slightly from day to day.
  - Rapport (easy to establish, initially difficult but easier over time, difficult to establish, tenuous, easily upset)
  - Facial and Emotional Expressions (relaxed, tense, smiled, laughed, became insulting, yelled, happy, sad, alert, day-dreamy, angry, smiling, distrustful/suspicious, tearful when discussing such and such)
  - Response to Failure on Test Items (unaware, frustrated, anxious, obsessed, unaffected)
  - Anxiety (note level of anxiety, any behaviors that indicated anxiety, ways they handled it)

○ Characteristics of the patient's speech and language (e.g., rate, rhythm, can you understand what the patient is saying or is speech slurred or difficult to understand),

○ The patient's movement and posture. Includes gait and motor coordination (awkward, staggering, shuffling, rigid, trembling with intentional movement or at rest), posture (slouched, erect), work speed, any noteworthy mannerisms or gestures.

○ The patient's thoughts and perceptions:
  - Spontaneously expressed worries, concerns, thoughts, impulses, and perceptual experiences.
  - Cognitive and perceptual symptoms of specific mental disorders, usually elicited by specific questioning and including hallucinations, delusions, ideas of reference, obsessions, and compulsions. Hallucinations and Delusions (presence, absence, denied visual but admitted olfactory and auditory, denied but showed signs of them during testing, denied except for times associated with the use of substances, denied while taking medications).
Suicidal, homicidal, violent, or self-injurious thoughts, feelings, or impulses. If present, details are elicited regarding their intensity and specificity, when they occur, and what prevents the patient from acting them out (19). (Make SI/HI its own specific section of the MSE)

Coherence and thought processes, such as loose or idiosyncratic associations and self-contradictory statements. This may include:

- Coherence (responses were coherent and easy to understand, simplistic and concrete, lacking in necessary detail, overly detailed and difficult to follow, vague, tangential, circumstantial)
- Thought Processes (difficult to understand line of reasoning, showed loose associations, confabulations, flight of ideas, ideas of reference, illogical thinking, grandiosity, magical thinking, obsessions, perseveration)

The patient's understanding of his or her current situation. Judgment and Insight (based on explanations of what they did, what happened, and if they expected the outcome, good, poor, fair, strong)

Elements of the patient's cognitive status, including the following:

- Level of consciousness/alertness (sleepy, alert, tired for working late, dull and uninterested, highly distractible)
- Orientation (person, place, time, presidents, your name)
- Concentration and Attention (based on Digit Span and attention to your questions, serial 7's or 3's in which they count backwards from 100 to 50 by 7s or 3s, naming the days of the week or months of the year in reverse order, spelling the word "world", their own last name, or the ABC's backwards)
- Language functions (naming, fluency, comprehension, repetition, reading, writing)
- Memory
- Fund of knowledge (appropriate to sociocultural and educational background)
- Calculation (appropriate to educational attainment)
- Drawing (e.g., copying a figure or drawing a clock face)
- Abstract reasoning (e.g., explaining similarities or interpreting proverbs).
- Executive (frontal system) functions (e.g., list making, inhibiting impulsive answers, resisting distraction, recognizing contradictions)

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data
- MSE documentation defined for chart abstraction as evidence of an encounter that includes at least 5 of the 10 core MSE elements (defined above) by the same practitioner. Abstractors look for the most comprehensive MSE (contains the most core elements).
Performance Measure Technical Documentation

Module: Cross Cutting Indicator (All Modules)

Indicator Statement: Reassess severity of symptoms between the beginning of the second month and the end of the fourth month

Indicator Number: 7

Executive Summary: The following indicator is based on clinical care recommendations in the VA/DoD Clinical Practice Guidelines for Management Post-Traumatic Stress (2004), Major Depressive Disorder (2000), Substance Use Disorders (2001), and Psychoses (2004), and applies across all diagnoses relevant to this evaluation. Although the importance of symptom reassessment has been affirmed and supported by the VA clinical guidelines referenced above and by the VA Mental Health Program Evaluation Consultation Group, this is a descriptive indicator due to the lack of substantial or sufficient evidence to support the assertion that the time period specified in this indicator is demonstrably related to quality of care. This indicator addresses the following IOM domains: Effectiveness and patient-centeredness.

Numerator: All patients for whom severity of symptoms were reassessed between the second and fourth month after the start of the new treatment episode

Denominator: Patients in a new treatment episode

Patient cohorts: All diagnoses

Strength of Evidence: Grade III

Definitions:

- New Treatment Episode: See the “Key Definitions” document
- Symptoms reassessed: Findings from the assessment are likely to be in the mental status exam. Any note that refers to assessment of symptoms will suffice for passing, including whether they have improved, gotten worse or stayed the same. The Mental Status Exam (MSE) may be used and that includes the following core elements (although it should be tailored based on the problems found in the first assessment):
  - The patient's appearance which may include:
    - Presenting appearance including sex, chronological and apparent age, ethnicity, apparent height and weight (average, stocky, healthy, petite), any physical deformities (hearing impaired, injured and bandaged right hand)
    - Basic grooming and hygiene, dress and whether it was appropriate attire for the occasion (e.g. like a heavy coat in hot summer weather) and personal hygiene (e.g. foul odor, being unkempt, dirty clothes, evidence of not bathing)
  - The patient’s general behavior which may include: Level of distress, degree of eye contact, attitude toward the interviewer
  - The patient's expressions of mood and affect which may include:
    - Mood or how they feel most days (happy, sad, despondent, melancholic, euphoric, elevated, depressed, irritable, anxious, angry). Think of the climate in an area.
- Affect or how they felt a given moment (comments can include range of emotions like broad, restricted, blunted, flat, inappropriate, labile, consistent with the content of the conversation and facial expressions, pessimistic, optimistic) as well as inappropriate signs (began dancing in the office, verbally threatened examiner, cried while discussing recent happy event and unable to explain why). Think of the weather, which varies slightly from day to day.
- Rapport (easy to establish, initially difficult but easier over time, difficult to establish, tenuous, easily upset)
- Facial and Emotional Expressions (relaxed, tense, smiled, laughed, became insulting, yelled, happy, sad, alert, day-dreamy, angry, smiling, distrustful/suspicious, tearful when discussing such and such)
- Response to Failure on Test Items (unaware, frustrated, anxious, obsessed, unaffected)
- Anxiety (note level of anxiety, any behaviors that indicated anxiety, ways they handled it)
  - Characteristics of the patient's speech and language (e.g., rate, rhythm, can you understand what the patient is saying or is speech slurred or difficult to understand),
  - The patient's rate of movement and the presence of any purposeless, repetitive, or unusual movements or postures. Includes gait and motor coordination (awkward, staggering, shuffling, rigid, trembling with intentional movement or at rest), posture (slouched, erect), work speed, any noteworthy mannerisms or gestures.
  - The patient's current thoughts and perceptions, including the following:
    - Spontaneously expressed worries, concerns, thoughts, impulses, and perceptual experiences.
    - Cognitive and perceptual symptoms of specific mental disorders, usually elicited by specific questioning and including hallucinations, delusions, ideas of reference, obsessions, and compulsions. Hallucinations and Delusions (presence, absence, denied visual but admitted olfactory and auditory, denied but showed signs of them during testing, denied except for times associated with the use of substances, denied while taking medications)
Suicidal, homicidal, violent, or self-injurious thoughts, feelings, or impulses. If present, details are elicited regarding their intensity and specificity, when they occur, and what prevents the patient from acting them out (19). (Make SI/HI its own specific section of the MSE)

Features of the patient's associations, such as loose or idiosyncratic associations and self-contradictory statements. This may include:

- Coherence (responses were coherent and easy to understand, simplistic and concrete, lacking in necessary detail, overly detailed and difficult to follow, vague, tangential, circumstantial)
- Thought Processes (difficult to understand line of reasoning, showed loose associations, confabulations, flight of ideas, ideas of reference, illogical thinking, grandiosity, magical thinking, obsessions, perseveration)

The patient's understanding of his or her current situation. Judgment and Insight (based on explanations of what they did, what happened, and if they expected the outcome, good, poor, fair, strong)

Elements of the patient's cognitive status, including the following:

- Level of consciousness/alertness (sleepy, alert, tired for working late, dull and uninterested, highly distractible)
- Orientation (person, place, time, presidents, your name)
- Concentration and Attention (based on Digit Span and attention to your questions, serial 7's or 3's in which they count backwards from 100 to 50 by 7s or 3s, naming the days of the week or months of the year in reverse order, spelling the word "world", their own last name, or the ABC's backwards)
- Language functions (naming, fluency, comprehension, repetition, reading, writing)
- Memory
- Fund of knowledge (appropriate to sociocultural and educational background)
- Calculation (appropriate to educational attainment)
- Drawing (e.g., copying a figure or drawing a clock face)
- Abstract reasoning (e.g., explaining similarities or interpreting proverbs).
- Executive (frontal system) functions (e.g., list making, inhibiting impulsive answers, resisting distraction, recognizing contradictions)

Feasibility/Data Collection Issues:
- Denominator will come from administrative data
- Numerator will come from medical record data.
- Chart abstractors look for evidence of an objective measure or a subjective/interview assessment of symptoms as long as it includes a comparison with a previous score or assessment.
- For dually-diagnosed patients, a reassessment of severity of either diagnoses is abstracted as a reassessment.
- Patient self-report of “feeling better” is abstracted as evidence of a re-assessment of severity.
REFERENCES


Wu L-T, Ringwalt CL, Williams CE. 2003. Use of substance abuse treatment services by persons with mental health and substance use problems. Psychiatri Serv, 54(3): 363-9;


