Report to the Legislature

Service Coordination Organizations- Accountability Measures Implementation Status

ESHB 1519, Section 5 Chapter 320 Laws of 2013

December 1, 2014

Washington State Department of Social and Health Services

Department of Social and Health Services

Behavioral Health and Service Integration Administration (BHSIA)

Children's Administration (CA)

Juvenile Justice and Rehabilitation Administration (JJ&RA)

and

Washington State Health Care Authority

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Executive Summary

Background

In 2013, the legislature passed both Engrossed House Bill 1519 (EHB 1519) and Second Substitute Senate Bill 5732 (2SSB 5732). Both bills mandated that contracts with Regional Support Networks, county chemical dependency coordinators, Area Agencies on Aging, and managed health care plans include performance measures to improve specific outcome areas. In addition, 2SSB5732 directed the Department of Social and Health Services and the Health Care Authority to develop an adult behavioral health improvement strategy, including the identification of performance measures that mirror the outcomes identified in EHB 1519. 2SSB5732 also directed DSHS to convene a Steering Committee. Due to the similarity of outcome measures called out in both bills, the initial work of EHB 1519 was folded into the work of the Steering Committee.

Accomplishments

In partnership with the 5732/1519 Cross-System Steering Committee and its subsequent workgroups, DSHS and HCA created preliminary cross-system performance measures encompassing the multiple outcome areas identified in the legislation.

The Steering Committee process resulted in the identification of 51 potential performance measures. The Committee also identified key components required for successful implementation:

- shared ownership and accountability for the performance measures
- establish supportive relationships and working agreements between systems partners
- robust coordination services

Following the measure development process, the state agencies then prioritized a selected subset of performance measures for initial adoption.
We want to express our sincere thanks to the partners across the mental health, chemical dependency, medical, long term services and supports, housing and criminal justice systems that joined us in this work on the 5732/1519 steering committee and the workgroups formed to accomplish the committee's charge. Due to their hard work and willingness to think outside traditional service silos, we are able to work toward a new, cross-system approach to service delivery and program measurement that we believe is unique to Washington State. DSHS and HCA will continue to rely upon the consultation with the 5732/1519 Steering Committee as we move forward with implementation.

Challenges

The Impact of 2014 Legislation and Data Complexities on the Timeline for Implementation of EHB 1519:

The passage of Second Substitute Senate Bill 6312 in the 2014 Legislature impacted the implementation of EHB 1519. While EHB 1519 requires the inclusion of performance measures in contracts with Regional Support Networks and county chemical dependency coordinators in 2015, 2SSB 6312 re-defines the entities with which the state will contract for these services.

The new entities, known as Behavioral Health Organizations (BHO), will manage the delivery of both mental health and chemical dependency treatment services beginning April 1, 2016. Counties are also

given the opportunity in 2SSB 6312 to become "early adopters" and move immediately to fully integrated purchasing of medical, mental health and chemical dependency treatment services. These changes to the behavioral healthcare system affect the implementation timeline of performance measures in contract to align with the formation of the BHOs or early adopter regions in April 2016.

Successful outcomes in broad measurement areas are dependent on collaborative work across service delivery systems. For example, an Area Agency on Aging alone cannot be responsible for decreases in avoidable emergency room use, but they can play a valuable role in achieving this outcome. For this reason, as we develop payment methods linked to improved performance, we will want to consult closely with the Steering Committee and develop methods that incentivize cross system work and improved performance.

Timeline for Implementation:

While EHB 1519 requires DSHS and HCA to include the cross-system performance measures in contracts with service contracting entities starting July of 2015, 2SSB 6312 directs DSHS to begin contracting with the newly formed BHOs in April of 2016. If DSHS initiates contracts inclusive of performance measures for mental health and substance use disorder treatment in July of 2015, they will be doing so with entities that will no longer exist as of April 2016. DSHS and HCA jointly sought approval from the legislature to include the performance measures in the Behavioral Health Organization detailed plan request that will be issued on or before July 2015, and for HCA to include the performance measures in their medical managed care plan request for proposals that will be issued on or before July 2015, with the expectation that the performance measures will be included as contractual terms in their 2016 contracts.

With this plan, performance measures for contracted long term supports and services with the Area Agencies on Aging should also align with the July 1, 2016 implementation date in order to be congruent with the goal of shared outcomes and performance measures, with consistent baselines and measures' definitions.

Data Complexities:

There are several steps which need to be completed and issues that need to be considered before the identified measures and performance targets are included in contract language. These steps will require additional time and analytic resources. These additional considerations also support the inclusion of performance measures in contracts starting in July 2016.

- **Building an integrated Medicaid/Medicare analytic database**
  Medicare claims and encounter data is not currently linked into the DSHS Integrated Client Database with sufficient timeliness to support the analytical work required for performance measurement of health outcomes for persons dually eligible for Medicare and Medicaid. Integration of more current Medicare data into the DSHS Integrated Client Database will not occur until early 2015.
- **Building a client attribution methodology and validation process**.
  To hold individual contractors to performance levels for the clients they are responsible for, methods need to be developed to attribute clients to specific accountable contractors. There are also needs to be additional work to determine, based upon population sizes, whether changes in performance metrics could be attributable at an individual contractor level at a statistical significance.
- **Determining baseline performance levels**.
  Complicating the development of baseline performance levels by contractor is the ACA adult expansion population, for whom we have limited claims history. Baseline performance levels will need to account for potential variation across service contracting entities in the proportion of newly eligible adults among their attributed client population.

- **Case-mix/risk adjustment**.
  Case-mix adjustment methods need to be considered for each measure. If it is determined that case-mix adjustment is required, case-mix parameters would need to be developed and empirically tested before incorporating into contracts.
- **Setting contractor-specific performance levels / improvement targets, reporting requirements and rewards/penalties**.
  Mechanisms should be developed to create cross-system incentives, rather than the historical disincentive where savings created by one part of the system reduces the costs of another part of the system with no reciprocal support.
- **Building performance feedback reports.**
  It is likely to be more difficult for contractors to achieve desired performance levels if they have no knowledge of their performance levels on an on-going basis, or methods of receiving timely information they can use for interventions. In many cases the 1519 performance measures are not available to the contractor through their own claims billing systems.

Care Coordination:

Robust care coordination services provide a foundation for achieving the identified common outcome and performance measures. Measuring outcomes will result in some improvement. However cross-system coordination between long term services and supports, medical, mental health, and substance use disorder treatment, as well as other community partners who are not subject to contractual performance measures under EHB 1519 adds a crucial element previously missing from the system as a whole. This cross-system coordination will require both using the resources of the collective system and potentially demand targeted investments in interventions and care coordination designed to address non-health related measures such as homelessness and quality of life.

Adequate funding to ensure clients are efficiently, adequately and safely sustained in the community is needed. DSHS has included a request for additional funding in its 2015-17 submission to OFM which, if funded, would ensure caseload sizes are consistent with established workload metrics.

Effective care coordination requires that sufficient and quality clinical capacity is present to work with clients and across systems of care to achieve the shared outcomes envisioned by EHB1519.

Engrossed Second Substitute House Bill 2572:

HCA is instructed by E2SHB 2572 to establish a performance measures committee for the purpose of identifying and recommending standard statewide measures of health performance to inform health care purchasers and set benchmarks, including for both the public and private sectors. As part of its charge, this committee is expected to align their measures with the common measure requirements specific to Medicaid delivery systems.

Next Steps

Successful outcomes in broad measurement areas are dependent on collaborative work across service delivery systems. It is not possible for a single type of service contracting entity acting in isolation to achieve the desired outcomes or, in some cases, even a single performance measure related to an outcome, because of the necessarily interrelated and interdependent nature of the medical, behavioral health, and long term services and supports contracting entities.

For example, achieving the outcome of improved *Health and Wellness* by a performance measure of *Increasing Chemical Dependency Treatment Penetration Rates* could require: 1) better screening and

referral by several of the system partners; 2) follow-up by treatment providers working within multiple service entities; and, 3) coordination and collaboration across disciplines and distinct contracted service entities.

Implementation requires further refinement of the newly developed measures, development of appropriate benchmarks and formulas for financial incentives, and alignment of 5732/1519 measures with other initiatives related to performance measurement. The Department will continue to actively collaborate with the Steering Committee as this work progresses.

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Department of Social and Health Services
The Service Coordination Organizations-Accountability Measures Implementation Status

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Introduction

With the 2013 passage of Engrossed House Bill 1519 and Second Substitute Senate Bill 5732, the Washington State Legislature directed that state contracts the Department of Social and Health Services and the Health Care Authority execute with "service contracting entities" or "service coordination organizations" (i.e. Regional Support Networks, county chemical dependency coordinators, Area Agencies on Aging, and the managed health care plans) must include performance measures to address shared outcomes in the following areas:

- Improvement in client health status
- Increases in client participation in employment, education, and meaningful activities
- Reduced client involvement in criminal justice systems and increased access to treatment for forensic patients
- Reduced avoidable use of hospital, emergency rooms, and crisis services
- Increased housing stability in the community
- Improved client satisfaction with quality of life
- Decreased population level disparities in access to treatment and treatment outcomes

These common outcome and performance measures move the public healthcare and social service system towards a model of shared ownership and accountability and will require new ways of doing business.

Subsequent to the passage of EHB 1519 and 2SSB 5732, the Legislature passed Second Substitute Senate Bill 6312 and Engrossed Second Substitute House Bill 2572 during the 2014 legislative session. Both of these bills contain provisions impacting the implementation of EHB 1519 and 2SSB 5732.

This report will describe the progress to date and the next steps toward fulfilling the requirements of EHB 1519 including identified performance measures and their relationship to expected improvements in client outcomes, mechanisms for reporting, and options for applying the performance measures and outcome processes to other health and social service programs.

Performance Measure Development Strategy

5732/1519 Cross System Steering Committee- On September 6, 2013, DSHS and HCA convened the 5732/1519 Cross System Steering Committee to provide a streamlined mechanism to develop and vet performance measures across systems. As enacted, 2SSB 5732 directed DSHS to convene a Steering Committee. Due to the similarity of outcome measures called out in both bills, the initial work of EHB 1519 was folded into the Steering Committee. *(A roster of Steering Committee membership can be found in Appendix A.)*

At this initial meeting, the Steering Committee agreed to nominate individuals to participate on workgroups four of which were tasked with development of common performance measures:

- Health, Wellness, Utilization, and Disparities
- Housing, Employment, Education, and Meaningful Activity
- Criminal Justice and Forensic Patients

- Quality of Life

Steering Committee members conducted a robust recruitment for workgroup membership, resulting in large workgroups. DSHS and HCA staff, including staff from the Research and Data Analysis Division (RDA), participated on each workgroup, preparing materials for the workgroup to respond to and organizing the on-going process. Workgroups ranged in size from approximately 20 members to as many as nearly 40 members with a combined membership that included at least 60 community organizations, state agencies, and Tribes. Each group met at least eight times between late November 2013 and early April 2014, often working electronically between meetings to continue the workflow. A high level of sustained engagement throughout the Steering Committee and workgroup processes strengthened the resulting performance measures recommendations. *(A combined roster of workgroup memberships is provided in Appendix B.)*

While 2SSB 5732 dedicated attention to the adult behavioral healthcare system, it should be noted that the performance measures developed under EHB 1519 were not specific to adults, rather they are intended across the lifespan. However, due to the strong focus on the adult behavioral healthcare improvement strategy, child-specific measures received less discussion.

The 10 Principles- RDA developed the following principles to guide the Steering Committee and workgroups' development and selection of performance measures:

1. Meaningfulness – The measure reflects an important aspect of the delivery of health services
2. Feasibility – The measure is well-defined and can be collected with a reasonable level of resources
3. Responsiveness to change ("Impactability")
4. Outcome over process
5. Objective over subjective
6. Uniform centralized data collection—minimizes the cost of data collection and promote comparability across reporting entities
7. Use administrative data where feasible – minimizes the cost of data collection, allows measures to be built on a population basis, and supports higher-frequency reporting to better monitor changes in performance
8. Use national standards where feasible – provides transparent definitions and facilitates comparisons with other states and commercial populations
9. Align measures with existing reporting requirements where appropriate
10. Incentive compatibility – Minimizes the risk of "gaming" and unanticipated negative consequences by including risk adjustment consideration

Conclusion of the Workgroup Process- The workgroup process concluded with a presentation of each workgroup's recommendations to the Steering Committee. On April 18, 2014, the Committee approved the workgroup recommendations as successfully satisfying the task they had been given by the Committee and under the legislation. Additionally, the Committee recommended that state agencies choose a subset of the 51 potential measures for inclusion into contracts and that selected measures be shared across the healthcare and social service systems. The agencies and Committee agreed to actively collaborate in later phases of the implementation of these performance measures.

Performance Measure Workgroup Reports

Health, Wellness, Utilization, and Disparities (HWUD) Workgroup Report:

EHB 1519 instructed this workgroup to develop measures for:

- Improvements in client health status and wellness

- Reductions in avoidable costs in hospitals, emergency rooms, crisis services
- Reductions in population-level health disparities

The language in 2SSB 5732 supported measures toward:
- Improved health status
- Reduction in avoidable utilization of and costs associated with hospital, emergency room, and crisis services
- Decreased population level disparities in access to treatment and treatment outcomes

Population Disparities:

As directed under the legislation, the HWUD workgroup sought to address the issue of reducing population health disparities. It should be noted that all of the workgroups received direction to include the issue of population level disparities as part of their exploration. To support the measurement of disparities and differences in performance across service contracting entities, the HWUD workgroup agreed that where feasible and appropriate, metrics should be measurable across groups defined by:
- Race/ethnicity and primary language
- Age and gender, where appropriate
- Geographic region
- Service-contracting entities
- Delivery system participation
- Medicaid coverage (e.g., persons with disabilities, newly eligible adults, child welfare system participation)
- Chronic physical and behavioral health conditions
- History of criminal justice involvement
- Housing stability
- Co-occurring mental health and substance use disorders

Policy Considerations:

The selection and endorsement of potential performance measures supported the following policy considerations:
- Incentivize access to effective and appropriate primary care
- Incentivize prevention and early intervention
- Incentivize access to a range of mental health treatment and community-based recovery support services
- Incentivize access to a range of treatment and community-based recovery support services for substance use disorders
- Incentivize provision of long-term services and supports in home and community-based settings
- Incentivize coordinated care for persons with complex needs
- Incentivize quality health care
- Incentivize achievement of desirable health outcomes
- Incentivize reduction in avoidable service utilization and costs
- Recognize risk of tying performance metrics to wellness and disease prevalence measures in ways that would reinforce incentives for service contracting entities to achieve favorable risk selection
- Recognize measures appropriate for monitoring delivery system performance that may not be appropriate for contract accountability measures
- Recognize the lack of public transportation and its impact on access to services and the increased use of tele-health usage

Health, Wellness, Utilization, and Disparities Workgroup Recommended Performance Measures		
Access and effectiveness of care		
1.	**Measure**	Adults' Access to Preventive/Ambulatory Care
	Definition	The percentage of members 20 years and older who had an ambulatory or preventive care visit
	Populations	All service contracting entities
	Source	NCQA HEDIS
Access and effectiveness of care		
2.	**Measure**	Well-Child Visits (Age dependent schedules)
	Definition	The percentage of children with Well-Child Visits according to prescribed schedule for their age
	Populations	All service contracting entities serving children
	Source	NCQA HEDIS
Access and effectiveness of care		
3.	**Measure**	Comprehensive Diabetes Care: Hemoglobin A1c Testing
	Definition	Percentage of enrollees ages 18 to 75 with diabetes (type 1 and type 2) that had a Hemoglobin A1c test
	Populations	All service contracting entities
	Source	NCQA HEDIS
Access and effectiveness of care		
4.	**Measure**	Alcohol/Drug Treatment Penetration
	Definition	Percent of adults identified as in need of drug or alcohol (AOD) treatment where treatment is provided during the measurement year
	Populations	All service contracting entities
	Source	State defined
Access and effectiveness of care		
5.	**Measure**	Mental Health Treatment Penetration
	Definition	Percent of adults identified as in need of mental health treatment where treatment is received during the measurement year
	Populations	All service contracting entities
	Source	State defined
Access and effectiveness of care		
6.	**Measure**	SBIRT Service Penetration
	Definition	The percentage of members who had an outpatient visit and who received a Screening, Brief Intervention or Referral to Treatment (SBIRT) service during the measurement year or the year prior to the measurement year
	Populations	All service contracting entities
	Source	State defined
Access and effectiveness of care		
7.	**Measure**	Home- and Community-Based Long Term Services and Supports Use*
	Definition	Proportion of person-months receiving long-term services and supports (LTSS) associated with receipt of services in home- and community-based settings during the measurement year

	Populations	All service contracting entities
	Source	State defined
Access and effectiveness of care		
8.	**Measure**	Suicide and drug overdose death rate
	Definition	Age-adjusted rate of suicide and drug overdose death per 100,000 covered lives
	Populations	System monitoring only
	Source	State defined
Utilization		
9.	**Measure**	Psychiatric Hospitalization Readmission Rate
	Definition	Proportion of acute psychiatric inpatient stays during the measurement year that were followed by an acute psychiatric readmission within 30 days
	Populations	All service contracting entities
	Source	Modified version of NCQA HEDIS “Plan All-Cause Readmission” metric
Utilization		
10.	**Measure**	Ambulatory Care - Emergency Department (ED) Visits**
	Definition	Rate of emergency department (ED) visits per 1,000 member months
	Populations	All service contracting entities
	Source	CHIPRA (extended to all ages)
Utilization		
11.	**Measure**	Inpatient Utilization
	Definition	Inpatient Utilization – General Hospital/Acute Care
	Populations	All service contracting entities
	Source	NCQA HEDIS
Utilization		
12.	**Measure**	Plan All-Cause Readmission Rate
	Definition	Proportion of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days
	Populations	All service contracting entities
	Source	NCQA HEDIS
Utilization		
13. – 16.	**Measure**	Ambulatory Care Sensitive Condition Hospital Admissions
	Definition	The number of discharges per 100,000 MM age 18+ for: (13.) diabetes short-term complications, (14) chronic obstructive pulmonary disease, (15) congestive heart failure, and (16) asthma
	Populations	All service contracting entities
	Source	AHRQ-PQI
Care Coordination		
17.	**Measure**	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia
	Definition	The percentage of members 18–64 years of age with schizophrenia and cardiovascular disease, who had an LDL-C test during the measurement year
	Populations	All service contracting entities
	Source	NCQA HEDIS
Wellness		

18.	Measure	Medical Assistance with Smoking and Tobacco Use Cessation
	Definition	Rolling average represents the percentage of Medicaid enrollees age 18 and older that were current smokers or tobacco uses and who received advise to quit, discussed or were recommended cessation medications, and discussed or were provided cessation methods or strategies during the measurement year.
	Populations	System monitoring only
	Source	HEDIS – survey
Wellness		
19.	Measure	Body Mass Assessment
	Definition	The percentage of members who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year
	Populations	All service contracting entities
	Source	NCQA HEDIS
Wellness		
20.	Measure	Tobacco Use Assessment
	Definition	The percentage of members who had an outpatient visit and who had a tobacco use assessment during the measurement year or the year prior to the measurement year
	Populations	All service contracting entities
	Source	State defined

*This measure was also endorsed by the Housing, Employment, Education, and Meaningful Activities Workgroup as addressing housing stability relevant to the long-term care population.
**This measure was identified by the Quality of Life Workgroup as a relevant administrative data measure for the purposes of looking at quality of life on a population-basis.

The above menu of health, wellness, and utilization related measures are expected to evolve over time, as clinical standards change and as clinical data measures become available through a centralized clinical data repository. The Steering Committee strongly supported the notion that once clinical data becomes available, contracts should include incentives for improved clinical outcomes rather than for the performance of tests aimed at improving these outcomes. Additionally, while oral health is not currently addressed in these measures, it will likely be included in a later phase of this process.

Housing, Employment, Education, and Meaningful Activity (HEEM) Workgroup Report:

The HEEM workgroup addressed the outcome areas called out by each bill, which varied with each other to some degree. EHB 1519 identified:

- Increases in stable housing in the community
- Increases in client participation in meaningful activities

2SSB 5732 directed work towards:

- Increased housing stability
- Increased participation in employment and education

Special Consideration for Housing Stability Measures

The issue of housing stability received special attention. The workgroup sought to align housing measures with homelessness measures used by other systems such as the U.S. Department of Housing and Urban Development (HUD), the Washington State Department of Commerce, and local housing providers. Three separate populations sought for measurement included: individuals living in places not

meant for housing (such as the street, tents, or cars), individuals homeless but sheltered (such as in emergency shelters), and individuals at risk of homelessness (such as those staying temporarily with friends or family members).

Special focus was paid to the need to identify housing and residential measures appropriate for long-term care clients. After much discussion and additional analyses of proposed measures, this was accomplished through a measure included in the HWUD workgroup's recommended measures: for Home- and Community-Based Long Term Services and Supports Use, the proportion of person-months receiving long-term services and supports associated with receipt of services in home- and community-based settings during the measurement year. Additionally, as the housing measures go forward, the state must guard against the use of institutions (nursing facilities, state psychiatric hospitals) as a method to reduce housing instability.

Housing, Employment, Education, and Meaningful Activity Workgroup Recommended Performance Measures		
Housing Stability		
21.	**Measure**	Homelessness/housing instability (broad)
	Definition	Number and percent of clients with any identified homelessness or housing instability in any of five data systems
	Populations	System monitoring only
	Source	ACES, HMIS, and medical/behavioral health data systems
Housing Stability		
22.	**Measure**	HMIS-recorded housing assistance penetration
	Definition	Percent of homeless clients who receive housing assistance recorded in HMIS
	Populations	All service contracting entities
	Source	ACES, HMIS, and medical/behavioral health data systems
Housing Stability		
23.	**Measure**	Homelessness (narrow)
	Definition	Number and percent of clients in two mutually exclusive categories: 1) Homeless without housing in ACES and not receiving HMIS-recorded assistance and 2) Receiving HMIS-recorded Emergency Shelter or Transitional Housing (regardless of ACES status)
	Populations	All service contracting entities
	Source	ACES, HMIS, and medical/behavioral health data systems
Housing Stability		
24.	**Measure**	Residential instability*
	Definition	Number of address changes
	Populations	System monitoring only
	Source	ACES, HMIS, and medical/behavioral health data systems
Employment		
25.	**Measure**	Employment Rate
	Definition	Number and percent of clients with any earnings in the quarter of service
	Populations	All service contracting entities for clients aged 18-65
	Source	Employer-reported earnings and hours data collected by the Washington State Employment Security Department on quarterly basis. Excluded data: earnings from self-employment, federal employment, employment in other states, and other unreported earnings

Employment		
26.	**Measure**	Earnings
	Definition	Average monthly wages and hourly wage rate in the quarter of service
	Populations	All service contracting entities for clients aged 18-65
	Source	Employer-reported earnings and hours data collected by the Washington State Employment Security Department on quarterly basis Excluded data: earnings from self-employment, federal employment, employment in other states, and other unreported earnings
Employment		
27.	**Measure**	Hours Worked
	Definition	Average weekly hours in the quarter of service
	Populations	All service contracting entities for clients aged 18-65
	Source	Employer-reported earnings and hours data collected by the Washington State Employment Security Department on quarterly basis Excluded data: earnings from self-employment, federal employment, employment in other states, and other unreported earnings
Education		
28.	**Measure**	School-age children enrolled in school
	Definition	Number of youth enrolled in K-12 divided by the number of youth ages 5-18
	Populations	For all service contracting entities: children served by any DSHS program and adults served by the DSHS Economic Services Administration between SFY 2000 and 2012
	Source	INVEST database, which contains de-identified education data from the P20 data warehouse linked to the DSHS Integrated Client Database
Education		
29.	**Measure**	On time and late graduation from high school
	Definition	Number and proportion of youth who graduate high school in 4 years, as well as those who graduate late (within 6 years)
	Populations	For all service contracting entities: children served by any DSHS program and adults served by the DSHS Economic Services Administration between SFY 2000 and 2012
	Source	INVEST database, which contains de-identified education data from the P20 data warehouse linked to the DSHS Integrated Client Database
Education		
30.	**Measure**	Adult enrollment in post-secondary education or training
	Definition	Adult (age 18+) enrollment in any class or program at a community or technical college, 4-year college, career school, non-credit workforce program, or apprenticeship program
	Populations	For all service contracting entities: adults served by the DSHS Economic Services Administration between SFY 2000 and 2012
	Source	INVEST database, which contains de-identified education data from the P20 data warehouse linked to the DSHS Integrated Client Database
Meaningful Activities		
31.	**Measure**	Meaningful activity survey item
	Definition	Meaningful activity survey question: "To what extent do you do things that are meaningful to you?"
	Populations	All service contracting entities
	Source	Item is included in the survey the Quality of Life group recommended

* Residential instability is an aspirational measure requiring further development.

Criminal Justice and Forensic Patients Workgroup Report:

EHB 1519 charged this workgroup with developing performance measures aimed at:

- Reduced involvement with the criminal justice system
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons

While 2SSB 5732 targeted:

- Reduced involvement with the criminal justice system
- Enhanced safety and access to treatment for forensic patients

This workgroup began by agreeing on two areas of focus: reducing the involvement of adults with behavioral health needs in the criminal justice system and access to behavioral health treatment for forensic patients; which they defined as:

- *Reduce involvement with the criminal justice system*: Criminal justice involvement is any felony- or misdemeanor-related arrests, charges, convictions or periods of incarceration in a given time period.
- *Access to treatment for forensic patients:* Forensic patients are criminally-involved adults—in the community or at the time of discharge from a criminal justice facility—with an indicator of mental illness or alcohol or drug treatment need.

Policy Considerations:

Throughout these discussions, the workgroup observed the following policy considerations:

Criminal Justice Involvement

- Promote cross-system awareness of unmet behavioral health needs and their impact on local criminal justice systems
- Balanced with public safety needs, encourage services and practices that reduce the number of bookings and length of jail stays for those with behavioral health problems
- Incentivize greater collaboration between behavioral health and criminal justice agencies (e.g. create memorandums of understanding or rules to increase communication and define expectations/responsibilities about individuals being served in multiple settings)
- Guard against penalizing agencies for serving individuals with criminal justice involvement
- Better connect the behavioral health treatment and the criminal justice data systems in order to measure the impact of treatment on criminal justice-involved populations

Access to Treatment

- Promote access to treatment for criminally involved patients in the community and at time of discharge from a criminal justice or psychiatric facility
- Encourage outreach by behavioral health agencies and engagement with persons with criminal justice involvement and behavioral health needs
- Incentivize collaboration between behavioral health and criminal justice agencies to identify and effectively serve persons with behavioral health needs
- Enrolling eligible adults involved in the criminal justice system into Medicaid and other available health care plans

Criminal Justice and Forensic Patients Workgroup Recommended Performance Measures		
Criminal Justice Involvement		
32.	**Measure**	Criminal Justice Involvement
	Definition	Number and proportion of adults—with and without indicators of mental illness or AOD treatment need—who have any criminal justice involvement in a SFY.
	Populations	All service contracting entities
	Expectation	Decline in criminal justice involvement or maintenance of target goal (to be determined). Narrow the gap between those with and without behavioral health needs.
	Considerations	Includes only those recently served by DSHS/HCA and may not reflect the prevalence of behavior health needs overall.
Criminal Justice Involvement		
33.	**Measure**	Jail Admissions
	Definition	Number and proportion of adults—with and without indicators of mental illness or AOD treatment need—who are booked in local jails one or more days during a SFY.
	Populations	All service contracting entities
	Expectation	Decline in admissions or maintenance of target goal (to be determined). Narrow the gap between those with and without behavioral health needs.
	Considerations	Includes only those recently served by DSHS/HCA and requires successful linkage with jail data.
Criminal Justice Involvement		
34.	**Measure**	Days in Jail
	Definition	Total days jailed per 100 adults in a SFY—with and without indicators of mental illness or AOD treatment need.
	Populations	All service contracting entities
	Expectation	Decline in days jailed or maintenance of target goal (to be determined). Narrow the gap between those with and without behavioral health needs.
	Considerations	Includes only those recently served by DSHS/HCA and requires successful linkage with jail data.
Criminal Justice Involvement		
35.	**Measure**	Referrals for Competency Evaluation
	Definition	The number of adults referred for a competency evaluation during a SFY.
	Populations	All service contracting entities
	Expectation	Decline in the number of referrals.
	Considerations	This measure may be subject to considerable variation due to differences in practices of local police, courts, prosecutors, and defense attorneys. Requires acquisition of administrative data on referrals.
Criminal Justice Involvement		
36.	**Measure**	Persons in Prison with Serious Mental Illness
	Definition	Number and proportion of newly incarcerated persons (from county of conviction) with serious mental illness in a SFY.
	Populations	All service contracting entities
	Expectation	Decline in the rate of newly incarcerated offenders with serious mental illness or maintenance of target goal (to be determined).
	Considerations	DOC population only. There is no uniform, statewide psychiatric screening process

		available for local jail populations. Requires acquisition of new administrative data from DOC.
Access to Treatment for Forensic Patients		
37.	**Measure**	Mental Health Treatment after Release from Incarceration
	Definition	Number and proportion of adults with an indicator of mental illness who received intake or psychiatric outpatient services within a specified number of days after release from jail or prison in a SFY.
	Populations	All service contracting entities
	Expectation	Increase in rates served within specified number of days or maintenance of target goal (to be determined).
	Considerations	Includes only those recently served by DSHS/HCA and requires successful linkage with jail data. Providers depend upon jails for notifications of release.
Access to Treatment for Forensic Patients		
38.	**Measure**	Serving Previously Un-served Offenders
	Definition	Proportion of criminally involved persons previously not-served (by DSHS/HCA), receiving publicly funded behavioral health services in a SFY.
	Populations	Systems monitoring measure
	Expectation	Increase in rates served or maintenance of target goal (to be determined).
	Considerations	The measure is not based solely on individuals with identifiable behavioral health services.
Access to Treatment for Forensic Patients		
39.	**Measure**	Alcohol or Drug Treatment after Release from Incarceration
	Definition	Number and proportion of adults with an indicator of AOD treatment need who receive publicly funded treatment services within a specified number of days after release from incarceration in a SFY.
	Populations	All service contracting entities
	Expectation	Increase in rates served or maintenance of target goal (to be determined).
	Considerations	Includes only those recently served by DSHS/HCA and requires successful linkage with jail data. Providers depend upon jails for notifications of release
Access to Treatment for Forensic Patients		
40.	**Measure**	Alcohol or Drug Treatment Retention
	Definition	Number and proportion of adults with and without criminal involvement who receive an AOD treatment service at least every 30 days in the first 90 days of admission to treatment (or completed treatment within 90 days of admission) in a SFY.
	Populations	All service contracting entities
	Expectation	Increase in rates served or maintenance of target goal (to be determined). Narrow the gap between those with and without criminal involvement.
	Considerations	--
Access to Treatment for Forensic Patients		
41.	**Measure**	Mental Health Treatment Engagement
	Definition	Number and proportion of adults with and without criminal involvement who receive a mental health treatment service within 28 days of intake in a SFY.
	Populations	All service contracting entities
	Expectation	Increase in rates served or maintenance of target goal (to be determined). Narrow the gap between those with and without criminal involvement.
	Considerations	--

Access to Treatment for Forensic Patients		
42.	**Measure**	New Medicaid Enrollments after Release from Criminal Justice Facilities
	Definition	Number and proportion of persons discharged from corrections, jail, or JRA facilities who enroll in Medicaid coverage within 30 days in a SFY.
	Populations	Systems monitoring measure
	Expectation	Increase in rates served or maintenance of target goal (to be determined).
	Considerations	The measure is not based solely on individuals with identifiable behavioral health services.

Data Sources

Unless otherwise noted, measures are based on extracts from existing administrative data, including one or more combinations of the following:

- Department of Corrections Offender Management Network Information (OMNI)
- Mental Health Consumer Information System (MHCIS)
- ProviderOne
- Treatment and Assessment Reports Generation Tool (TARGET)
- Washington Association of Sheriffs and Police Chiefs (WASPC) Jail Data*
- Washington State Patrol Arrest Records Washington State Institute for Public Policy Criminal Justice System (CJS)

*Newly available jail records are not yet available for linkage with other administrative data.

Quality of Life (QOL) Workgroup Report:

The Quality of Life workgroup developed their recommended measures by addressing, per EHB 1519:

- Improvements in client satisfaction with quality of life

And per 2SSB 5732:

- Improved quality of life, including measures of recovery and resilience

Key Considerations

Early discussion within the group produced consensus that "quality of life" is multi-dimensional and includes the following domains: physical, emotional, social, hope, respect, meaningful activities, and safety/autonomy. Feedback from the Steering Committee resulted in one additional domain, cultural connectedness, for measurement consideration. Additionally, the workgroup agreed that quality of life is self-perceived and individual. While the workgroup endorsed the use of administrative data elements to efficiently measure some components of quality of life on a population basis, strong feeling emerged that due to the self-perceived and individual nature of this concept, a survey tool will result in the most direct and accurate measurement.

The workgroup reviewed five possible survey tools that address Quality of Life: the EuroQoL, the CDC Healthy Days and Wellbeing measures, the World Health Organization's Quality Of Life Instrument-Short Version (WHOQOL-BREF), the Rand-36, and the InterRAI, considering the pros and cons of each. Of special importance were the psychometric properties, the use of recovery-oriented language, the length of survey, and whether the tools are available in the public domain. Group consensus landed on the WHOQOL-BREF due to the fact that it met most of the above criteria, is available in multiple languages, and includes recovery-oriented language and concepts. The workgroup then identified and developed questions in the following domains for complete coverage: hope, respect, and meaningful activities (in

collaboration with HEEM workgroup). Based on feedback from the 5732/1519 Steering Committee, an additional question addressing the issue of "cultural connectedness" will be developed.

Due to the nature of quality of life concepts and the introduction of new survey tool for measurement, the workgroup recommends that measures from the survey tool as systems monitoring measures, rather than contract performance measures.

Example question from the WHOQOL-BREF:

The following are sample questions from the WHOQOL-BREF, the recommended survey instrument. The workgroup constructed survey items will use scaled responses that are consistent with the WHOQOL-BREF. The questions that follow inquire as to **how much** an individual has experienced certain things in the last two weeks.

		(Please circle the number)				
For office use		**Not at all**	**A little**	**A moderate amount**	**Very Much**	**An extreme amount**
F1.4 / F1.2.5	**3. To what extent do you feel that physical pain prevents you from doing what you need to do?**	**1**	**2**	**3**	**4**	**5**
F11.3 / F13.1.4	**4. How much do you need any medical treatment to function in your daily life?**	**1**	**2**	**3**	**4**	**5**
F4.1 / F6.1.2	**5. How much do you enjoy life?**	**1**	**2**	**3**	**4**	**5**

Quality of Life Workgroup Recommended Performance Measures		
Self-reported quality of life: physical health		
43.	**Definition**	WHOQOL-BREF Physical Health Scale
	Domain	Physical health
	Populations	Systems monitoring measure
	Source	Survey: WHOQOL-BREF
Self-reported quality of life: psychological health		
44.	**Definition**	WHOQOL-BREF Emotional Health Scale
	Domain	Emotional health
	Populations	Systems monitoring measure
	Source	Survey: WHOQOL-BREF
Self-reported quality of life: social health		
45.	**Definition**	WHOQOL-BREF Social Relationships Scale
	Domain	Social health
	Populations	Systems monitoring measure
	Source	Survey: WHOQOL-BREF

Self-reported quality of life: safety and autonomy		
46.	**Definition**	WHOQOL-BREF Environment Scale
	Domain	Autonomy/Safety
	Populations	Systems monitoring measure
	Source	Survey: WHOQOL-BREF
Self-reported overall quality of life		
47.	**Definition**	WHOQOL-BREF Overall Quality of Life and General Health items
	Domain	Overall Quality of Life
	Populations	Systems monitoring measure
	Source	Survey: WHOQOL-BREF
Self-reported outlook towards future		
48.	**Definition**	"How positive do you feel about the future?"
	Domain	Hope
	Populations	Systems monitoring measure
	Source	Survey item: WHOQOL 100
Self-reported participation in meaningful activities (HEEM)		
31.	**Definition**	"To what extent do you do things that that are meaningful to you?"
	Domain	Meaningful Activities
	Populations	Systems monitoring measure
	Source	Survey item: Workgroup constructed
Self-reported perception of respect		
49.	**Definition**	"To what extent are you respected and treated fairly?"
	Domain	Respect
	Populations	Systems monitoring measure
	Source	Survey item: Workgroup constructed
Self-reported perception of autonomy		
50.	**Definition**	"To what extent do you make your own choices?"
	Domain	Choice
	Populations	Systems monitoring measure
	Source	Survey item: Workgroup constructed
Placeholder for "cultural connectedness" survey item		
51.	**Definition**	New survey item: to be defined
	Domain	Cultural connectedness
	Populations	Systems monitoring measure
	Source	Survey item: Workgroup constructed
Homelessness or housing instability (HEEM)		
21.	**Definition**	Number and proportion of individuals who have any incidence of homelessness or housing instability in a SFY
	Domain	Autonomy/Safety
	Populations	All service contracting entities
	Source	Administrative data: ACES, HMIS, TARGET, CIS, Provider One
Proportion of working age adults who are employed (HEEM)		
25. – 27.	**Definition**	Number and proportion of adults age 18-64 received any wages during the SFY Can also report: Earnings (average wages), Hours Worked (average weekly hours worked)
	Domain	Autonomy/Safety

	Populations	All service contracting entities
	Source	Administrative data: Employment Security Department, Unemployment Insurance Wage Records
Emergency department use rate (Health/Wellness)		
10.	**Definition**	The number of emergency department visits per 1,000 member months in SFY. Member months are the months with medical eligibility coverage under Medicaid or other forms of medical assistance as recorded in Provider One.
	Domain	Physical health
	Populations	All service contracting entities
	Source	Administrative data: Provider One

Next Steps and Considerations

Key issues must be answered in order to move forward with the recommended survey. The feasibility of implementation may be driven by the costs associated with administration, sampling plans, and the need to construct measurements across demographic and service populations.

- This survey is best suited for centralized data collection and should not fall to the providers or plan to perform
- Considerations need to be addressed related to special populations and their participation in the survey, such as cognitive impairment and translated version for non-English speakers
- Determine frequency and timing of survey administration. A detailed sampling plan, including sampling across health plans and delivery areas is required to determine actual costs and feasibility.
- Establish baseline measurements across service populations

Sample Minimum Cost Estimate, Year 1

The implementation of the proposed survey is subject to funding. The cost of the survey is driven in large part by the survey sample size. Below is an estimate of the survey cost if 100 individuals from 37 counties and 200 individuals from King and Pierce counties were surveyed:

> 39 Counties x (n = 100/county, n = 200/King, Pierce) resulting in 4,100 to be surveyed at a cost of $120 per survey would result in a total cost of $492,000.

Next Steps for Operationalizing Performance Measures:

The Steering Committee's approval of the 51 potential performance measures concluded the first phase of the development and identification of common performance measures. The state will continue to actively collaborate with the 5732/1519 Cross-System Steering Committee as the implementation progresses. Work to be performed during the next phase includes:

- Incorporate Medicare data into the integrated data warehouse
- Further refinement of newly defined measures
- In coordination with each other and with their respective contracting entities, the agencies will develop appropriate measure benchmarks or targets for specific contracting environments and in consideration of the impact of Medicaid expansion
- In coordination with each other and with their respective contracting entities, the agencies will develop formulas relating performance across a set of contract measures to contract financial incentives
- Identification and performance of needed risk adjustment of contractor performance standards for some contracting contexts

- Design and implement a transparent quality management system, currently planned to be a similar application as RDA's One Department Data Repository (1DDR). 1DDR is a centralized, automated and highly structured repository for DSHS aggregate performance measure data.
- Align the 5732/1519 measures with the ESHB 2572 Performance Measures Coordinating Committee's work, HCA's Clinical Quality Council's identified measures, with the goals identified in the Healthier Washington grant application for the State Innovations Models funding from the Center for Medicare and Medicaid Innovation, and with the Washington State Prevention Framework. (Developed out of the early planning for the Healthier Washington grant application, the Washington State Prevention Framework is a blueprint for state, regional, and local partners to drive population health improvement and its success will likely be measured through those metrics employed within the overall healthcare system.)
- Consultation and collaboration with tribal governments

The Impact of 2014 Legislation and Data Complexities on the Timeline for Implementation of EHB 1519:

Second Substitute Senate Bill 6312- The passage of 2SSSB 6312 in the 2014 Legislative session brought new direction to the implementation of EHB 1519. The new Senate bill provides further guidance to process of reforming and integrating the behavioral healthcare system. The complete bill can be viewed at: http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/6312-S2.SL.pdf
Provisions include:

- With guidance from the Legislative Behavioral Health Task Force, HCA and DSHS will jointly establish common regional service areas for the purposes of purchasing behavioral and medical healthcare services
- The formation of "behavioral health organizations" (BHOs), an organization within each common regional service area, responsible for the provision of both mental health and chemical dependency treatment in a managed care structure, replacing the RSNs and county CD coordinators
- Authorization for DSHS to hold back a portion of resources to incentivize outcome based performance and clinical integration of behavioral health and primary care, and improved care coordination for people with complex care needs

Timeline for Implementation- It is important to note that while EHB 1519 requires DSHS and HCA to include the cross-system performance measures in contracts with service contracting entities starting July of 2015, 2SSB 6312 directs DSHS to begins contracting with the newly formed BHOs in April of 2016. If DSHS initiates contracts inclusive of performance measures for mental health and substance use disorder treatment in July of 2015, they will be doing so with entities that will no longer exist as of April 2016. DSHS and HCA jointly sought approval from the legislature to include the performance measures in the Behavioral Health Organization detailed plan request that will be issued on or before July 2015, and for HCA to include the performance measures in their medical managed care plan request for proposals that will be issued on or before July 2015, with the expectation that the performance measures will be included as contractual terms in their 2016 contracts.

With this plan, performance measures for contracted long term supports and services with the Area Agencies on Aging should also align with the 2016 implementation date in order to be congruent with the goal of shared outcomes and performance measures, with consistent baselines and measures' definitions.

Data Complexities- There are also several steps which need to be completed and issues that need to be considered before the identified measures and performance targets are included in contract language. These steps will require additional time and analytic resources. These additional considerations also support the inclusion of performance measures in contracts starting in 2016.

- **Building an integrated Medicaid/Medicare analytic database**. Medicare and Medicaid data are currently integrated on a weekly basis into the PRISM predictive modeling application to support clinical decision-making by entities with care management responsibilities (e.g., Health Homes). However, Medicare claims and encounter data is not currently linked into the DSHS Integrated Client Database with sufficient timeliness to support the analytical work required for performance measurement of health outcomes for persons dually eligible for Medicare and Medicaid. For example, approximately 80% of individuals receiving long term services and supports are eligible for both Medicaid and Medicare. The most recent integrated dataset covers SFY 2011, which is too dated for 2015 contracting. Integration of more current Medicare data into the DSHS Integrated Client Database will not occur until early 2015.
- **Building a client attribution methodology and validation process**. To hold individual contractors to performance levels for the clients they are responsible for, methods need to be developed to attribute clients to specific accountable contractors. There are also needs to be additional work to determine, based upon population sizes, whether changes in performance metrics could be attributable at an individual contractor level at a statistical significance.
- **Determining baseline performance levels**. Complicating the development of baseline performance levels by contractor is the ACA adult expansion population, for whom we have limited claims history. Baseline performance levels will need to account for potential variation across service contracting entities in the proportion of newly eligible adults among their attributed client population.
- **Case-mix/risk adjustment**. We know from modeling performance measures that not taking case-mix into account can result in unintended adverse incentives (For an illustration of the issues, see "Patterns of Hospital Readmissions and Nursing Facility Utilization among Washington State Dual Eligibles: Opportunities for Improved Outcomes and Cost Savings http://publications.rda.dshs.wa.gov/1464/). (Insert Figure 6 if you need a visual). Case-mix adjustment methods need to be considered for each measure. If it is determined that case-mix adjustment is required, case-mix parameters would need to be developed and empirically tested before incorporating into contracts.
- **Setting contractor-specific performance levels / improvement targets, reporting requirements and rewards/penalties**. There are many ways to structure performance incentives; the options need to be reviewed, vetted and carefully chosen to avoid putting a contracted entity in the position of being responsible for achieving a performance measure without sufficient authority or scope of control to achieve it. Mechanisms should be developed to create cross-system incentives, rather than the historical disincentive where savings created by one part of the system reduces the costs of another part of the system with no reciprocal support. Further discussion about performance incentives will be critical to successfully incorporating broad, cross-system measures into contracts with entities that have a role within the system for achieving successful outcomes but for whom the broad measures are not fully within their span of control.
- **Building performance feedback reports.** It is likely to be more difficult for contractors to achieve desired performance levels if they have no knowledge of their performance levels on an on-going basis, or methods of receiving timely information they can use for interventions. In many cases the 1519 performance measures are not available to the contractor through their own claims billing systems.

Care Coordination- Robust care coordination services provide a foundation for achieving the identified common outcome and performance measures. Measuring outcomes will result in some improvement. However cross-system coordination between long term services and supports, medical, mental health, and substance use disorder treatment, as well as other community partners who are not subject to contractual performance measures under EHB 1519 adds a crucial element previously missing from the system as a whole. This cross-system coordination will require both using the resources of the collective system and potentially demand targeted investments in interventions and care coordination designed to address non-health related measures such as homelessness and quality of life.

The great recession impacted funding for all of Washington's care coordination entities. The RSNs and county chemical dependency services weathered significant across the board funding cuts in both the 2009/2011 and 2011/2013 biennia. Care coordination/case management within the Area Agency on Aging system has suffered because funding levels have not kept pace with modest increases in costs over the past decade. As a result caseload ratios and the time per client case managers have to fully assess and address clinical and social support needs has decreased significantly. This decrease in care coordination levels has happened at the same time the complexity and needs of clients receiving services has grown. Adequate funding to ensure clients are efficiently, adequately and safely sustained in the community is needed. DSHS has included a request for additional funding in its 2015-17 submission to OFM which, if funded, would ensure caseload sizes are consistent with established workload metrics.

Effective care coordination requires that sufficient and quality clinical capacity is present to work with clients and across systems of care to achieve the shared outcomes envisioned by EHB1519.

Engrossed Second Substitute House Bill 2572- HCA is instructed by E2SHB 2572 to establish a performance measures committee for the purpose of identifying and recommending standard statewide measures of health performance to inform health care purchasers and set benchmarks, including for both the public and private sectors. As part of its charge, this committee is expected to align their measures with the common measure requirements specific to Medicaid delivery systems. The complete bill can be viewed at: http://apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/House/2572-S2.SL.pdf

Performance Measures and the Expected Improvement in Client Outcomes

The following chart delineates the relationship between the expected improvements in client outcomes with the identified performance measures. As required under EHB 1519, reductions in population-level health disparities, will be addressed as an added dimension by which all of the metrics below may be measured.

Improvements in client health status and wellness	**1.** Adults' Access to Preventative/Ambulatory Care
	2. Well-Child Visits
	3. Comprehensive Diabetes Care: Hemoglobin A1c Testing
	4. Alcohol/Drug Treatment Penetration
	5. Mental Health Treatment Penetration
	6. SBIRT Service Penetration
	17. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia
	18. Medical Assistance with Smoking and Tobacco Use Cessation
	19. Body Mass Assessment
	20. Tobacco Use Assessment
Reductions in avoidable costs in hospitals, emergency rooms, crisis services, and jails and prisons	**9.** Psychiatric Hospital Readmission Rate
	10. Emergency Department (ED) Visits
	11. Inpatient Utilization
	12. Plan All-Cause Readmission Rate
	13. Hospital Admissions for diabetes complications
	14. Hospital Admissions for Chronic Obstructive Pulmonary Disease
	15. Hospital Admissions for Congestive Heart Failure
	16. Hospital Admissions for Asthma
	32. Criminal justice involvement

	33. Jail admissions
	34. Days in jail
	35. Referrals for competency evaluation
	36. Person in jail with serious mental illness
Increases in stable housing in the community	**7.** Home and Community-Based Long Term Services and Supports Use
	21. Homelessness/housing instability (broad)
	22. HMIS-recorded housing assistance penetration
	23. Homelessness (narrow)
	24. Residential instability
Increases in client participation in meaningful activities	**25.** Employment rate
	26. Earnings
	27. Hours worked
	28. School-age children enrolled in school
	29. On time and late graduation from high school
	30. Adult enrollment in post-secondary education or training
	31. Survey item: "To what extent do you do things that are meaningful to you?"
Reductions in client involvement with criminal justice systems	**32.** Criminal justice involvement
	33. Jail admissions
	34. Days in jail
	35. Referrals for competency evaluation
	36. Person in jail with serious mental illness
	37. Mental health treatment after release from incarceration
	38. Serving previously un-served offenders
	39. Alcohol or drug treatment after release from incarceration
	40. Alcohol or drug treatment retention
	41. Mental health treatment engagement
	42. New Medicaid enrollments after release from criminal justice facilities
Improvements in client satisfaction with quality of life	**7.** Home and Community-Based Long Term Services and Supports Use
	10. Emergency Department (ED) Visits
	21. Homelessness/housing instability (broad)
	23. Homelessness (narrow)
	25. Employment rate
	26. Earnings
	27. Hours worked
	31. Survey item: "To what extent do you do things that are meaningful to you?"
	43. WHOQOL-BREF Physical Health Scale
	44. WHOQOL-BREF Emotional Health Scale
	45. WHOQOL-BREF Social Health Scale
	46. WHOQOL-BREF Autonomy/Safety Scale

	47. WHOQOL-BREF Overall Quality of Life Scale
	48. WHOQOL-BREF "How positive do you feel about the future?"
	49. New survey item: "To what extent are you respected and treated fairly?"
	50. New survey item: "To what extent do you make your own choices?"
	51. New survey item: to be defined regarding cultural connectedness

Expected Outcomes and Performance Measures by Program:

Cross-Agency Performance Measurement Initial Selection Process

Following the conclusion of the workgroup process and the Steering Committee's approval of the identified performance measures, a cross-agency and cross-administration group of HCA and DSHS staff (1519 Interagency Workgroup) met to select the first set of performance measures for contracting. This workgroup utilized the following criteria to guide their selection process:

- Desire for shared measures across DBHR, HCS, and HCA
- Need to address each of the identified outcomes in the two bills
- Selection of measures that are relevant to the populations served
- Need to limit the number of measures so that contractors can focus their energies and be successful

Division of Behavioral Health and Recovery Contracts with Behavioral Health Organizations

The Division of Behavioral Health and Recovery has selected the following performance measures by which to begin negotiation with the newly forming Behavioral Health Organizations:

Outcome Area		Performance Measure	Measure Type
Health/Wellness		**1.** Adults' Access to Preventative/Ambulatory Care	Contract
Health/Wellness		**4.** Alcohol/Drug Treatment Penetration	Contract
Health/Wellness		**5.** Mental Health Treatment Penetration	Contract
Stable housing in community	Quality of Life (population basis)	**7.** Home and Community-Based Long Term Services and Supports Use	Systems Monitoring
Health/Wellness		**8.** Suicide and drug overdose mortality rates	Systems Monitoring
Reduction in avoidable hospitalizations		**9.** Psychiatric Hospital Readmission Rate	Contract
Reductions in costs and utilization	Quality of Life (population basis)	**10.** Emergency Department (ED) Visits	Contract
Reduction in avoidable hospitalizations		**12.** Plan All-Cause Readmission Rate	Contract
Stable housing in	Quality of Life (population	**23.** Homelessness (narrow)	Contract

community	basis)		
Meaningful activity	Quality of Life (population basis)	**25.** Employment rate	Contract
Reduction in criminal justice involvement		**32.** Criminal justice involvement	Contract- 2nd phase
Reduction in criminal justice involvement		**37.** Mental health treatment after release from incarceration *(modify to include release from prison & community corrections, hold off on jail populations)*	Contract- 2nd phase
Reduction in criminal justice involvement		**40.** Alcohol or drug treatment retention	Contract

DBHR has provided RDA with the prioritized performance measures and RDA is preparing the data for analysis and reporting.

Home and Community Services Division Contracts with Area Agencies on Aging

Home and Community Services (HCS), a division of the Aging and Long Term Supports Administration (ALTSA), through its work within the 1519 Interagency Workgroup, selected a draft set of measures utilizing the criteria established by the Workgroup.

HCS then entered into discussions with the Area Agencies on Aging (AAAs) and there was a preliminary agreement to a draft set of six performance measures for inclusion in the first contracting period in 2016 (FY 2017). These six measures are shared by one or both of the other contracting agencies and will require, and can be leveraged, to drive strategies that cut across health sectors. Once RDA has been able to prepare the measurement data (including Medicare data) and there has been an opportunity for review and analysis, confirmation of the set of measures will occur. The number of individuals covered under each Area Agency on Aging contract varies widely based upon the population size receiving in-home Medicaid long term services and supports in their geographic region. This variation ranges from 1,000 in Kitsap County to 11,000 in King County and there are two tribal government AAAs that serve less than 200 individuals each. Part of RDA's assistance includes how difference in population size should be factored into measures and performance targets.

Outcome Area		**Performance Measure**	**Measure Type**
Health/Wellness		**1.** Adults' Access to Preventative/Ambulatory Care	Contract
Health/Wellness		**4.** Alcohol/Drug Treatment Penetration	Contract
Health/Wellness		**5.** Mental Health Treatment Penetration	Contract
Stable housing in community	Quality of Life (population basis)	**7.** Home and Community-Based Long Term Services and Supports Use	Contract
Reductions in costs and utilization	Quality of Life (population basis)	**10.** Emergency Department (ED) Visits	Contract
Reduction in avoidable		**12.** Plan All-Cause Readmission Rate	Contract

hospitalizations		

Phase 2 - Performance Measures Considerations:

Residential instability (performance measure 24) will be considered in subsequent contract negotiations if the RDA is able to accurately capture client addresses and number of avoidable moves.

The participation in meaningful activity survey item (performance measure 31) will be considered in subsequent contract negotiations as part of a centrally implemented Quality of Life survey, if funded.

Increased employment rate (performance measure 25) could be considered in subsequent contract negotiations. . The number of individuals receiving long term services and supports that are working age has increased over the past ten years.

Reductions in client involvement with the criminal justice system will not be addressed in contracts with the Area Agencies on Aging because arrest rates are very low among the population receiving long term services and supports. RDA does not recommend this a focal outcome area for clients receiving long term support services through the AAAs.

Additional Consideration: As noted above there are considerations related to case management funding levels, variance in population sizes served, methods for creating shared savings/risk pools and ways to invest in interventions that are critical for achieving shared outcomes that must be fully explored to leverage the outcomes envisioned in EHB1519.

Health Care Authority Contracts with Managed Care Health Plans

The Health Care Authority (HCA), in collaboration with the Department of Social and Health Services (DSHS), will be contracting with service coordination entities to include specific performance measures to improve client health status, increase client participation in employment, education and meaningful activities, as well as reduce client involvement with the criminal justice system and increase access to treatment for forensic patients. The potential outcomes of the proposed 2015 Apple Health managed care contract performance measures, include but are not limited to: reduction in avoidable use of hospital emergency rooms/ crisis services, increased housing stability within the community, improved client satisfaction with quality of life, and decreased population level disparities in access to treatment and treatment outcomes.

From the menu of the fifty one performance measures accepted by the 2SSB 5732/ EHB 1519 Steering Committee on April 18th, 2014, the proposed performance measures chosen by the HCA for inclusion in the 2015 Apple Health managed care contracts are:

Outcome Area	**Performance Measure**	**Measure Type**
Health/Wellness	**1.** Adults' Access to Preventative/Ambulatory Care	Contract
Health/Wellness	**2**. Well Child Visits	Contract
Health/Wellness	**3**. Comprehensive Diabetes Care: HgbA1c testing	Contract
Health/Wellness	**18.** Medical Assistance with Smoking and Tobacco use Cessation	Contract
Health/Wellness	**19.** Body Mass Assessment	Contract
Health/Wellness	**17**. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	

Utilization		**13-16.** Ambulatory Care Sensitive Conditions - Hospital Admissions	Contract
Reductions in costs and utilization	Quality of Life (population basis)	**10.** Emergency Department (ED) Visits	Contract
Utilization		**12.** Plan All-Cause Readmission Rate	Contract
Utilization		**11**. Inpatient Utilization	Contract

Proposed supplemental measures in the 2015 Apple Health managed care contracts are:

- Mental Health Utilization – Outpatient or ED measure
- Diabetes Screening for Individuals with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Diabetes Monitoring for Individuals with Diabetes and Schizophrenia
- Adherence to Antipsychotic Medications by Individuals with Schizophrenia
- Preventive Care and Screening: Screening For Clinical Depression and Follow-Up Plan

It is proposed that the 2015 Apple Health managed care contracts will include more questions to the CAHPS Survey from the World Health Organization Quality of Life survey regarding physical health, emotional health and overall quality of life. Proposed measures for further development involve a possible housing instability assessment, as well as collaborative efforts with DOC to better serve released offenders. The 2015 Apple Health managed care contract language requires the MCOs to pilot one clinical PIP which will piloting a mental health intervention that is evidence-based, research-based or a promising practice and is recognized by the Washington State Institute for Public Policy (in the report and inventory of adult behavioral health evidence-based, research-based and promising practices in May 2014). This first selection of performance measures, survey questions and pilot will be included in the 2015 Apple Health managed care contracts starting in January 2015.

We plan to develop appropriate baselines and benchmarks, design risk adjustment for some contractor performance standards in some contexts and develop formulas for financial incentives relating to performance. The proposed performance measure selection was completed with anticipated improvements in client outcomes, to be more specifically determined and benchmarked when more information is received from Research and Data Analysis. The HCA selected the above measures to improve the accountability of health plans, improve the health status of enrollees, to ensure cost-effective treatment delivery and to align with other initiatives, including but not limited to: 5732/ 1519 cross system measures, Statewide Core Performance measures, and National Quality Initiatives/ federal requirements.

Applying the Performance Measures Development Process to other Health and Social Service Programs

1519 provides DSHS and HCA with the establishment of performance measures to support achieving improved outcomes defined in 1519. This interagency and Cross- System Steering Committee's work will help define and establish performance measures and outcomes as we move into a future of accountable communities of health.

Appendix A: 5732/1519 Cross-System Steering Committee Membership

Name	Title	Organization
Gordon R. Bopp (Alternate: Cassandra Ando)	President	NAMI Washington
Abby Murphy (Alternate: Kirby Richards)	Policy Director	Washington State Association of Counties
Anders Edgerton (Alternate: Jean Robertson)	Executive Director	Peninsula Regional Support Network
Cheri Dolezal (Alternate: Marty Driggs)	Executive Director	OptumHealth Pierce Regional Support Network
Joe Avalos (Alternate: Jim Vollendroff)	Chemical Dependency Program Manager	Thurston/Mason Counties, Thurston County Public Health and Social Services
Judy Snow	Mental Health Director	Pierce County Jail
Liz Mueller (Alternate: Nancy Dufraine)	Chair	Indian Policy Advisory Committee
Marilyn Scott	Chair	Upper Skagit Tribe
Ann Christian (Alternate: Gregory Robinson)	Executive Director	Washington Community Mental Health Council
Claudia D'Allegri	Vice President, Behavioral Health Services	Sea Mar Community Health Centers
Mary Langley	Advance Practice Psychiatric Nurse	Association of Advance Practice Psychiatric Nurses
Alice Shobe	Executive Director	Building Changes
Melet Whinston (Alternate: Matt Canedy)	Chief Medical Officer	Amerigroup
Flanna Perkins	Regional Director	ResCare
Lori Brown (Alternate: Roy Walker)	Chair	Washington Association of Area Agencies on Aging
Kristen West (alternate: Brian Myers)	Vice President	Empire Health Foundation
Ellie Menzies (Alternate: Claudia Chika)	Legislative Director	SEIU Healthcare 1199NW
Scott Bond (Alternate: Chelene Whiteaker)	President and CEO	Washington State Hospital Association
Ray Hsiao (Alternate: Susan Peterson)	1st Vice-President	Washington State Medical Association
Jurgen Unutzer (Alternate: Richard Veith)	Professor and Chair, Psychiatry and Behavioral Sciences	University of Washington
Lucy Berliner	Director	Harborview Center for Sexual Assault and Traumatic Stress
Erin Hafer	Manager of New Programs Integration	Community Health Plan of Washington
Mary Looker (Alternate: Shirley Prasad)	Executive Director	Washington Association of Community and Migrant Health Centers
Paul Pastor	Sheriff	Pierce County
Brad Berry (Alternate: Heather Moore)	Executive Director	Consumer Voices Are Born
Janna Wilson (Alternate: Kirsten Wysen)	Senior External Relations Officer	Public Health- Seattle and King County
Matt Zuvich	Legislative and Political	Washington State Federation of State Employees

(Alternate: Marilyn Ronnei)	Action	
MaryAnne Lindeblad (Alternate: Nathan Johnson)	Medicaid Director	Washington State Health Care Authority
Bill Moss (Alternate: Bea Rector)	Assistant Secretary	Aging and Long Term Services Administration, DSHS
Jane Beyer (Alternate: Chris Imhoff)	Assistant Secretary	Behavioral Health and Service Integration Administration, DSHS

Appendix B: Combined Roster of 5732/1519 Workgroups

* Denotes Steering Committee member

Quality of Life Workgroup

Name	Organization
Joe Valentine	North Sound Mental Health Administration (RSN)
Doug Porter	Pierce County
Flanna Perkins *	ResCare
Melet Whinston * (alt. Matt Canedy)	Amerigroup
Maureen Linehan	King Co. Aging and Disability Services
Carol Koepp	NAMI-WA
David Johnson	NAVOS
Brad Berry *	CVAB
Susan Mclaughlin	King County (housing rep)
Emily Savoie	SEIU- Catholic Community Services
Troy Christensen	Making A Difference in Community (MDC)
BHSIA/DBHR Staff	Eric Larson Jennifer Bliss Felix Rodriguez Martha Perla Greg Endler Kara Panek
RDA Staff	Barb Lucenko
HCS Staff	Nancy Brubaker Colette Rush
HCA Staff	Alice Lind Stefanie Zier

Criminal Justice/Forensic Patients Workgroup

Name	Organization
Judy Snow *	Pierce County Jail
Kevin Black	Senate
Jean Robertson	King RSN
Matt Zuvich*	WA Federation of State Employees
Chief Ralph Wyman	Chehalis Tribe
Theresa Power-Drutis	New Connections
Cheryl Strange	Pioneer Human Services
Bruce Buckles	Aging & Adult Care of Central WA
Cassandra (Sandi) Ando	NAMI-WA
Terri Card	Greater Lakes MH
Barry Johnson	Kitsap AAA
Tim Hunter	Dept of Corrections
Laura Collins	Harborview Medical Center
John Taylor	ABHS

Janelle Sgrignoli	Snohomish County Courts
Dean Runolfson	Thurston County
Rainbow Shearon (alt. Erica Healy)	SEIU- DSHS SEIU- DESC
Declan Wynne	Sound Mental Health (housing rep)
Pamala Sacks	JR&RA
Bette Pine	King County Jail Health Services
Jim Vollendroff	King County CD Services
April Dickinson	CHPW
BHSIA/DBHR Staff	Earl Long Keri Waterland Mark Nelson Ted Lamb Kara Panek
RDA Staff	Jim Mayfield
HCA Staff	Mark Westenhaver Stefanie Zier

Health/Wellness, Utilization and Disparities Workgroup

Name	Organization
Cheri Dolezal * (alt. Marty Driggs)	OptumHealth Pierce RSN
Connie Mom-Chhing	SW BH RSN
Bob Perna	WA State Medical Association
Lori Brown *	W4A
Melet Whinston* (alt. Matt Canedy)	Amerigroup
Charlene Abrahamson/ Nancy Dufraine	Chehalis Tribe
Sabrina Craig	Grays Harbor County
Mary Looker * (alt. Shirley Prasad)	WA Assoc. of Community and Migrant Health Centers
Anne Farrell-Sheffer	YWCA (housing rep)
Katy Miller	King County (housing rep)
Kelli Larsen	Plymouth Housing (housing rep)
Tom Carter	NAMI-WA
Rita Niles (alt. Addy Adwell	SEIU- BHR SEIU- DESC
Brian Myers	Empire Health Foundation
Ann Christian*	WA Comm. MH Council
Janna Wilson* (alt. Karen Milman)	WA State Assoc. of Local Public Health Officials
Mary Jadwisiak	Holding the Hope
Darcy Jaffe	Harborview Medical Center
Dale Sanderson	Sound Mental Health
Erin Hafer*	CHPW
Julie Lindberg	Molina Healthcare

BHSIA/DBHR Staff	Scott Waller Andrea Parrish David Daniels Kara Panek
RDA Staff	Bev Court David Mancuso
HCS Staff	Candy Goehring Colette Rush Ann Clark (student intern)
HCA Staff	Dr. Daniel Lessler Dr. Charissa Fotinos Stefanie Zier

Employment, Education, Meaningful Activity, and Housing Workgroup

Name	Organization
Suzie McDaniel	Spokane County RSN
Abby Murphy *	WA Assoc. of Counties
Gordon Bopp *	NAMI-WA
Joel Chavez	Benton/Franklin Counties
Alice Shobe * (Vitoria Lin, alternate)	Building Changes
Jerry Fireman	W4A
Tedd Kellaher	Dept. of Commerce
Andres Aguire	DVR- DSHS
Sunny Lovin	Harborview
Elani Papadakis	WA Workforce Training and Education Coordinating Board
Dave Pavelchek	WA Workforce Training and Education Coordinating Board
Kelsey Thompson	WA Workforce Training and Education Coordinating Board
Carla Reyes	ESA- DSHS
Cathy Knight	W4A
Bob Beckman (alt. Kelli Hurley)	SEIU- DESC staff Catholic Community Services
Gregory Robinson	WA Comm. MH Council
Kate Ireland	CVAB
Betsy Kruse	Evergreen BH Services
Beth Dannhardt	Triumph Treatment Services
Enola Joefield	Recovery Innovations
Claudia Chika	SEIU
Brigita Fody Landstrom	Molina Healthcare
Kate Baber	Low Income Housing Alliance
BHSIA/DBHR Staff	Melodie Pazolt LaRessa Fourre Aaron Starks Kara Panek
RDA Staff	Melissa Ford Shah
HCS Staff	Liz Prince Jim Kenney

	Colette Rush
HCA Staff	Stephen Kozak Stefanie Zier

5732-1519 Recommended Performance Measures

APRIL 24, 2014

Health/Wellness, Utilization and Disparities

Access/effectiveness	1	Adults' Access to Preventive/Ambulatory Care	Contract
	2	Well-Child Visits	Contract
	3	Comprehensive Diabetes Care: Hemoglobin A1c Testing	Contract
	4	Alcohol/Drug Treatment Penetration	Contract
	5	Mental Health Treatment Penetration	Contract
	6	SBIRT Service Penetration	Contract
	7	Home- and Community-Based Long Term Services and Supports Use	Contract
	8	Suicide and drug overdose mortality rates	System Monitoring
Utilization	9	Psychiatric Hospitalization Readmission Rate	Contract
	10*	Emergency Department (ED) Visits	Contract
	11	Inpatient Utilization	Contract
	12	Plan All-Cause Readmission Rate	Contract
	13	Hospital Admissions for diabetes complications	Contract
	14	Hospital Admissions for Chronic Obstructive Pulmonary Disease	Contract
	15	Hospital Admissions for Congestive Heart Failure	Contract
	16	Hospital Admissions for asthma	Contract
Care coordination	17	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Contract
Wellness	18	Medical Assistance with Smoking and Tobacco Use Cessation	System Monitoring
	19	Body Mass Assessment	Contract
	20	Tobacco Use Assessment	Contract

Health Disparities

To support measurement of disparities and performance differences across service contracting entities, where feasible and appropriate, metrics will be reported by:

- Race/ethnicity or primary language
- Age group and gender
- Geographic region
- Service-contracting entities
- Delivery system participation (for example, measuring mental health service penetration for clients receiving long-term services and supports, relative to its own benchmark or the experiences of other disabled clients not served in the long-term services and supports delivery system)
- Medicaid coverage type (for example, persons with disabilities, newly eligible adults)
- Chronic physical and behavioral health conditions
- History of criminal justice involvement
- Housing stability

Housing, Employment, Education and Meaningful Activities

Housing	21*	Homelessness/housing instability (broad)	System Monitoring
	22	HMIS-recorded housing assistance penetration	Contract
	23	Homelessness (narrow)	Contract
	24	Residential instability	Aspirational
Employment	25*	Employment rate	Contract
	26*	Earnings	Contract
	27*	Hours worked	Contract
Education	28	School-age children enrolled in school	Contract
	29	On time and late graduation from high school	Contract
	30	Adult enrollment in post-secondary education or training	Contract
Meaningful Activities	31*	Survey item: "To what extent do you do things that are meaningful to you?"	System Monitoring

Criminal Justice and Forensic Patients

Criminal Justice Involvement	32	Criminal Justice Involvement	Contract
	33	Jail Admissions	Contract
	34	Days in Jail	Contract
	35	Referrals for Competency Evaluation	Contract
	36	Persons in Prison with Serious Mental Illness	Contract
Access to Treatment for Forensic Patients	37	Mental Health Treatment after Release from Incarceration	Contract
	38	Serving Previously Un-served Offenders	System Monitoring
	39	Alcohol or Drug Treatment after Release from Incarceration	Contract
	40	Alcohol or Drug Treatment Retention	Contract
	41	Mental Health Treatment Engagement	Contract
	42	New Medicaid Enrollments after Release from Criminal Justice Facilities	System Monitoring

Quality of Life

Physical Health	43	WHOQOL-BREF Physical Health Scale	System Monitoring
Emotional Health	44	WHOQOL-BREF Emotional Health Scale	System Monitoring
Social Health	45	WHOQOL-BREF Social Health Scale	System Monitoring
Autonomy/Safety	46	WHOQOL-BREF Autonomy/Safety Scale	System Monitoring
Overall Quality	47	WHOQOL-BREF Overall Quality of Life Scale	System Monitoring
Hope	48	WHOQOL item: "How positive do you feel about the future?"	System Monitoring
Respect	49	New survey item: "To what extent are you respected and treated fairly?"	System Monitoring
Choice	50	New survey item: "To what extent do you make your own choices?"	System Monitoring
Cultural Connectedness	51	New survey item: to be defined	System Monitoring

**Measures 10 under Health/Wellness, Utilization, and Disparities and 21, 25, 26, 27, and 31 under Housing, Employment, Education and Meaningful Activities are shared with Quality of Life.*