**TABLE 1. Quality Measures for Patients with Co-Occurring Medical & Psychiatric Conditions Treated in Primary Care Settings**

| STRUCTURE | PROCESS | OUTCOME |
|---|---|---|
| **Clinicians**<br>• competencies: % of PCPs (or staff) demonstrating competencies in recognition and treatment of mental disorders / SUD<br>• specialist availability: MHS (adult & child psychiatrists, therapists) availability per # beneficiaries in health plan<br>**Services**<br>• **Level of care availability for SUD treatment**<br>  o # beds available per # beneficiaries: detoxification, inpatient rehabilitation, clinically managed residential<br>  o # programs per # beneficiaries: partial hospital, intensive outpatient, outpatient<br>• **Evidence-based treatment models for depression in PC**<br>  o registry: % of PC practices using depression registry<br>  o measurement: % of PC practices using structured severity assessment for depression<br>  o care mgmt: % of PC practices providing care mgmt for depression<br>  o self-management: % of PC practices providing self-management education/tools<br>  o training—meds: % PCP's who complete depression medication management training<br>  o training—CBT: % of eligible clinicians receiving training on CBT based techniques<br>• **Buprenorphine treatment for opioid addiction in PC**<br>  o training: # PCP's who have received training in buprenorphine treatment per capita or per # beneficiaries in health plan<br>  o registry: % of PCP's who prescribe buprenorphine that utilize a registry to track patients treated with buprenorphine<br>**Clinical Information Systems**<br>• % of PC practices which provide PCPs with immediate access to MHS / SUD records<br>• % of MHS/SU specialists in plan who have immediate access to PC records<br>• % of practices with procedures guiding consent to access MHS / SUD records<br>**Financing**<br>• Care mgmt. reimbursement: % of beneficiaries in plan whose PC is eligible for reimbursement for care management for depression<br>• PCP reimbursement: % of beneficiaries in plan whose PC is eligible for reimbursement for visit with primary diagnosis of mental disorder or SUD | **Detection**<br>• % of PC patients screened annually for depression<br>• % of PC patients with high risk conditions (p-MI, p-CVA, CHF, DM) screened annually for depression<br>• % of PC patients screened for substance use disorder<br>**Assessment**<br>• % of PC patient dx'd with mental disorder with qualifying DSM sx documented on assessment<br>• % of PC patient dx'd with MDD with presence or absence documented on assessment: psychosis; suicidality; h/o mania; substance use<br>• % PC pts w/ MDD meeting severity/complexity criteria for MHS referred for/receive MHS care<br>**Access to specialty care**<br>• % of patients referred to MH/SU specialty care who attend initial visit<br>• Average time to initial visit after referral to MH/SU specialty care<br>• % of patients with SUD who are referred to the appropriate (ASAM) level of care<br>**Treatment fidelity to evidence based treatment models**<br>• **Evidence-based treatment of depression in PC**<br>  o % of PC patients with depression w/ # acute-phase contacts with care manager<br>  o % of PC patients with depression w/ structured severity assessment<br>    o on initial evaluation; ~ 4-6 weeks; ~ 12 weeks; ~ 6 months<br>  o % of PC patients with depression w/o response at ~6 weeks w/ change in treatment<br>• **Brief intervention for SUD in PC**<br>**Coordination between PCP and MHS Following Referral**<br>• patient report of coordination<br>  o "my clinicians kept each other informed about my treatment and progress"<br>  o "my clinicians worked well together to coordinate my care for depression"<br>  o "I knew which clinician to turn to when I had a problem related to depression"<br>• % of referrals resulting in appropriate MHS/SU feedback to PCP w/in # days<br>**Safety**<br>• **Avoidance of prescribing drugs of abuse for patients with SUD**<br>  o % of patients with h/o alcohol abuse or dependence prescribed benzodiazepines<br>  o % of patients with h/o opiate abuse or dependence prescribed opiates | **Symptom change**<br>• mean sx change (e.g., PHQ-9) at 12-weeks, 6-months<br>• % patients meeting remission criteria at 12-weeks, 6 months<br>**Functional change**<br>**Behavioral change**<br>• abstinence<br>• reduced SU<br>• change in ASI score |

**Key**: PC= primary care; MHS=mental health specialist; SUD=substance use disorder; **Notes**: Psychiatric disorders includes mental and substance-use disorders

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**TABLE 2. Quality Measures for Patients with Co-Occurring Medical & Psychiatric Conditions Treated in the Mental Health Specialty Settings**

| STRUCTURE | PROCESS | OUTCOME |
|---|---|---|
| **Clinician Characteristics**<br>• % of prescribing MH practitioners with competence in detecting and monitoring diseases with high prevalence in the SMI (CV conditions, smoking, obesity, pulmonary disease, thyroid disease and infectious disease<br>• % of MH practitioners trained to detect diseases with high prevalence in the SMI<br>• # of PCP physicians available for pts with severe mental illness<br>• nurse and physician assistant to MD staff ratio<br><br>**Clinical Information Systems**<br>• % of pts for whom medical records and laboratory data are available<br>• % of charts with permission to communicate with PCP is obtained<br>• % of practices w/ disorder specific registries<br><br>**Service Linkages**<br>• Modified Continuity of Care Index: a ratio assessing the degree to which general medical IP and OP services are provided at the same VA facility: {1-[#facilities/(#visits+0.01)]/[1-(1/(#visits+0.01)]<br><br>**Financing**<br>• % of MH practitioners are reimbursed for monitoring medical conditions<br>• % of plans or organizations that provide financial incentives for quality improvement and monitoring | **Detection**<br>• % pts with annual fasting glucose<br>• % pts with fasting lipid profile and glucose 12 wks after initiating atypical antipsychotics<br>• % of pts with fasting lipid profile every 5 years<br>• % pts screened for HIV/hepatitis who engage in high risk behaviors<br>• % pts screened with TSH, B12, FA, RPR, Calcium<br>**Assessment**<br>• % pts with complete medical history, smoking history, family medical history, risk factors for CV, TB, and ID transmission, and ROS in chart<br>• % pts with height, weight, blood pressure, pulse, waist circum. recorded every 6 mos in chart<br>• % of pts with all current meds (including non-psychiatric) listed in chart<br>• Access:% of pts with significant medical/lab findings referred to medical care<br>• Availability: % of pts who are referred to primary care who attend initial visit<br>• Time: Average length of time to initial visit<br>• % of pts who saw a primary care physician within 12 months of their last MH visit<br>**Treatment:**<br>Preventive medicine and maintenance<br>• % of eligible women who had a pap test in a two year period<br>• % of pts on psychotropic medications for 6 months who receive appropriate monitoring every 6 mos.*<br>• VPA with levels, LFT's, CBC q6months<br>• TCA and EKG prior to initiation<br>• Lithium with BUN/creat + TSH<br>• % of pts asked and advised about level of physical activity<br>• % of pts between 50-80 who had appropriate screening for colorectal cancer.<br>CV disease and risk factors<br>• % of pts with dx of hypertension whose BP < 140/90<br>• % of eligible pts placed on beta blocker therapy post AMI<br>• % of eligible pts who received beta blocker tx 6 mo post AMI<br>• % of pts post MI or with CAD who have LDL-C <130 or <100<br>• % of pts who smoke who received advice to quit smoking, who were recommended smoking cessation medications, or who discussed smoking cessation strategies<br>• % of pt who smoke who were prescribed smoking cessation medications<br>Diabetes: % of pts with DM type 1 or 2 with the following<br>• HbA1c testing; HbA1c poorly controlled (>9); Eye exam performed; LDL-C screening performed; LDL-C <130 mg/dL; LDL-C <100 mg/dL; Kidney disease monitored<br>Pulmonary<br>• % of pts with asthma who were appropriately prescribed medication<br>• % of pts with new dx or newly active COPD who received appropriate spirometry testing<br>• % of pts given influenza and pneumococcal vaccines<br>**Coordination**<br>• Pt report: Perception of coordination<br>  o "my clinicians kept each other informed about my tx and progress"<br>  o "my psychiatrist knows my medical conditions"<br>• Need for standards: Communication of physical health care<br>• % of MH practitioners who communicate with PCP every 6 months, during IP MH hospitalization<br>• % of MH practitioners who receive communication from PCP within 2 weeks after specific referral regarding detection of medical disease<br>• % of MH visits that review non-psychotropic medications and adherence<br>• % of IP medical hospital stays with discharge summaries sent to the pt's primary MH specialist | **Behavior change**<br>• % of pts who are abstinent from smoking for 6 months<br>• % of pts with > 1 point improvement in BMI over year<br>• % of pts involved in increased level of physical activity<br><br>**Medical outcomes**<br>• Mortality Rate<br>• LDL-C <130 mg/dL<br>• LDL-C <100 mg/dL<br>• Eye exam performed<br><br>**Quality of life**<br>• change in health status over defined interval (e.g., SF-12, etc.)<br><br>**Patient Satisfaction**<br>• % of pts with SMI who are satisfied with their physical healthcare |

Key: PC= primary care; MHSC=MH specialty care; SUD=substance use disorder, pt=patient, IP=IP, OP=outpatient, dx=diagnosis, tx=treatment, BP=blood pressure

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**TABLE 3. Quality Measures for Patients with Co-Occurring Substance Use & Psychiatric Conditions Treated in the Mental Health Specialty Settings**

| STRUCTURE | PROCESS | OUTCOME |
|---|---|---|
| **Clinician Characteristics**<br>• % of MH providers that are trained to treat SA disorders and have a certificate, license or some other documentation to prove training.<br>• Evidence of documented formal referral policies for SUD in MHSC settings.<br><br>**Clinical Information Systems**<br>• % of MH providers who reported being able to access any patient tx information, laboratory information, or medical records from a SUD specialty settings<br><br>**Service Linkages**<br>• % of programs that have:<br>Integrated services (MH and SA services in the same treatment program)<br>o Co-location (MH and SA services in the same location)<br>o Formal relationships (referral agreements or contractual relationships among providers)<br>o Informal or ad hoc (absence of formal relationships)<br><br>**Financing**<br>• % of MH providers reporting the inability to bill for SA services provided to pts<br>• % of MH providers that report coding SA services as MH services in order to be reimbursed. | **Detection**<br>• % of pts screened for SA upon IP or residential admission in a MHSC setting.<br>• % of pts in MHSC with a newly identified SA disorder over a period of 12 months (after a 6 month washout period).<br><br>**Assessment**<br>• % of pts with a SUD with qualifying DSM documentation on assessment at a MHSC setting.<br>• % of pts who are admitted to a MHSC IP or residential facility whose medical record includes an assessment of both their MH and SUD history<br>• % of pts admitted to a hospital for a mental disorder who are also assessed for a SA disorder upon admission<br>• % of pts who receive a psychiatric evaluation that includes a drug and alcohol use assessment<br>• % of surveyed behavioral health plan members with a MH diagnosis who report being asked about alcohol or drug use by a plan clinician in the prior year<br>• % of pts discharged from a hospital with a MH disorder as their primary diagnosis whose IP admission or discharge assessment note includes an assessment of SA or dependence<br><br>**Treatment**<br>• Average fidelity score across participating programs:<br>o New Hampshire/Dartmouth Integrated Dual Disorder Treatment (IDDT) model<br>o 26 Item fidelity scale<br>o Each item represents an org. or tx component of model<br>o Scores from individual programs can be compared to the mean score or a recognized benchmark<br>• % of pts discharged from IP or residential care with COD who had at least one MH and one SUD clinic visit within 6 months of discharge<br>• % of pts identified with both a SUD and MH condition who report receiving 3 or more minutes of counseling from their physician about both disorders<br><br>**Coordination**<br>• % of dually diagnosed pts receiving case management who report that their MH manager assisted them in obtaining SUD tx<br>• % of dually diagnosed pts who are participating in a case management program and have a documented plan of care to address both conditions<br>• % of dually diagnosed pts who report that their case manager or managed behavioral healthcare organization assisted them in obtaining all necessary MH and SUD services<br>• % of dually diagnosed pts in a MHSC IP setting whose medical record documents contact between the pts MH and SUD providers<br>• % of dually diagnosed pts admitted for a SUD that had an OP mental health visit 30 days prior to admission | **Behavior change**<br>• % of pts with any SUD dx discharged from a IP or residential MHSC setting who report abstinence from drugs and/or alcohol over 6 months.<br><br>**Medical outcomes**<br>• % of dually diagnosed pts with a reduction in psychiatric symptoms 6 mos.<br>• % of dually diagnosed pts in MHSC settings with a significant reduction in ASI alcohol or drug scores 6 months after index tx episode.<br><br>**Function Improvement**<br>• % of pts with any SA diagnosis treated in a MH specialty setting that are employed.<br>• % change in absentee rates of employees with both MH and SUD conditions treated in a MHSC setting 6 months after index tx episode.<br><br>**Quality of life**<br>• % of pts receiving both MH and SA specialty services who report a high quality of life.<br><br>**Patient Satisfaction**<br>• % of pts receiving both MH and SUD specialty services who report a high satisfaction with their care. |

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