Report to the Legislature

The Behavioral Health Improvement Strategy Implementation Status

2SSB 5732, Section 2 Chapter 388 Laws of 2013

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Behavioral Health and Service Integration Administration
Office of Service Integration
PO Box 45600
Olympia, WA 98504-5600
(360) 725-1400
Fax: (360) 725-2280

Executive Summary

In 2013, the legislature passed Second Substitute Senate Bill 5732. This bill directed the Department of Social and Health Services and the Health Care Authority to develop an adult behavioral health improvement strategy. This report provides an update of the status of the implementation, including strategies developed or implemented to date, timelines, and costs to accomplish the phased implementation of the adult behavioral health improvement strategy.

In addition to 2SSB 5732, the 2013 Legislature passed Engrossed House Bill 1519. Both bills mandated that state contracting 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. The Senate bill 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. 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 engaged in an initial process that resulted in the identification of 51 potential performance measures. The second phase of work will require the state agencies to prioritize and select a subset of performance measures for initial adoption.

Additional steps to implement these performance measures include:

- further refinement of newly developed measures
- development of appropriate benchmarks and formulas for financial incentives
- alignment of 5732/1519 measures with other initiatives related to performance measurement

The Steering Committee also identified key components required for successful implementation:

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

The Department will continue to actively collaborate with the Steering Committee as this work progresses.

The Senate bill directed the Washington State Institute for Public Policy (WSIPP) to issue its *Inventory of Evidence-based, Research-based, and Promising Practices: Prevention and Intervention Services for Adult Behavioral Health*. Building off of WSIPP's inventory, this report also includes recommendations related to the selection and implementation of evidence-based, research-based, and promising practices for adult behavioral healthcare.

The behavioral health improvement strategy includes recommendations specific to workforce development. These recommendations were developed in support of the broad workforce serving individuals with behavioral health needs and to address current challenges in the field related to workforce capacity and the move towards integrated service delivery.

The passage of Second Substitute Senate Bill 6312 in the 2014 Legislature impacts the implementation of 2SSB 5732. While 2SSB 5732 requires the inclusion of performance measures in contracts, 2SSB 6312 re-defines the entities with which the state will contract and provides DSHS with more authority to incentivize outcome-based contracts. These changes to the behavioral healthcare system will likely impact the costs and timelines associated with implementing 2SSB 5732.

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Department of Social and Health Services
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Introduction

With the 2013 passage of Second Substitute Senate Bill 5732 and Engrossed House Bill 1519, the Washington State Legislature directed the Department of Social and Health Services and the Health Care Authority to develop a comprehensive strategy to improve the adult behavioral healthcare system and to better integrate physical and behavioral healthcare and long term supports and services to improve outcomes in the lives of their shared clients. Both bills mandated state contracting 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) to include specific performance measures to address outcomes in the following areas:

- Improvement in client health status
- Increases in client in 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 2SSB 5732, including strategies implemented to date, timelines, costs, and next steps to accomplish the phased implementation of the adult behavioral health improvement strategy.

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 and to formulate strategies to improve the public behavioral healthcare system. 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 in the following organizational structure:

Four workgroups 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

Two workgroups tasked with developing recommendations in additional areas of interest called out in 2SSB 5732:

- Workforce Development
- Adult Behavioral Health Evidence-Based Practices (inclusive of research-based and promising practices, as well)

Steering Committee members conducted a robust recruitment for workgroup membership, resulting in six 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 70 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 and 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. Statewide reporting of child-specific mental health performance measures can be found online at:
http://www.dshs.wa.gov/pdf/dbhr/MH/Childrens%20Behavioral%20Health%20Measures%202014.pdf

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:

2SSB 5732 instructed this workgroup to develop measures for:

- 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

The language in EHB 1519 supported measures toward:

- Improvements in client health status and wellness
- Reductions in avoidable costs in hospitals, emergency rooms, crisis services
- Reductions in population-level health disparities

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 six 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	
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	
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	
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	
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	
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	
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	
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	
Measure	Suicide rate
Definition	Age-adjusted rate of suicide per 100,000 covered lives
Populations	System monitoring only
Source	State defined
Access and effectiveness of care	
Measure	Drug overdose death rate
Definition	Age-adjusted rate of drug overdose deaths per 100,000 covered lives
Populations	System monitoring only
Source	State defined
Utilization	
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	
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	
Measure	Inpatient Utilization
Definition	Inpatient Utilization – General Hospital/Acute Care
Populations	All service contracting entities
Source	NCQA HEDIS
Utilization	
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	
Measure	Ambulatory Care Sensitive Condition Hospital Admissions
Definition	The number of discharges per 100,000 MM age 18+ for: (1) diabetes short-term complications, (2) chronic obstructive pulmonary disease, (3) congestive heart failure, and (4) asthma

Populations	All service contracting entities
Source	AHRQ-PQI
Care Coordination	
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	
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	
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	
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. 2SSB 5732 directed work towards:

- Increased housing stability
- Increased participation in employment and education

EHB 1519 identified:

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

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	
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	
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	
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	
Measure	Residential instability*
Definition	Number of address changes
Populations	System monitoring only
Source	ACES, HMIS, and medical/behavioral health data systems

Employment	
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	
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	
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	
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	
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	
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	
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:

2SSB 5732 charged this workgroup with developing performance measures aimed at:

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

While EHB 1519 targeted:

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

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:

<u>Criminal Justice Involvement</u>

- 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

<u>Access to Treatment</u>

- 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	
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	
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	
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	
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	
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	
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	
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	
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	
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	
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	
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 2SSB 5732:

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

And per EHB 1519:

- Improvements in client satisfaction with quality of life

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 5732/1519 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	
Definition	WHOQOL-BREF Physical Health Scale
Domain	Physical health
Populations	Systems monitoring measure
Source	Survey: WHOQOL-BREF
Self-reported quality of life: psychological health	
Definition	WHOQOL-BREF Emotional Health Scale
Domain	Emotional health
Populations	Systems monitoring measure
Source	Survey: WHOQOL-BREF

Self-reported quality of life: social health	
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	
Definition	WHOQOL-BREF Environment Scale
Domain	Autonomy/Safety
Populations	Systems monitoring measure
Source	Survey: WHOQOL-BREF
Self-reported overall quality of life	
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	
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)	
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	
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	
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	
Definition	New survey item: to be defined
Domain	Cultural connectedness
Populations	Systems monitoring measure
Source	Survey item: Workgroup constructed
Homelessness or housing instability (HEEM)	
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)	
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)	
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 identified performance measures concludes 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:

- Further refinement of newly defined measures
- In coordination with each other, the agencies will select a subset of measures appropriate for their contracting environment
- In coordination with each other, 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, 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.
- Alignment of the 5732/1519 measures with the ESHB 2572 Performance Measures Coordinating Committee's work, HCA's Clinical Quality Council's identified measures and with the Washington State Prevention Framework. (Developed out of the State Health Care Innovation Plan, 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

Evidence-Based Practices and Workforce Development Workgroup Recommendations

(The full EBP Workgroup report can be found in Appendix D.)

Evidence-Based Practices Workgroup Recommendations:

As enacted, 2SSB 5732 directs the Washington State Institute for Public Policy, in consultation with DSHS, HCA, and the University of Washington's Alcohol and Drug Abuse Institute and Evidence-Based Practices Institute to develop an inventory of evidence-based, research-based and promising practices. In support of these efforts, DSHS and HCA asked the 5732 Steering Committee to convene a workgroup tasked with providing recommendations regarding the selection and implementation of evidence-based, research-based, and promising practices. In doing so, the workgroup took into account three guiding principles:

1. Practical: Organizations implementing programs and practices need strategies that can be applied in the real world
2. Sustainable: Focus on long-term implementation and integration vs. rapid start-up and limited follow-up
3. Recovery-oriented: The process of selection/implementation – and the programs and practices themselves – need to align with the values of a person-centered approach, self-determination, recovery and resiliency

Selection Recommendations:

Statewide selection- DSHS and HCA should prioritize 1-2 programs or practices to be implemented statewide. Among these, the state should consider implementation of culturally relevant programs/practices. The decision to implement a "statewide" program or practice should be determined based on identification of regional/local need.

Regional selection- DSHS and HCA should direct their contractors to prioritize three to five programs or practices to be implemented based on locally identified needs. Additionally, contractors should honor local voice by engaging a range of community stakeholders (e.g., consumers, families, providers, service coordination entities) in the selection process.

Recommended program and practice selection considerations (to be prioritized at the state and regional levels):

- **Alignment with core outcome domains-** Targeted outcomes need to link to Results Washington and the State's strategic plans.
- **Identified service gaps in the system-** Consider conducting a gaps analysis and incorporating the system gaps identified at the national or federal level (e.g.; Olmstead, HCBS).
- **Serve the needs of the most-** Identify the programs and practices that meet the needs of most adults in the public behavioral health system. Consider looking to the process that DBHR Children's mental health team utilized that resulted in the selection of "CBT+". Conduct an analysis of the service utilization patterns by diagnosis- an approach that could be used to help address #2 above.
- **Successful pilots-** Learn from the pilots currently funded by DSHS or HCA. Additional pilots are funded at the regional or local level.
- **Targeting service integration-** Utilize programs or practices that align with integration of mental health, substance use, and/or primary care.
- **Cultural relevance-** Identify programs and practices that are conducive to implementation or adaptation for diverse populations (e.g., racially or ethnically diverse, LGBTQ, older adults) as well as for rural or frontier areas
- **Best value:** Look at the cost to benefit ratio and identify lower cost alternatives at equal value.

Inventory for selection- The workgroup strongly recommends that the WSIPP inventory of adult behavioral health evidence-based, research-based, and promising practices continue into the future as a "living" list that continues to be updated over the next several years. This is particularly true of promising programs and practices which are often still in the process of developing a supportive base of research.

WSIPP's Inventory of Evidence-based, Research-based, and Promising Practices: Prevention and Intervention Services for Adult Behavioral Health identified a relatively small number of EBPs. Given the limited number of EBPs, a biennial update would be greatly beneficial. WSIPP estimates that over the next biennium it would take 1/3 full-time employee each year of a senior researcher to expand and update the inventory at a total cost of $110,000. *(A copy of WSIPP's Inventory of Evidence-based, Research-based, and Promising Practices: Prevention and Intervention Services for Adult Behavioral Health can be found in Appendix E or online at:* http://www.wsipp.wa.gov/Reports/538 *)*

Implementation Recommendations:

Take a developmental approach to implementation- tailor implementation support to providers' readiness to implement evidence-based, research-based & promising practices.

Tailor funding to needed resources- At the state level, provide funding for start-up and ongoing implementation for one to two selected programs or practices. On the regional level, consider other local resources such as the reallocation of existing resources, the 1/10th of one percent sales tax funding, or the possibility of state funding for programs or practices implemented more broadly.

Employ core implementation drivers-

- Support clinician selection by tailoring job announcements, skills demonstration in interviews, and providing realistic job previews (e.g., job shadowing).
- Provide clinician training that focuses on skills practice rather than didactic methods, utilize train-the-trainer models, and consider training across the agency in core skills and competencies.
- Rather than putting resources toward broad training, provide consultation that focuses on skills practice and consider an approach where consultation can serve as a model for ongoing supervision.

- Outcome monitoring provides key information. Ideally, there is a mechanism to give individual provider- and consumer-level feedback, while also generating program-, agency- and state-level reporting.
- Fidelity assessment should be the focus but can guide ongoing consultation and quality improvement. Include a range of possible ways to assess fidelity and solicit feedback from stakeholders on an agreeable approach across programs and practices.

Establish learning collaboratives- build local "EBP champions" and implement ways to learn from other sites, such a group learning, implement new learning onsite, share experiences, and come back together to plan further practice improvement.

Structure oversight process so that it is not duplicative- coordinate processes such as contract monitoring, licensing, and fidelity reviews across State, service coordination organizations, providers, and external review entities.

Implementation Costs:

As reported in the December 2013 Engrossed Second House Bill 2536 report, the mandate to increase the use of evidence-based, research-based, and promising practices carries with it increased costs during the initial years of implementation. Successful implementation will require adequate funding for fixed costs. These fixed costs include: training, re-training, local implementation costs, licensing fees, staffing, ongoing supervision and coaching to a specific model (internal/external), manuals, monitoring practice (internal/external), adaptation for underserved populations, infrastructure implementation, and analytical support.

Workforce Development Workgroup Recommendations:

The Senate bill directed the Steering Committee to address "Identification of effective methods for promoting workforce capacity, efficiency, stability, diversity, and safety." To satisfy this directive, the Workforce Development workgroup utilized the following considerations:

- Consider the expanded and evolving workforce serving people with behavioral healthcare needs.
- Be mindful of the varied needs of and solutions for behavioral health providers and clients across the state, including those in rural communities.
- Recommendations should be:
  - Practical
  - Actionable
  - Consistent with existing and successful examples
  - Not overlapping with the work of the evidence-based practice (EBP) workgroup
  - Forward thinking and inclusive

The Workforce Development workgroup produced three over-arching recommendations and identified a series of actions for each, aimed at fulfilling their recommendations.

Recommendations:

Address underlying financial barriers which impact the stability of a skilled work force and ensure that recruitment and retention strategies address financial considerations.

Actions:

- Increase reimbursement rates to reflect market conditions to include sufficient funding for providers to hire and retain a competent workforce.
- Provide salaries that are competitive with private practice for each type of provider.

- Offer broader access to student loan repayment for those serving in shortage areas to encourage recruitment of providers.
- Provide for payment of new technology and evolving practices, such as tele-health, consultation, and multidisciplinary team based activities.

To systematically support professional development of a statewide expanded behavioral health workforce to implement consistent treatment models and EBPs aligned with the goals and outcomes designated by DSHS, HCA, and the legislature.

Actions:
- Recognize the shift towards recovery and resilience principles and incorporate this perspective into all behavioral health (BH) workforce development efforts.
- Promote training that requires follow up clinical supervision and practice transformation support to help BH providers integrate evidence-based, research-based, and promising practices.
- Invest time/payment for professional development to promote integrated, team-based practice.
- Work "upstream" with the professional schools to provide certificate training in the evidence-based practices and tele-health.
- Expand the use of tele-behavioral healthcare by developing greater access to training, as well as the payment, administrative, and technological infrastructure to support it.
- Target training efforts at the broad and changing workforce serving individuals with behavioral health conditions, including: home care workers, primary care providers, health home care coordinators, community health workers, as well as mental health, problem gambling, and substance use disorder treatment providers.

Provide training and support practice change to promote integrated behavioral healthcare and team based approaches.

Actions:
- Provide training in EBPs and other priority methodologies, including care coordination and client transitions.
- Provide training for reaching and supporting geographically and culturally disparate groups.
- Encourage health and behavioral health providers to work to the greatest extent of their license and/or certification in order to extend the workforce.
- Provide funding to support the incorporation of evidence-based practices and integrated care content in the core curriculum for health and behavioral health professionals at state community college and universities.
- Establish a state institute to engage learners innovate training methods and approve high quality training in integrated care and practice transformation through collaborative training venues.
- Target training to support broad intermixing and shared experiences for those in direct care including but not limited to:

    - ARNPs
    - Chemical Dependency professionals
    - Community Health Workers
    - Doctors
    - Emergency First Responders
    - Law Enforcement
    - Long Term Care workers
    - Medical Assistants
    - Nurses
    - Peer Providers
    - Physical Therapists
    - Psychiatrists
    - Psychologists
    - Social Workers

While the legislation did not specify any particular mechanism to implement the recommendations above, effort should be made to connect the workgroup's guidance with other workforce development efforts.

The Steering Committee suggests that these recommendations be made available to the State Health Care Innovation Plan's workforce development planning, as well as other initiatives.

The Impact of 2014 Legislation and Timeline and Costs for Implementation of 2SSB 5732:

Second Substitute Senate Bill 6312- The passage of 2SSSB 6312 in the 2014 Legislative session brought new direction to the implementation of 2SSB 5732. 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", 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 2SSB 5732 and 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. One solution is for DSHS 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 April 2016 implementation date in order to have consistent baselines.

Implementation Costs- The course for behavioral health organizations to deliver an integrated mental health and chemical dependency benefit through managed care contracts is set forth in 2SSB 6312. The state, through the behavioral health organizations, will have responsibility for ensuring the fiscal integrity and quality of services. This includes utilization management, quality oversight, and rigorous fiscal and contract compliance, including cross-systems performance measures. The expectation is that there will be cost savings through more efficient utilization of services. This will be balanced by the possibility that in order to realize the improved physical health outcomes, investment in behavioral health services may be required, particularly in substance abuse treatment. Rates will have to be actuarially sound, and adequate to support a provider network that can achieve the best possible outcomes. This includes support of evidence based practices and their requirements for quality assurance and fidelity. Additionally, it appears that the implementation of SSB 6312 will result in chemical dependency treatment being included in the state's caseload forecast.

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 2SSB 5732 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.

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

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	Director of Strategic Initiatives	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 (Alternate: Marilyn Ronnei)	Legislative and Political Action	Washington State Federation of State Employees
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 Change
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
Finding new member	Corporation for Supportive Housing
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

Evidence Based Practices Workgroup (non-performance measure)

Name	Organization
Marc Bollinger	SW BH RSN
Maria Monroe-DeVita	WIMHRT
Linda Grant	Evergreen Manor
Gretchen Bruce	King County (housing rep)
Kelli Larsen	Plymouth Housing (housing rep)
Shirley Prasad (alt. Mary Looker)*	WA Assoc. of Community and Migrant Health Centers
Lisa Utter	NAMI-WA
Rick Weaver	Central WA Comprehensive MH
Wendy Tanner	WA Com. MH Council
Stephanie Lane	Consultant
Roy Walker	W4A
Mark Snowden	Harborview Medical Center
Pamala Sacks	JR&RA
Anne Shields	CHPW
Jan Ward Olmstead	American Indian Health Commission for Washington State
Marna Miller	Washington State Institute for Public Policy (WSIPP)
Britt Anderson	SEIU- Mukilteo E&T
Margaret Soukup	MHCADSD- King County
Carrie Horwitch	American College of Physicians
June Bredin	DSHS, Developmental Disability Administration
Jayleen Harland	Molina Healthcare
BHSIA/DBHR Staff	Yolanda Lovato Greg Endler David Reed Julia Greeson Kara Panek
HCA Staff	Dr. Daniel Lessler Dr. Charissa Fotinos Stefanie Zier

Workforce Development Workgroup (non-performance measure)

Name	Organization
Joe Avalos*	Thurston/Mason Counties
Joe Valentine	North Sound Mental Health Administration (RSN)
Ray Hsiao *	WA State Medical Association
Roy Walker	Olympic AAA
Wendy Tanner	WA Comm. MH Council

Mary Looker * (alt. Shirley Prasad)	WA Assoc. of Community and Migrant Health Centers
Dennis Mahar	LMTAAA (W4A)
Trez Buckland	NAMI-WA
Jurgen Unutzer * (alt. Anna Ratzliff)	UW
Brigitte Folz	Harborview Medical Center
Donna Allis	Seattle & King Co. Prevention Division- chronic disease unit
Heather Moore	Capital Recovery Center
Chelene Whitaker	WA State Hospital Association
Kelly Dang	King County Dept. of Community and Human Services
Lindsey Grad	SEIU
Bonnie Edwards (alt. Jeff Nogler	SEIU- Compass Health SEIU- E&T, Behavioral Health Resources
Jonathan Beard	Progressive Strategies
Lucy Berliner	UW/Harborview
BHSIA/DBHR Staff	Judy Holman Amy Martin Cheryl Wilcox Kara Panek
HCA Staff	Rebecca Burch 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.*