How to Build a Family of Measures for Improving Behavioral Health Follow-up Care

Measuring progress is essential to successful quality improvement (QI) initiatives. There are three types of measures in QI: outcome measures, process measures, and balancing measures. Taken together, these three measure types make up a family of measures. This document provides suggested outcome measures, process measures, and balancing measures that can be used in QI initiatives to improve behavioral health follow-up. Below are suggestions for how to build a family of measures for a QI project to improve behavioral health follow-up.

- Review the measures in the tables below for outcomes, process, and balancing measures to use in your QI initiatives. Adapt the measures as needed for your project. You may also want to use measures you are currently collecting or develop your own measures based on the needs of your state.

- A manageable family of measures includes no more than seven measures. Consider starting with one measure in each category and adding additional measures over time.

- **Outcome measures**: Outcome measures capture what you are trying to accomplish and how you will know you've achieved improvement. *Recommendation: 1-2 measures*.

- **Process measures**: Process measures capture how the incremental changes you are testing will collectively improve your outcome measure(s). Your process measures should relate to your outcome and be calculated frequently (for example, monthly). *Recommendation: 3-4 measures*.

- **Balancing measures**: Balancing measures capture other consequences, both intended and unintended, that might result as part of your project. *Recommendation: 1 measure.*

- **A note about claims lag:** Claims lag can be a concern when using data for improvement. It is acceptable to look at your quality measures before all the claims have been submitted; 1-2 months runout may be sufficient. For QI projects, you are looking for signs of progress, not perfection. You may test the impact of shorter claims run out by calculating the measure with 1-month runout, 2 months, 3 months, etc. This will help you better understand the impact of claims lag on your QI project measures. Note that measures for accountability, such as those needed to assess contract performance or for incentive payments, require more analytic rigor and longer claims run out.

Improving Behavioral Health Follow-up: Suggested Measures

Outcome Measure Examples (Recommendation: 1-2 measures)			
Measure Name	**Brief Measure Specifications**	**Data source**	**Notes**
Follow-Up After Hospitalization for Mental Illness within 7 days or 30 days after discharge (FUH)	**Child Core Set measure (FUH-CH)** **Numerator:** # of discharges for which the child received follow-up within 7 or 30 days after discharge **Denominator:** # of discharges for children ages 6 to 17 who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses **Exclusions:** Beneficiaries in hospice are excluded from the eligible population	Administrative data	Child Core Set The measure steward is NCQA Two rates are reported: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); and Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)
	Adult Core Set measure (FUH-AD) **Numerator:** # of discharges for which the beneficiary received follow-up within 7 or 30 days after discharge **Denominator:** # of discharges for beneficiaries age 18 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses **Exclusions:** Beneficiaries in hospice or using hospice services anytime during the measurement year	Administrative data	Adult Core Set The measure steward is NCQA Two rates are reported: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); and Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)
	Health Home Core Set measure (FUH-HH) **Numerator:** # of discharges for which the health home enrollee received follow-up within 7 or 30 days after discharge **Denominator:** # of discharges for Health Home enrollees age 6 and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses **Exclusions:** Enrollees in hospice or using hospice services anytime during the measurement year	Administrative data	Health Home Core Set The measure steward is NCQA Two rates are reported: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); and Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)
Follow-up after Emergency Department (ED) Visit for Alcohol and Other Drug Abuse or Dependence Within 7 or 30 Days of the ED Visit (FUA)	**Adult Core Set measure (FUA-AD)** **Numerator:** # of ED visits for which the beneficiary received follow-up within 7 or 30 days of the ED visit **Denominator:** # of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence **Exclusions:** Beneficiaries in hospice or using hospice services anytime during the measurement year	Administrative data	Adult Core Set The measure steward is NCQA Two rates are reported: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); and Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Outcome Measure Examples (Recommendation: 1-2 measures)			
Measure Name	**Brief Measure Specifications**	**Data source**	**Notes**
	Health Home Core Set measure (FUA-HH) **Numerator:** # of ED visits for which the health home enrollee received follow-up within 7 or 30 days of the ED visit **Denominator:** # of emergency department (ED) visits for Health Home enrollees age 13 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence **Exclusions:** Enrollees in hospice or using hospice services anytime during the measurement year	Administrative data	Health Home Core Set The measure steward is NCQA Two rates are reported: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); and Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)
Follow-up after Emergency Department (ED) Visit for Mental Illness Within 7 or 30 Days of the ED Visit (FUM)	**Adult Core Set measure (FUM-AD)** **Numerator:** # of ED visits for mental illness for which the beneficiary received follow-up within 7 or 30 days of the ED visit **Denominator:** # of emergency department (ED) visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm **Exclusions:** Beneficiaries in hospice or using hospice services anytime during the measurement year	Administrative data	Adult Core Set The measure steward is NCQA Two rates are reported: Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days); and Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)

Process Measure Examples (Recommendation: 3-4 measures)			
Measure Name	**Brief Measure Specifications**	**Data source**	**Notes**
Electronic admission alerts sent to primary care physician (PCP) or behavioral health (BH) provider regarding hospital stay or ED visit	**Numerator:** # of patients for whom an admission alert was sent to patient's PCP or BH provider within a specified period of time after admission to hospital stay or ED visit to prompt scheduling of follow-up appointment **Denominator:** # of patients discharged following hospital stay or ED visit for behavioral health treatment/care with referral for follow-up	Health information exchange (HIE) or Electronic Alert System (EAS)	

Process Measure Examples (Recommendation: 3-4 measures)			
Measure Name	**Brief Measure Specifications**	**Data source**	**Notes**
Electronic discharge alerts sent to primary care physician (PCP) or behavioral health (BH) provider following hospital stay or ED visit	**Numerator: #** of patients for whom a discharge alert was sent to patient's PCP or BH provider within a specified period of time after discharge from hospital stay or ED visit to prompt scheduling of follow-up appointment **Denominator:** # of patients discharged following hospital stay or ED visit for behavioral health treatment/care with referral for follow-up	HIE or EAS	
Care Transitions and Referrals Percentage	**Numerator:** # of transitions of care and referrals in which a summary of care record was created and exchanged electronically **Denominator:** # of transitions of care and referrals for patients admitted for BH treatment or care for which the eligible hospital or emergency department was the transitioning or referring provider	HIE or EAS	Measure specifications have been adapted to specify patients receiving behavioral health treatment or care This activity supports referrals
Discharge Planning Warm Hand-offs	**Numerator:** # of in-person warm hand-offs made between hospital or ED staff and provider team **Denominator:** # of patients discharged following hospital stay or ED visit for behavioral health treatment/care with referral for follow-up	Hospital Providers	A warm handoff is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family (AHRQ) Provider team may include PCP or BH provider, hospital or ED staff, care coordinators, or other staff members affiliated with providers
Managed care plan (MCP) care coordinator or case manager staff follow-up with patients	**Numerator:** # of calls and contacts made from MCP care coordinator or case manager to patient to ensure follow-up appointment occurred **Denominator:** # of patients discharged following hospital stay or ED visit for behavioral health treatment/care with referral for follow-up care	Clinic or Physician Providers	
Follow-up appointments scheduled within 24 hours of discharge	**Numerator:** # of appointments scheduled with a PCP or BH provider within 24 hours of hospital or ED discharge **Denominator:** # of alerts sent to patient's PCP or BH provider following discharge from hospital stay or ED visit for behavioral health treatment/care	Clinic or Physician Providers	

Process Measure Examples (Recommendation: 3-4 measures)			
Measure Name	**Brief Measure Specifications**	**Data source**	**Notes**
Follow-up appointment reminders sent to patients	**Numerator:** # of patients who are sent one or more follow-up appointment reminders, e.g., outreach calls, text messages, or e-mails, regarding scheduled follow-up appointment with a PCP or BH provider, within a specified timeframe **Denominator:** # of patients with a scheduled appointment with PCP or BH provider following discharge from hospital stay or ED visit for BH treatment or care	MCP or Clinic or Physician Providers	
Follow-up appointments completed for patients assigned to care coordination staff	**Numerator:** # patients connected to care coordination staff who complete behavioral health follow-up visit within 7 days after discharge from hospital stay/ED visit **Denominator:** # of patients connected to care coordination staff upon discharge from hospital stay/ED visit for behavioral health treatment/care	Clinic or Physician Providers	Care coordination staff may include care coordinators, case managers, patient navigators, and community health workers

Balancing Measure Examples (Recommendation: 1 measure)			
Measure Name	**Description**	**Data source**	**Notes**
Hospital readmissions within 30 days for mental illness	**Numerator:** # of patients who are readmitted to hospital for behavioral health treatment within 30 days of discharge. **Denominator:** # of patients who were discharged from hospital for behavioral health care	Administrative data	
Repeat ED visits within 30 days for mental illness	**Numerator:** # of ED visits for mental illness among patients who were seen in the ED for mental illness within the last 30 days **Denominator:** # of ED visits related to mental illness	Administrative data	