United Behavioral Health

Supplemental & Measurable Performance Measurement Tool

Document Number: N/A **Effective Date**: January, 2019

Table of Contents **Page**

Adults Diagnosed with Bipolar I or II Disorder	1
Adults Diagnosed with Major Depressive Disorder	2
Adults Diagnosed with a Substance-Related Disorder	2
Children Ages 6-12 Diagnosed with Attention-Deficit/Hyperactivity Disorder	3

Optum®[1] annually measures performance against at least two important aspects of each of two clinical practice guidelines to determine provider adherence. Performance measurement is related to the clinical process of care found within Optum's clinical practice guidelines that is most likely to affect care.

The method of analysis that Optum implements allows it to use the results to improve provider performance with the guidelines and allows Optum to segregate results for identification of the percentage of practitioners who are not following specific aspects of the clinical practice guidelines.

ADULTS DIAGNOSED WITH BIPOLAR I OR II DISORDER

Background: According to the American Psychiatric Association, Bipolar I and II Disorders are generally episodic, lifelong illnesses with variable courses. The prevalence of Bipolar I Disorder in adults is estimated at 0.8% of the adult population while the prevalence of Bipolar II Disorder in adults is estimated at 0.5% of the adult population (American Psychiatric Association, 30).

Suicide rates are high among people diagnosed with Bipolar I or II Disorder, and the condition is known to cause substantial psychosocial morbidity, frequently affecting a person's relationships, their occupation, and other aspects of their life (American Psychiatric Association, 30).

People diagnosed with Bipolar I or II Disorder are frequently ambivalent about treatment. This ambivalence often takes the form of noncompliance with medication and other treatments, which is a major cause of relapse (American Psychiatric Association, 30).

Measures:

1. The number of people diagnosed with Bipolar I or II Disorder who have had at least:
   a. One medication management visit or session of ECT within 30 days (1 month) of the initial diagnosis.
   b. Three medication management visits or sessions of ECT between 31 and 180 days (6 months).
   c. One medication management visit or session of ECT between 180 and 301 days (10 months).
2. The number of people diagnosed with Bipolar I or II Disorder who have had at least 2 visits with a behavioral health provider within the initial 6 months of outpatient treatment.
3. The number of people diagnosed with Bipolar I or II Disorder who have had a follow-up appointment within 7 days of discharge from an inpatient facility.

[1] Optum is a brand used by United Behavioral Health and its affiliates

Sources:

American Psychiatric Association 2002. Practice Guideline for the Treatment of Patients with Bipolar Disorder, Second Edition. Retrieved from https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines.

ADULTS DIAGNOSED WITH MAJOR DEPRESSIVE DISORDER

Background: Background: According to the American Psychiatric Association, information on the current prevalence of Major Depressive Disorder comes from two large community surveys, the National Comorbidity Survey Replication (NCS-R) study and the National Epidemiologic Survey of Alcoholism and Related Conditions (NESARC). In the NCS-R, the 12-month prevalence of Major Depressive Disorder was 6.6%. The NESARC, found that the 12-month prevalence rate was 5.28% (American Psychiatric Association, 78)

The impact of major depressive disorders on individuals and their families is substantial. Virtually all individuals in the NCS-R who had a major depressive episode in the preceding 12-month period experienced significant levels of symptom severity. For more than 50% of individuals, symptoms were rated at severe or very severe and were associated with substantial role impairment (American Psychiatric Association, 78).

Treatment of major depressive disorder does not always occur and may be delayed. The average time to treatment in the NESARC was approximately 3 years, and only about 60% of the sample with major depressive disorder received treatment. The NCS-R also evaluated history and adequacy of treatment for major depressive disorder. Of respondents who reported having had a major depressive episode in the last year, just more than one-half had received treatment but less than one-half of these individuals received adequate treatment (American Psychiatric Association, 78).

Measures:

1. People diagnosed with Major Depressive Disorder receive a minimum of 6 medication management and/or psychotherapy visits during the 84 days (12 weeks) following a new diagnosis of Major Depressive Disorder.
2. People diagnosed with Major Depressive Disorder receiving care from a behavioral health provider continue antidepressant medication for at least 180 days following a new diagnosis and prescription.

Sources:

American Psychiatric Association 2002. Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition. Retrieved from https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines.

ADULTS AND ADOLESCENTS DIAGNOSED WITH A SUBSTANCE-RELATED DISORDER

Background: Background: The prevalence of substance-related disorders varies. For example, according to the Substance Abuse Mental Health Services Administration, the 12-month prevalence of an alcohol disorder in people ages 12 and older is 5.6% while the 12-month prevalence for illicit drug use in the same age range is 2.7% (Substance Abuse and Mental Health Services Administration).

According to the American Psychiatric Association, there is a considerable need for treatment of substance use disorders. For example, in the National Comorbidity Survey Replication, about 67% of individuals with an alcohol or other substance use disorder did not receive even minimally adequate mental health specialty services, with even a lower portion receiving minimally adequate health care services (American Psychiatric Association, 128).

Measures:

The percentage of people ages 12 and older with a new episode of alcohol or other drug (AOD) dependence who receive the following:

1. The percentage of people ages 12 and older who are admitted for inpatient treatment, have an outpatient visit, or are admitted to an Intensive Outpatient Program or Partial Hospital Program within 14 days of diagnosis.

2. The percentage of people ages 12 and older who had two or more additional services within 30 days of the initial visit.

Sources:

American Psychiatric Association 2002. Practice Guideline for the Treatment of Patients with Substance Use Disorders, Second Edition. Retrieved from https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines.

Substance Abuse and Mental Health Services Administration 2017. Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Retrieved from https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#sud1.

CHILDREN AGES 6-12 DIAGNOSED WITH ATTENTION-DEFICIT/HYPERACTIVITY DISORDER (ADHD)

Background: Background: According to the American Psychiatric Association, the prevalence of ADHD is estimated at 5% of children (American Psychiatric Association, 61). According to the National Institute of Mental Health, ADHD is the most prevalent behavioral health condition in children (National Institute of Mental Health).

ADHD is associated with reduced school performance and academic attainment, as well as social rejection (American Psychiatric Association, 63).

Measures:

1. Children ages 6-12 who are diagnosed with ADHD and engaged in treatment with a behavioral health provider should be seen at least 4 visits within 6 months of the initial diagnosis of ADHD. This component takes into account the variability in access to treatment.
2. Children ages 6-12 seeing a behavioral health prescriber (rather than a primary care provider) the time between the initial and second visit should be 30 days or less. The 30-day interval takes into acccount the variability in access to treatment.

Sources:

American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA: American Psychiatric Association, 2013. Print.

National Institute of Mental Health. Statistics, Prevalence: Any Disorder in Children. Retrieved from https://www.nimh.nih.gov/health/statistics/prevalence/any-disorder-among-children.shtml.

REVISION HISTORY

Date	Action/Description
February, 2003	• Version 1
January, 2015	• Version 13
January, 2016	• Version 14
January, 2017	• Version 15
January, 2018	• Version 16
January, 2019	• Version 17