



Defense Health Agency

PROCEDURAL INSTRUCTION

NUMBER 6490.02

July 12, 2018

DAD, MEDICAL AFFAIRS

SUBJECT: Behavioral Health (BH) Treatment and Outcomes Monitoring

References: See Enclosure 1.

1. PURPOSE. This Defense Health Agency-Procedural Instruction (DHA-PI), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (k):

a. Establishes the Defense Health Agency's (DHA) procedures for the collection and analysis of BH outcome data.

b. Addresses how DoD will standardize BH outcome data collection to: assess variations in mental health and substance use care among in-garrison medical treatment facilities (MTFs) and clinics; assess the relationship of treatment protocols and practices to BH outcomes; and identify barriers to provider implementation of evidence-based clinical guidance approved by DoD.

c. Designates the Army as the DoD lead Service for maintenance and sustainment of the Behavioral Health Data Portal (BHDP) in specialty care mental health and substance use clinics, referred to collectively as BH clinics, until BHDP functionality can be integrated with GENESIS or another electronic health record (EHR) system managed by DHA.

d. Designates DHA Information Operations (J-6) as lead on transitioning BHDP functional requirements related to outcomes monitoring to future EHR data collection platforms and processes.

2. APPLICABILITY. This DHA-PI applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Office of the Inspector General of the DoD, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this DHA-PI as the "DoD Components").

3. POLICY IMPLEMENTATION. It is DHA's instruction, pursuant to References (d) through (k), to promote the use of evidence-based treatments (EBTs), and monitor patient outcomes in pursuit of continuous improvements in BH care for all adult DoD beneficiaries.

a. This DHA-PI implements:

(1) Reference (d), which specifies screening and outcome measures to be collected in MTFs and the use of BHDP as the data collection platform.

(2) Reference (e), which identifies standards for implementing and maintaining quality in the delivery of BH services in primary care.

(3) Reference (f), which requires the collection and analysis of clinical care data to monitor and advance patient outcomes.

(4) Reference (g), which requires monitoring of adherence to DoD guidance on prescribing practices for posttraumatic stress disorder (PTSD) at MTFs.

b. This DHA-PI defines:

(1) Requirements for BHDP implementation, utilization, and data reporting.

(2) Responsibilities for the management, collection, and analysis of structure, process, and outcome measures by BH providers, BHDP data managers, internal behavioral health consultants (IBHCs) and behavioral health care facilitators (BHCFs) in primary care clinics and DHA.

(3) Procedures to compile data on BH care provided by DoD, to include: data related to implementation and utilization of BHDP; treatment outcomes; types of treatment provided; variations in BH care outcomes; and implementation of EBTs recommended by DoD.

(4) Expectations for compliance with monitoring outcomes through BHDP and transmitting BHDP data to the Military Health System (MHS) Data Repository (MDR).

(5) Responsibilities to ensure sufficient support in developing and maintaining interoperability between BHDP and any future EHR data collection platforms and processes, or the transition of the full range of BHDP capabilities to future EHR systems.

(6) Expectations for data aggregation and analysis of: adoption and utilization of BHDP or any other EHR data collection platforms and processes that support or replace BHDP functions; application of EBTs as determined by MHS governance; outcomes monitoring; and examination of relationships between demographic data, clinic data, systematic treatment and outcomes monitoring, and EBT use with treatment outcomes.

July 12, 2018

4. CANCELLED DOCUMENT. This DHA-PI cancels the originally issued document DHA-PI 6490.01, “Behavioral Health (BH) Treatment and Outcomes Monitoring,” due to an inaccuracy regarding the duplication of the publication number under the same series.

5. RESPONSIBILITIES. See Enclosure 2.

6. PROCEDURES. See Enclosures 3 through 6.

7. RELEASABILITY. **Cleared for public release**. This DHA-PI is available on the Internet from the Health.mil site at: www.health.mil/DHAPublications.

8. EFFECTIVE DATE. This DHA-PI:

a. Is effective upon signature.

b. Will expire 10 years from the date of signature if it has not been reissued or cancelled before this date in accordance with DHA-PI 5025.01 (Reference (c)).



R. C. BONG
VADM, MC, USN
Director

Enclosures

1. References
2. Responsibilities
3. Procedures
4. Behavioral Health Data Portal Adoption Rate
5. Evidence-based Treatment Reporting
6. Outcome Metrics Specifications

Glossary

ENCLOSURE 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013, as amended
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” August 21, 2015
- (d) Assistant Secretary of Defense for Health Affairs Memorandum, “Military Treatment Facility Mental Health Clinical Outcomes Guidance,” September 9, 2013
- (e) DoD Instruction 6490.15, “Integration of Behavioral Health Personnel (BHP) Services Into Patient-Centered Medical Home (PCMH) Primary Care and Other Primary Care Service Settings,” November 20, 2014
- (f) National Defense Authorization Act for Fiscal Year 2016, Section 729
- (g) National Defense Authorization Act for Fiscal Year 2017, Section 745
- (h) Military Health System Behavioral Health Data Management Working Group Charter, October 1, 2015¹
- (i) Department of Defense, Department of Veterans Affairs, and Department of Health and Human Services, 2013 Annual Report: Interagency Task Force on Military and Veterans Mental Health
- (j) “Joint Fact Sheet: DoD and VA Take New Steps to Support the Mental Health Needs of Service Members and Veterans,” August 26, 2014
- (k) MHS Behavioral Health Clinical Community Charter¹, August 11, 2017

¹ This reference can be found by calling the DHA Operations (J-3) Front Office at (703) 681-8555 or contacting via email at dha.ncr.health-opns.mbx.hco-fo@mail.mil.

ENCLOSURE 2

RESPONSIBILITIES

1. DIRECTOR, DHA. The Director, DHA, will:

a. Establish procedures to implement Assistant Secretary of Defense for Health Affairs' policy regarding BHDP implementation and data collection.

b. Develop and oversee plan for analyzing and reporting BHDP implementation metrics, BH care process data, patient outcomes, and variations in BH outcomes in primary and specialty care clinics across MTFs, excluding deployed and expeditionary facilities.

c. Monitor activities to fully implement and utilize BHDP and to import BHDP data and primary care data into the MDR.

d. By end of Fiscal Year (FY) 2019, submit implementation plan to ASD(HA) for deployment of BHDP or other EHR data collection platform or process that supports or replaces BHDP functions in all primary care clinics by end of FY 2021.

e. Ensure DHA Information Operations (J-6) includes functional requirements related to outcomes monitoring in any and all future EHR data collection platforms and processes and consults with relevant functional communities of interest to ensure development of optimal BH outcome monitoring capabilities.

f. Develop, coordinate, and facilitate recommendations to support Service-level outcomes monitoring and to evolve EHR data collection functions and processes to assess, monitor, and impact patient outcomes. Coordination of BHDP data collection and metric development activities will be addressed through MHS governance groups that focus on operational requirements of BHDP hardware and software, and on developing, monitoring, and revising BHDP structure, process, and outcome metrics.

g. Review and maintain updated list of EBTs by diagnosis, based on guidance endorsed by DoD as detailed in Department of Veterans Affairs (VA)/DoD clinical practice guidelines (CPGs) and other communications, such as the Assistant Secretary of Defense for Health Affairs' memorandums and DoD Directives, or as recommended by the Behavioral Health Clinical Community (BHCC).

h. Report patient outcomes and BHDP utilization data periodically to the appropriate MHS governance boards and, when appropriate, make recommendations to implement policy changes and recommendations, as needed or suggested by data findings regarding BHDP functionality or BH outcomes monitoring. Develop similar reports as appropriate as MTFs and clinics transition to future EHR data collection platforms and processes.

i. Support modernization of BHDP as needed to execute the requirements in this document.

- j. Support establishment of one BHDP base survey for use across all Service specialty care clinics.
- k. Ensure the development and maintenance of interoperability capabilities between BHDP and any future data collection systems and the EHR, or ensure the transition of all BHDP capabilities to such future data collection systems for efficient documentation of treatment and outcomes data in the EHR.
- l. Implement incentives and other methods, as needed, to maximize provider use of outcomes monitoring procedures.
- m. Assess procedures and outcomes of this DHA-PI for possible adaptation across other BH care settings.
- n. Track and provide structure, process, and outcomes metrics data (See Enclosure 3), to MHS governance in order to reduce variability in BH care and facilitate transition from an encounter-based view of health care to a value-based focus on improved patient outcomes.
- o. Fully transition outcomes monitoring requirements to future data collection and storage systems, to include transferring BHDP capabilities to new EHR systems or ensuring full interoperability of future EHR systems that support BHDP.
- p. Assume all responsibilities assigned to Secretary of the Army in section 3 of this enclosure upon transfer of full BHDP functionality to an updated EHR system.

2. SURGEONS GENERAL OF THE MILITARY DEPARTMENTS AND DIRECTOR, NATIONAL CAPITAL REGION MEDICAL DIRECTORATE/J-11. Under the authority, direction, and control of the Secretaries of the Military Departments, the Surgeons General of the Military Departments and the Director, National Capital Region Medical Directorate/J-11, will:

- a. Ensure that Medical Command-level policies and implementation guidance conform to this DHA-PI.
- b. Appoint a BHDP liaison (e.g., BHDP Program Manager) to be the Service point of contact for management and oversight of Service BHDP operations and for participation in BHDP governance and related work groups or integrated provider teams as needed to ensure effective use of BHDP. The BHDP liaison will coordinate identification and resolution of data or interface issues that impact optimal use of BHDP.
- c. Appoint representatives to governance workgroups responsible for behavioral health data monitoring.
- d. Ensure that Service BHDP liaisons adhere to data requirements of this DHA-PI.

July 12, 2018

e. Track and provide outcomes monitoring status data (e.g., number of staff and providers trained, amount of deployed and operational equipment, etc.) to MHS governance in order to optimize communication and support for the proliferation of outcomes based practice.

f. Fully implement BHDP, or any other EHR data collection platforms and processes that support or replace BHDP functions in the future, in all BH specialty care clinics, to include substance use disorder (SUD) clinics.

g. Ensure clinics that consistently underperform in the use of EBTs collect data on site-specific barriers to providing EBTs, and develop and report process-improvement plans to increase EBT adoption and utilization to DHA.

3. SECRETARY OF THE ARMY. Until BHDP functionality is fully transferred to or integrated into another EHR system, and at which time the responsibilities listed below will transfer to DHA, the Secretary of the Army will serve as DoD Service lead of BHDP and will:

a. Provide a supporting work force and facilities to sustain the BHDP application and database with funding through the Defense Health Program.

b. Ensure Service BHDP data are regularly transferred to the MDR or other authoritative data warehouse-like capability solution defined by DHA.

c. Update BHDP technical documentation in a timely manner.

d. Be available to train BHDP champions across the Department as needed.

e. Maintain accessibility and operational functionality of BHDP software requirements at installations.

4. MTF AND MENTAL HEALTH CLINIC COMMANDERS/DIRECTORS. Under the authority, direction, and control of the Surgeons General of the Military Departments (until transfer of authority, direction, and control over MTFs to DHA is complete, and at which time the responsibilities listed below will transfer to DHA), MTF and Mental Health Clinic Commander/Directors will:

a. Maintain accessibility and operational functionality of the BHDP hardware requirements at installations.

b. Ensure all BH clinic staff complete initial and refresher training on use of BHDP or other EHR data collection platforms and processes as recommended by the BHCC.

c. Ensure all specialty BH care providers follow outcomes monitoring procedures, to include noting key BH care elements, as directed in Enclosure 3.

d. Ensure all IBHCs and BHCFs follow outcomes monitoring procedures, as directed in Enclosure 3.

ENCLOSURE 3

PROCEDURES

This enclosure provides procedures for BHDP implementation and administration, outcomes monitoring in primary care and BH clinics, use of EBTs, and assessment of EBT barriers. As MTFs and clinics adopt other EHR data collection platforms and processes, similar capabilities and procedures will be developed to continue maintenance of minimum standards for treatment and outcomes monitoring.

1. BHDP DATA COLLECTION CAPABILITY IN SPECIALTY CARE BH CLINICS

a. Hardware. Each BH clinic will install and maintain a determined number of end-user devices to allow all patients to input self-report data into the BHDP application to collect standard data and track BH outcomes prior to the clinical appointment. Each BH clinic will also install a sufficient number of computer monitors for clinical and support staff to best utilize BHDP during patient check-in and individual direct care appointments. Equipment needs will be determined by each clinic's unique patient volume, population mix, and services provided. Patient devices should include privacy screens or provide sufficient space to protect patient privacy as they enter information into BHDP.

b. Software. Each BH clinic will ensure the configuration of patient self-report end user devices in a manner that maximizes clinic efficiency, ensures proper network security, allows for all types of beneficiary categories to use BHDP, and optimizes BH outcomes data collection across MHS.

2. BHDP ADMINISTRATION REQUIREMENTS IN SPECIALTY CARE BH CLINICS

a. BHDP Required Measures in Specialty Care BH Clinics. Measures employ diagnostic criteria from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Minimum measurement capabilities of BHDP will include:

- (1) Nine-item Patient Health Questionnaires (PHQ-9);
- (2) Posttraumatic Stress Disorder Checklist for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (PCL-5);
- (3) Seven-item Generalized Anxiety Disorder Scale;
- (4) Alcohol Use Disorders Identification Test-Consumption; and
- (5) Brief Addiction Monitor (BAM).

b. BHDP Required Measurement Frequencies in Specialty Care BH Clinics. For every patient with a diagnosis of major depressive disorder (MDD), PTSD, or SUD entered in BHDP, the following minimum measure frequencies are required (with optional additional measures administered at clinician's judgment). For the following, "at baseline" refers to the survey administered closest to the date of diagnosis session or the session after diagnosis. For follow-up administrations, if a patient is not seen at the time of required assessment, the provider will administer the assessment at the next patient visit.

(1) For patients with a diagnosis of MDD: Administer the PHQ-9 at baseline and no less frequently than every 30 days.

(2) For patients with a diagnosis of PTSD: Administer the PCL-5 at baseline and no less frequently than every 30 days.

(3) For patients with a diagnosis of SUD: Administer the 30-day version of BAM at baseline, and administer the 7-day version of BAM at follow-up no less frequently than every 30 days.

c. Modifications to BHDP Required Measures and Data Collection. The BHCC has the discretion to update or modify requirements for baseline and outcome measures and data-collection intervals.

3. ANALYSIS OF DATA FROM BH SPECIALTY CARE CLINICS. DHA will analyze patient outcomes, process data, and variations in outcomes among different MTFs. BHCC will report facilities that either fail to report metrics or do not meet targets for process metrics to the Enterprise Solution Board for follow-up and remedial action. Metrics to be collected include, but are not limited to:

a. Structure Metrics. Initial structure metrics will be reported by the Services once every quarter to the BHCC via the BHDP liaisons:

(1) Number and percent of MTFs that have implemented required BHDP equipment, operational network, and information technology requirements. Equipment needs will be determined by each clinic's unique patient volume, population mix, and services provided.

(2) Number of MTFs with 80% or more of their providers trained on BHDP functions and clinical scales to inform treatment monitoring and decision-making.

b. Process Metrics. Initial process metrics to be collected through BHDP and analyzed by DHA include:

(1) BHDP Adoption Rate. Number of patients who started a BHDP survey in the index month, in a direct care, outpatient BH clinic, divided by the number of patients with eligible encounters (number of patients with at least one eligible treatment encounter in the index month; see Enclosure 4). Target rates for BHDP Adoption for Active Duty Service members (ADSMs)

July 12, 2018

and Active Duty Family members (ADFM) are 30% within 3 months of issuance of this DHA-PI, 50% within 9 months, and 80% within 12 months.

(2) BHDP Survey Delivery Rate. Number and percent of patients per month with a PTSD, MDD, and/or SUD diagnosis entered in BHDP who were administered a survey in the index month (denominator), which included a diagnosis-specific questionnaire (numerator) as mandated in Section 2b(1) of this enclosure. Rates will be reported separately by diagnostic category (PTSD, MDD, and SUD), which are not mutually exclusive, so patients may be included in more than one disorder cohort. Target rates for BHDP Survey Delivery by disorder for ADSMs and ADFMs are 30% within 3 months of issuance of this DHA-PI, 50% within 9 months, and 80% within 12 months.

(3) BHDP Provider Utilization Rate. Percentage of patients in ongoing treatment with required BHDP Treatment Settings entered by a credentialed provider. All patients in ongoing treatment, defined as having at least two previous BHDP surveys delivered within the past 180 days, should have at least two fields entered in BHDP by providers including, but not limited to, the treating diagnoses and treatment modalities. Target rates for provider utilization for ADSMs and ADFMs are 20% within 3 months of issuance of this DHA-PI, 40% within 6 months, 60% within 9 months, and 70% within 12 months. The BHCC may specify utilization targets for each setting option.

(4) EBT Utilization Rate. Number and percent of patients with a PTSD, MDD, and/or SUD diagnosis who received EBTs across the MHS and by MTF/clinic. Target rates for EBT utilization for ADSMs and ADFMs are 20% within 3 months of issuance of this DHA-PI, 30% within 6 months, 40% within 9 months, and 50% within 12 months. See Enclosure 5 for EBT Utilization Rate definition and calculation. Additions and revisions to the list of EBTs may be developed by the BHCC.

(5) Treatment Dosage Rate. Number and percent of patients initially diagnosed with PTSD or MDD who met the requirement of initial visit plus three or more follow-up visits (individual or group encounters by a credentialed BH provider) within the first 90 days after initial diagnosis. Target rates for treatment dosage are 20% within 3 months of issuance of this DHA-PI, 30% within 6 months, 40% within 9 months, and 50% within 12 months. As compliance with dosage rates improve, metrics may change to set higher standards. Metrics for PTSD Treatment Dosage Rate and MDD Treatment Dosage Rate can change independently. DHA will make available to the Services the most recent metric definitions on the relevant document sharing platforms and through the Service BHDP liaisons.

c. Outcome Metrics. DHA will provide administrative support to analyze and report data examining the relationship between outcomes and BHDP utilization, EBT utilization, demographic data (e.g., Service branch, region, age, sex, ethnicity, rank, deployment history), clinic data (e.g., staff-to-patient ratio), and process data (e.g., number of sessions per time period). The BHCC, and any subordinate working groups, will be responsible for developing, monitoring, and recommending criteria to MHS governance for specific outcome metrics, to include score thresholds and/or score reduction thresholds that define clinical improvement and

remission. DHA will make available all indicators and updates to the Services on the relevant document sharing platforms and through the Service BHDP liaisons as needed.

4. REPORTING REQUIREMENTS FOR BH SPECIALTY CARE. Per Enclosure 2, DHA will ensure administrative support for data reporting. Periodic reports of structure, process, and outcome metrics will be provided to the BHCC for review and feedback. Reports will include:

a. Analysis of Factors Associated with Treatment Outcomes. As directed by the BHCC or MHS governance, analyses can include examination of factors that impact treatment outcomes.

b. Identification of Outlier Clinics in EBT Use. Reports to the BHCC will identify outlier clinics that consistently underperform or excel in use of EBTs.

(1) Consistent lower utilization is defined as not meeting targets established by Section 3b(4) of this Enclosure (or subsequently updated by the BHCC) and ranking in the bottom quartile in use of EBTs over two consecutive reporting periods.

(2) Consistent higher utilization is defined as ranking in the top quartile over two consecutive reporting periods.

5. EBT BARRIER ASSESSMENT IN BH SPECIALTY CARE. The BHCC will work with Service leadership and MHS governance to develop action plans for increasing performance of clinics with low EBT utilization and report progress on action plans as requested.

6. DATA COLLECTION CAPABILITY AND ADMINISTRATION REQUIREMENTS IN PRIMARY CARE CLINICS

a. Data Collection and Analysis. Where available, BHDP is the preferred method of data collection. Where BHDP is not fully integrated into primary care clinics, IBHCs will document data on Tri-Service Workflow Forms, and BHCFs will use the Fast Informative Risk & Safety Tracker and Stepped Treatment Entry & Planning System. By end of FY 2021, every primary care clinic will adopt and utilize the patient-entered data platform available in either BHDP or an EHR that replaces BHDP with every patient treated for a psychiatric disorder, in accordance with the implementation plan to be submitted to ASD(HA) by Director DHA by end of FY 2019. DHA's Psychological Health Center of Excellence, Psychological Health Performance & Analytics section will provide analyses. Methods for data collection, transfer, or reporting will be updated as necessary as DoD migrates to newer EHR platforms that support or replace BHDP.

b. Required Measures in Primary Care Clinics. Minimum measurement capabilities of primary care will include:

(1) PHQ-9;

(2) PCL-5; and

(3) Behavioral Health Measure-20 (BHM-20).

c. Primary Care Required Measurement Frequencies. For primary care patients seen by IBHCs and BHCFs, the following minimum measure frequencies are required. If a patient is not seen at time of required assessment, administer the required measures at the next visit.

(1) BHCFs. For patients with a diagnosis of MDD, administer the PHQ-9 at first contact, which should occur within 10 days of referral from the primary care manager (PCM); 4 weeks after initial diagnosis by PCM; and every 4 weeks thereafter. For patients with a diagnosis of PTSD, administer the PCL-5 at first contact, which should occur within 10 days of referral from the PCM; 4 weeks after initial diagnosis by PCM; and every 4 weeks thereafter.

(2) IBHCs. Administer the BHM-20 at every visit.

d. Modifications to Primary Care Required Measures and Data Collection. MHS governance has the discretion to update or modify requirements for baseline and outcome measures and data-collection intervals.

e. Reporting Requirements. Reports will be submitted quarterly to the Primary Care Clinical Community or designated workgroup and include the following:

(1) Process Metrics

(a) PCM Feedback Rate. Percentage of patients for which IBHCs gave PCM feedback within the quarter. Target is 85% within 3 months of issuance of this DHA-PI.

(b) IBHC Appointment Rate. Percentage of patients with more than four IBHC appointments within the quarter. Target is 10% within 3 months of issuance of this DHA-PI.

(c) PCM to BHCF Referral Rate. Percentage of patients who have initial BHCF appointment within 10 days of PCM referral. Target is 90% within 3 months of issuance of this DHA-PI.

(d) Pharmacotherapy EBT Rates for BHCF Patients

1. Percentage of patients with PTSD or MDD who received a prescription for a medication concordant with DoD-approved evidence-based clinical guidance.

2. Percentage of PTSD patients who received a prescription for more than two doses of a benzodiazepine. (Benzodiazepines are known to cause harm and should not be used for patients diagnosed with PTSD unless potential benefits outweigh known risks).

(2) Outcome metrics to be collected and analyzed in primary care:

July 12, 2018

(a) For patients who had at least two encounters with an IBHC, percentage of patients with baseline BHM-20 global mental health scores in a clinical range that demonstrated reliable deterioration, no change, and reliable improvement in BHM-20 global mental health score.

(b) For patients with PTSD who had at least two encounters with a BHCF, percentage who demonstrated clinical response, as defined by a five-or-more point reduction in PCL-5 score.

(c) For patients with MDD who had at least two encounters with a BHCF, percentage who demonstrated clinical response, as defined by a five-or-more point reduction in PHQ-9 score.

(3) The Primary Care Clinical Community will direct analyses, as needed, of factors associated with treatment outcomes.

ENCLOSURE 4

BEHAVIORAL HEALTH DATA PORTAL ADOPTION RATE

1. COHORT DEFINITION. Adult patients with an encounter (MDR/MHS Mart [M2]) in a direct care, BH clinic, with a Type 1 (psychiatrist or nurse practitioner) or 2 (psychologist or licensed clinical social worker (LCSW)) provider, and with at least one treatment encounter in the index month are included in the metric. The patient's beneficiary category (from MDR/M2) is used to determine whether the patient is included in the ADSM or ADFM report.

2. METRIC CALCULATION. The two metrics, BHDP Adoption Rates for ADSM and BHDP Adoption Rates for ADFMs, are reported as percentages using the following definitions.

a. Denominator. The denominator is the number of patients with at least one eligible treatment encounter, as defined above, in the index month.

b. Numerator. The numerator is the number of patients with at least one BHDP survey started in the index month, delivered in a direct care, outpatient BH clinic.

ENCLOSURE 5EVIDENCE-BASED TREATMENT REPORTING

1. REQUIRED REPORTS. Three monthly EBT reports are required, including reports on use of EBTs for patients with PTSD, MDD, and SUD. The reports present the rate at which patients in active, outpatient direct care, with primary diagnoses in one or more of the above categories, are receiving at least one EBT. A separate report will be generated to summarize use of evidence-based prescribing practices at MTFs and to support requirements of the National Defense Authorization Act for Fiscal Year 2017, Section 745 (Reference (g)), to monitor use of pharmaceutical agents discouraged from use under the VA/DoD CPG for the Management of PTSD and Acute Stress Disorder.

2. COHORT DEFINITION. To be included in the cohort for the report month, patients must be receiving ongoing BH direct care, which is defined as: a minimum of two previous electronic outcomes surveys delivered in a direct care outpatient BH clinic (proxy for visit) in the previous 6 months; initiation of an electronic outcomes survey in the index month in a BH clinic; and a primary diagnosis in BHDP, or other EHR, of PTSD, MDD, and/or SUD. The reports are not mutually exclusive, so patients may be included in more than one report.

3. EBT DEFINITION. Patients are considered to have received an EBT if there is documentation in BHDP of at least one recommended EBT from the most recent VA/DoD CPGs and other DoD guidance. The list of EBTs available to be selected in BHDP will be reviewed and updated annually by the BHCC.

4. METRIC CALCULATION. The three EBT metrics (PTSD, MDD, and SUD) are reported as percentages using the following definitions.
 - a. Denominator. The denominator is the number of patients in the disorder cohort as previously defined.

 - b. Numerator. The numerator is the number of patients from the denominator who received at least one EBT in the current month matching the diagnosis entered in BHDP.

ENCLOSURE 6

OUTCOME METRICS SPECIFICATIONS

1. REQUIRED REPORTS. Outcome metrics will be developed and reported for patients with PTSD and MDD seen in specialty care clinics, assessing the rate at which patients achieve clinical improvement or remission in the first 1 to 6 months of an episode of care. Patients can be a member of one or both outcome cohorts.

2. PTSD OUTCOMES

a. PTSD Episode of Care. The episode of care for this metric begins with a diagnosis of PTSD in a direct care BH clinic, following a period of at least 6 months without a treatment session for a PTSD diagnosis. The episode of care must include at least two sessions within the duration of 30–183 days.

b. Outcome Cohort. Patients included in the PTSD outcome cohort must meet the following diagnostic and symptom criteria:

(1) Diagnosis of PTSD

(a) Patient has one of the diagnostic codes for PTSD from the most recent revision of the International Classification of Diseases. DHA will make available to the Services the most recent codes determining eligibility on the relevant document sharing platforms and through the Service BHDP liaisons.

(b) Diagnosis must be made in a BH clinic by a Type 1 (psychiatrist or nurse practitioner) or Type 2 (psychologist or LCSW) provider.

(c) Diagnosis must be made in an individual face-to-face treatment appointment.

(2) PCL-5 score of 29 or greater completed in BHDP, or other EHR data collection platform that may replace BHDP, within 30 days of the diagnosis session. If multiple questionnaires are completed, the first PCL-5 score within 30 days of the first session in the episode of care will be used to determine the patient's cohort qualification and is considered the index questionnaire.

c. Definition of Outcomes. Patients have positive outcomes if they meet criteria for clinical improvement or remission within the episode of care, as defined by the most recent criteria based upon the literature and population adjusted factors (e.g., age, gender, race, education, marital status, rank, etc.). Since the criterion may be adjusted for recent evidence and changes in population factors, DHA will post and make available updated criteria for clinical improvement or remission to the Services on the relevant document sharing platforms and through the Service BHDP liaisons.

d. Outcome Calculation. The rate of patients who meet clinical improvement or remission is calculated for all patients in the episode of care on a monthly basis and reported as a percentage improved as follows:

(1) Numerator. The numerator is the number of patients who met clinical improvement or remission in the reporting month.

(2) Denominator. The denominator is the number of patients who meet the cohort definition for the reporting month.

3. MDD OUTCOMES

a. MDD Episode of Care. The episode of care for this metric begins with a diagnosis of MDD (defined below) in a direct care BH clinic, following a period of at least 6 months without a treatment session for an MDD diagnosis. The episode of care must include at least two sessions within the duration of 30–183 days.

b. Outcome Cohort. Patients included in the depression outcome cohort must meet the following diagnostic and symptom criteria:

(1) Diagnosis of Depression

(a) Patient has one of the diagnostic codes for MDD from the most recent revision of the International Classification of Diseases. DHA will make available to the Services the most recent codes determining eligibility on the relevant document sharing platforms and through the Service BHDP liaisons.

(b) Diagnosis must be made in a BH clinic by a Type 1 (psychiatrist or nurse practitioner) or Type 2 (psychologist or LCSW) provider.

(c) Diagnosis must be made in an individual face-to-face treatment appointment.

(2) PHQ-9 score of ≥ 10 completed in BHDP, or other EHR data collection platform that may replace BHDP, within 30 days of the diagnosis session. If multiple questionnaires are completed, the first PHQ-9 score within 30 days of the first session in the episode of care will be used to determine the patient's cohort qualification and is considered the Index questionnaire.

c. Definition of Outcomes. Patients have positive outcomes if they meet criteria for clinical improvement or remission within the episode of care, as defined by the most recent criteria based upon the literature and population adjusted factors (e.g., age, gender, race, education, marital status, rank, etc.). Since the criterion may be adjusted for recent evidence and changes in population factors, DHA will post and make available updated criteria for clinical improvement or remission to the Services on the relevant document sharing platforms and through the Service BHDP liaisons.

d. Outcome Calculation. The rate of patients who meet clinical improvement or remission is calculated for all patients in the episode of care on a monthly basis and reported as a percentage improved as follows:

(1) Numerator. The numerator is the number of patients who met clinical improvement or remission in the reporting month.

(2) Denominator. The number of patients who meet the cohort definition for the reporting month.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ADFM	Active Duty Family member
ADSM	Active Duty Service member
BAM	Brief Addiction Monitor
BH	behavioral health
BHCC	Behavioral Health Clinical Community
BHCF	behavioral health care facilitator
BHDP	Behavioral Health Data Portal
BHM-20	Behavioral Health Measure-20
CPG	clinical practice guideline
DHA	Defense Health Agency
DHA-PI	Defense Health Agency-Procedural Instruction
DSM-5	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
EBT	evidence-based treatment
EHR	electronic health record
FY	fiscal year
IBHC	internal behavioral health consultant
LCSW	licensed clinical social worker
MDD	major depressive disorder
MDR	Military Health System Data Repository
MHS	Military Health System
MTF	medical treatment facility
PCL-5	Posttraumatic Stress Disorder Checklist for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition
PCM	primary care manager
PHQ-9	Patient Health Questionnaire (nine-item)
PTSD	posttraumatic stress disorder
SUD	substance use disorder
VA	Department of Veterans Affairs

PART II. DEFINITIONS

Alcohol Use Disorders Identification Test-Consumption. A simple three-item alcohol screen that can help identify patients who are hazardous drinkers or have active alcohol use disorder.

BAM. A 17-item self-report questionnaire of alcohol and drug use and factors related to risk for relapse over the previous 7 or 30 days, depending on the version of the measure administered. The BAM produces composite scores for amount of alcohol and drug use, risk factors (e.g., craving, negative mood) and protective factors (e.g., self-help, social supports).

BHM-20. A 20-item questionnaire that assesses the most common mental health problems seen in outpatient therapy settings. It has one global scale (Global Mental Health) and five subscales (Well-being, Psychological Symptoms, Life Functioning, Depression, and Anxiety). It takes approximately 90 seconds for the patient to complete.

Generalized Anxiety Disorder Scale. A seven-item self-reported questionnaire for screening and severity measuring of generalized anxiety disorder. It measures severity of various signs of generalized anxiety disorder according to reported response categories (e.g., “not at all,” “several days,” “more than half the days,” and “nearly every day”). It cannot be used to establish a diagnosis of generalized anxiety disorder; further clinical assessments and evaluations are required to determine the diagnostic significance of reported symptoms.

outcome metrics. Measurement that quantifies effects of health care processes on patients, including their health status, knowledge, behavior, and satisfaction with care.

PCL-5. A 20-item self-report measure of the 20 DSM-5 symptoms of PTSD that can be completed by patients in a waiting room prior to a session or by participants as part of a research study. It takes approximately 5 to 10 minutes to complete and has a variety of purposes, including screening individuals for PTSD, a PTSD diagnostic aid, and monitoring symptom change during and after treatment. It cannot be used to establish a diagnosis of PTSD; further clinical assessments, interview, and evaluations are required to determine the diagnostic significance of reported symptoms.

PHQ-9. The nine-item depression scale that assists clinicians in diagnosing depression, as well as selecting and monitoring treatment. There are two components of the PHQ-9: assessing symptoms and functional impairment to make a tentative diagnosis of depression and deriving a severity score to help select and monitor treatment. This scale is based directly on the DSM-5 diagnostic criteria for MDD.

process metrics. Measurement that quantifies aspects of the interactions between patients and staff (e.g., the types and amount of services delivered). Service-delivery activities that can be measured include screening for symptoms, diagnosing, treating, educating, and consulting.

structure metrics. Measurement that quantifies aspects of the environment in which health care takes place and includes physical structures (e.g., clinic buildings and equipment), number and type of staff, staff training, and finances.