NMBHPA Metrics That Matter: Measure Tip Sheets

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Contents

PHQ-9 SCREENING

Measure Description

The PHQ-9 Screening measure evaluates the use of the Patient Health Questionnaire (PHQ-9) in assessing patients who are screened for depression or have an existing depression diagnosis. The PHQ-9 helps identify the presence and severity of depressive symptoms and supports appropriate treatment planning.

The PHQ-9 is a brief, patient-completed questionnaire administered at the time of the visit. It allows clinicians to quickly score depression severity, guide treatment decisions, and monitor patient progress over time. Research has demonstrated that PHQ-9 results are both reliable and valid for assessing depression severity.

Tips for Improving Performance on PHQ-9 Screening

- Provide staff training on PHQ-9 administration, scoring, and interpretation.
- Review results with patients to guide shared decision-making and collaborative care planning.
- Use tracking systems to monitor upcoming or overdue assessments.
- Educate patients on the purpose and benefits of the PHQ-9 to encourage completion.
- Incorporate PHQ-9 into intake and treatment plan reviews (e.g., at intake, quarterly, and during 90-day treatment plan reviews).
- Regularly review screening rates and provide direct feedback to clinicians to prompt action or understand barriers.

Source:

1. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001 Sep;16(9):606-13. doi: 10.1046/j.1525-1497.2001.016009606.x. PMID: 11556941; PMCID: PMC1495268, The PHQ-9: validity of a brief depression severity measure - PubMed.

SOCIAL NEEDS ASSESSMENT

Measure Description

The purpose of the Social Needs Assessment Tool is to identify non-medical social factors that may negatively impact a patient's health outcomes. Research shows that unmet health-related social needs such as food insecurity, housing instability, transportation barriers, unemployment, and exposure to violence can significantly affect overall health.
Screening for these factors helps health care providers better understand the challenges patients face, develop individualized care plans, and connect patients to appropriate community resources and support services.

Tips for Improving Performance on Social Needs Assessment

- Incorporate Social Needs Assessment Tools into intake and treatment plan reviews (e.g., at intake, quarterly, and during 90-day treatment plan reviews).
- Provide staff training on administering, scoring, and interpreting the Social Needs Assessment Tool.
- Review results with patients to guide shared decision-making and collaborative care planning.
- Regularly review screening rates and provide direct feedback to clinicians to prompt action or understand barriers.
- Implement a tracking system to monitor due assessments and alert staff when screenings are needed.
- Educate patients about the purpose and benefits of the assessment to increase engagement and completion.

Sources:

1. Health Aff Sch.2024 Nov 14;2(12):qxae151. doi: 10.1093/haschl/qxae151, **Standardizing social determinants of health data: a proposal for a comprehensive screening tool to address health equity a systematic review - PMC**
2. Closing the gap in a generation: health equity through action on the social determinants of health - Final report of the commission on social determinants of health

PATIENT EXPERIENCE OF CARE

Measure Description

The purpose of the Patient Experience of Care performance measure is to monitor the completion and consistency of patient experience assessments and to evaluate patients' perceptions of the care they receive. Tracking these assessments over time helps practices identify trends, increase completion rates, and informs quality improvement efforts.

Patient experience data provides helpful insights into communication, access to care, and overall satisfaction which are key elements that influence quality improvement efforts and organizational performance.

Tips for Improving Performance on Patient Experience of Care

- Educate staff on the importance of patient experience surveys and how results inform quality improvement
- Foster collaboration among care teams—engaging nurses, medical assistants, providers, and other staff—to ensure screenings are *timely* and consistently offered.
- Implement reminders or automated systems to encourage survey completion. Use calls, portal notifications, or text messages to remind patients about completing the experience of care assessment.
- Make surveys easily accessible via patient portals, mobile devices, or paper forms. Offer paper surveys for patients at check-in/check-out to capture patients that may not have access to technology.
- Communicate survey results to staff and integrate findings into improvement initiatives. Monitor and report performance by tracking compliance from the dashboard. Share results from the dashboard with the team for accountability.
- Provide patient-centered communication training to enhance interactions and build trust.

Sources:

1. BMJ Open. 2013 Jan 3;3(1):e001570. doi: 10.1136/bmjopen-2012-001570. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness
2. Section 2: Why Improve Patient Experience? | Agency for Healthcare Research and Quality

REGULAR ENGAGEMENT OF CARE

Measure Description

The purpose of this performance measure is designed to assess how consistently patients remain connected to and actively participate in their ongoing care. This measure evaluates whether patients are receiving routine visits or touchpoints that support continuous management of their health needs. By tracking the timeliness and consistency of follow-up care, clinicians can identify gaps before they lead to worsening outcomes and implement early interventions to support better disease management.

Tips for Improving Performance on Regular Engagement of Care

- Proactively identify patients who are overdue for follow-up or routine visits and engage in timely outreach.
- Coordinate care across the full team, engaging nurses, medical assistants, care managers, and behavioral health staff, to ensure follow-up and resolve patient barriers.
- Utilize electronic health record (EHR) tracking tools to monitor patient engagement and coordinate follow-up.
- Educate patients on the importance of regular visits and help them understand their care plans.
- Assist patients in overcoming barriers to care.
- Offer flexible appointment options to support ongoing engagement.

Sources:

1. Engaging patients in decision-making and behavior change to promote prevention - PMC
2. Treatment engagement of individuals experiencing mental illness: review and update, Treatment engagement of individuals experiencing mental illness: review and update Lisa B. Dixon, Yael Holoshitz, Ilana Nossel Columbia University Medical Center; Division of Mental Health Services and Policy Research & Center for Practice Innovations, New York State Psychiatric

DAYS FROM FIRST ADMINISTRATIVE CONTACT TO FIRST CLINICAL SERVICE

Measure Description

The purpose of this performance measure is to track the number of days between a patient's initial intake or referral and their first evaluation. Monitoring this measure enables clinicians to identify delays in access, improve workflow efficiency, and ensure patients receive timely evaluation and treatment. Prompt evaluation allows for early diagnosis, rapid initiation of appropriate interventions, and improved patient engagement, all of which contribute to better clinical outcomes and reduced risk of condition progression.

Tips for Improving Performance on Time from Initial Contact to First Billable Service

- Prioritize scheduling for new patients to ensure timely access.
- Offer flexible evaluation options, including same-day or telehealth appointments.
- Assign care team members to coordinate intake and evaluation appointments efficiently.
- Send reminders via phone calls, patient portal messages, or automated alerts.
- Track pending evaluations in the EHR and follow up promptly on delays.
- Regularly review workflows to identify and resolve scheduling bottlenecks.
- Clear definitions and accurate data collection are critical for reducing delays and improving performance.
- It is important to define and train staff on key data points such as day of initial contact and first billable service. Provide step-by-step instructions for entering dates in the EHR or tracking system.
- Emphasize why accurate data matters for compliance and quality reporting. If possible, use automated alerts for incomplete intake records. Regularly monitor and audit to share with teams and address discrepancies.
- If the data shows a need for improvement, create an improvement plan with clear targets (i.e., reduce average days to meet access standards defined by external and internal benchmarks).

Sources:

1. Mental health care is in high demand. Psychologists are leveraging tech and peers to meet the need, Emerging Trends: Mental health care is in high demand. Psychologists are leveraging tech and peers to meet the need amid a shortage of mental health providers, digital therapeutics could play an important role in providing support for underserved communities. By Heather Stringer Date created: January 1, 2024

2. Williams, M. E., Pfeiffer, D. L., Davis, S., & Phelps, S. (2008). Eliminating the wait for mental health services: Evidence from a community mental health outpatient setting. Psychiatric Services, 59(7), 804–807. https://pubmed.ncbi.nlm.nih.gov/17975730

ALL CAUSE READMISSION

Measure Description

The purpose of this performance measure is to track the proportion of patients achieving remission from any medical or behavioral health condition. Monitoring remission rates allows clinicians to evaluate treatment effectiveness across their patient population, adjust care plans as needed, and identify trends or gaps in treatment. Using these data to guide clinical decisions helps improve patient outcomes, enhance symptom management, and increase overall quality of care.

Tips for Improving Performance on All-Cause Readmissions

- Develop a comprehensive treatment plan post hospital discharge tailored to each patient's needs.
- Educate patients and caregivers and request feedback to ensure they understand the treatment plan.
- Coordinate care across the full care team, including primary care, specialists, and support services.
- Offer flexible appointment options, including same-day or telehealth appointments.
- Prioritize scheduling of patients to ensure timely access.
- Send reminders via phone calls, patient portal messages, or automated alerts.
- Implement or continue evidence-based treatment protocols for patients' medical or behavioral health conditions.
- Monitor patient progress regularly using standardized assessment tools.
- Engage patients in shared decision-making to improve adherence and self-management.
- Identify and address barriers to treatment adherence, including social, cultural, financial, or logistical challenges.
- Adjust care plans as needed based on ongoing assessment and patient outcomes.

Sources:

1. Winner et al. (2025). A quality improvement initiative to decrease behavioral health unit readmission rates. Winneretal.-2025
2. Reif et al. (2017). Reducing behavioral health inpatient readmissions for people with substance use disorders. Reducing Behavioral Health Inpatient Readmissions for People With Substance Use Disorders: Do Follow-Up Services Matter?

MEASUREMENT BASED CARE: OTHER (ANXIETY, SUD, GAD-7 ETC.)

Measure Description

The purpose of this performance measure is to focus on the routine use of standardized symptom scales to assess patients' clinical status and monitor changes over time. Tracking these measures allows clinicians to objectively evaluate treatment effectiveness, identify symptom improvement or deterioration, and make timely, data-driven adjustments to care plans.

Using measurement scores in clinical decision-making supports shared decision-making with patients, enhances early detection of emerging issues, and improves overall treatment outcomes. Measurement-based care helps ensure that interventions are tailored to each patient's needs and that progress is monitored consistently, which is associated with better symptom management, higher adherence to treatment, and improved functional outcomes.

Tips for Improving Performance on Measurement Based Care: Other (Anxiety, SUD, GAD-7, etc.)

- Ensure all members of the care team are trained in proper administration and interpretation of the performance measures.
- Use EHR tools or dashboards to flag patients with worsening symptoms for timely follow-up.
- Track and document scores over time to monitor treatment response and progression.
- Review results with patients to guide shared decision-making and collaborative care planning.
- Adjust treatment plans based on changes in symptom scores and patient-reported outcomes.
- Educate patients on the purpose of symptom tracking to encourage engagement and accurate reporting.
- Include screening into intake and treatment plan reviews (e.g., at intake, quarterly, and during 90-day treatment plan reviews).
- Regularly review screening rates and provide direct feedback to clinicians.

Sources:

1. American Psychological Association: Measurement-based care: A transformative approach to treatment
2. American Psychological Association: Measurement-based care
3. JAMA Psychiatry. Author manuscript; available in PMC: 2020 Mar 1. *Published in final edited form as:* JAMA Psychiatry. 2018 Dec 19:10.1001/jamapsychiatry.2018.3329. doi: 10.1001/jamapsychiatry.2018.3329 Implementing Measurement-Based Care in Behavioral Health: A Review - PMC

IMPROVING LANGUAGE ACCESS

Measure Description

The purpose of this performance measure is to ensure that patients can access care in their preferred language. Tracking language access helps clinicians identify barriers to communication, evaluate the effectiveness of interpreter services, and implement interventions that improve comprehension and patient engagement.

Improved language access is associated with better adherence, fewer errors, higher satisfaction, and improved health outcomes.

Tips for Improving Performance on Improving Language Access

- Collect Language Access information via a Social Determinants of Health validated screening tool.
- Train staff in culturally competent communication practices.
- Provide trained medical interpreters and language services.
- Offer multilingual educational materials and resources.
- Track usage and patient satisfaction with language services.
- Provide staff with comprehensive training and workflow instructions on accurately recording responses in systems.
- Configure EHR templates so that language access fields are mandatory during intake or done through the social needs screening tools. Training should emphasize both the importance of capturing this data and the correct process for doing so. For example, ensure your organization captures and reports the following questions in the CSV template for compliance:
    - PRAPARE: Question #5 – What language are you most comfortable speaking?
    - WellRx: Does not include a language question; an additional screening (e.g., paperwork or homegrown tool) must be used to collect this information.
    - Other/Homegrown Tools: Capture assessment date, primary language spoken, and any additional language-related needs.
    - Confirm that responses from screenings can be submitted in the correct format according to the CSV specifications outlined in the data dictionary.

Sources:

1. U.S. Department of Health and Human Services, Office for Civil Rights (HHS OCR). *Language Access Requirements under Title VI of the Civil Rights Act.*
Federal guidance requiring meaningful language access to ensure effective communication, reduce errors, improve patient engagement and adherence, and support equitable health outcomes for individuals with limited English proficiency.
hhs.gov/limited-english-proficiency

MEASURE OF FINANCIAL BURDEN

Measure Description

The purpose of this performance measure is to assess the financial impact of care on patients, including out-of-pocket costs and other barriers that may limit access or adherence. Tracking financial burden helps clinicians identify patients at risk, implement interventions to reduce cost-related barriers, and improve adherence and outcomes.

Understanding these barriers enables care teams to optimize treatment plans while minimizing patient hardship.

Tips for Improving Performance on Measure of Financial Burden to Patient

- Screen clients for financial barriers during visits. Establish clear definitions for what qualifies as "financial burden," based on the social needs assessment or homegrown tools your organization uses. Include standardized, consistent language access questions in this guide.
- Provide staff with comprehensive training and workflow instructions on accurately recording responses in tracking systems. Configure EHR templates so that financial burden fields are mandatory during intake or done through the social needs screening. Training should emphasize both the importance of capturing this data and the correct process for doing so. For example, ensure your organization captures and reports the following questions in the CSV template for compliance:
    - PRAPRE: housing insecurity, food insecurity, utilities insecurity, lack of childcare, transportation insecurity, unemployment, clothing insecurity, lack of money for health, no phone.
    - WellRx: Housing insecurity, food insecurity, utilities insecurity, lack of childcare, transportation insecurity, unemployed.
    - Other/Homegrown Tools: Capture assessment date and if financial burden was identified (yes or no).
    - Confirm that responses from screenings can be submitted in the correct format according to the CSV specifications outlined in the data dictionary.
- Provide cost-effective treatment alternatives when appropriate.
- Educate patients about available financial resources.
- Connect clients to assistance programs or support.
- Be transparent with clients on its usage.
- To comply with the measure, organizations must document that patients were screened for financial burden. Even if a patient does not experience financial burden, the screening fields should still be completed to confirm that the screening occurs.

Sources:

1. Centers for Medicare & Medicaid Services (CMS). *Meaningful Measures Initiative – Affordable Care*. Emphasizes assessing patient financial burden and cost-related barriers to care in order to improve access, adherence, patient outcomes, and value-based care delivery. cms.meaningful-measures-framework

ASD SET OF PATIENT-CENTERED MEASURES: FUNCTIONAL ASSESSMENT SCORE CHANGE, VINELAND ADAPTIVE BEHAVIOR SCALE ASSESSMENT

Measure Description

The purpose of a functional assessment such as the Vineland Adaptive Behavior Scale is to evaluate adaptive behaviors, daily living skills, and social functioning in patients, particularly those with developmental, behavioral, or functional challenges. Tracking Vineland scores over time allows clinicians to objectively assess functional progress, identify areas of need, and adjust individualized care plans.

Using this measure in clinical practice supports early identification of developmental or behavioral concerns, informs targeted interventions, and ensures treatment strategies are tailored to each patient's functional abilities. Consistent monitoring is associated with improved functional outcomes, better patient engagement, and more effective care planning.

Tips for Improving Performance on Vineland Adaptive Behavior Scale Assessment

- Train staff on proper administration, scoring, and interpretation of the FBA.
- Administer the Vineland assessment according to recommended schedules and protocols.
- Document and track scores over time to monitor functional progress and identify trends.
- Use assessment results to guide individualized treatment planning and intervention strategies.
- Communicate findings clearly with patients, families, and the broader care team.
- Adjust care plans based on longitudinal assessment results to optimize functional outcomes.
- To comply with the measure, organizations must document that patients completed the assessment. Ensure the date of the assessment and scores for each domain are submitted according to the data dictionary and CSV specifications.

Sources:

1. Pearson Assessments. *Vineland Adaptive Behavior Scales, Third Edition (Vineland-3).* Used to assess adaptive behavior, including communication, daily living skills, and socialization, to evaluate functional abilities, track progress over time, and inform individualized care planning for individuals with developmental, behavioral, or functional challenges. pearsonassessments.vineland-adaptive-behavior-scales

NET PROMOTER SCORE

Measure Description

The purpose of the Net Promoter Score (NPS) is to measure patient satisfaction. Tracking the NPS allows clinicians to identify strengths and areas for improvement in patient engagement and care delivery.

Using the insights the NPS provides allows for targeted interventions to improve patient experience, loyalty, and adherence to treatment plans to be implemented.

Tips for Improving Performance on Net Promoter Score

- Encourage clients to complete NPS surveys regularly.
- Analyze NPS scores regularly to identify areas for improvement.
- Address patient feedback quickly.
- Implement quality improvement initiatives based on NPS results.
- To comply for this measure, organizations must report the start date of the NPS, end date of NPS, and the percentage of Net Promoters that were scores of 9 or 10.
- Ensure that the data submitted matches the CSV specifications and data dictionary.

Source:

1. Bain & Company. *Net Promoter Score (NPS®).*
Used to measure patient satisfaction and loyalty by assessing patients' likelihood to recommend services, helping organizations identify strengths, areas for improvement, and opportunities to enhance patient engagement and care delivery.
netpromotersystem

DEPRESSION REMISSION

Measure Description

The purpose of monitoring Depression Remission is to track the proportion of patients with depression who achieve remission. Monitoring this measure helps clinicians evaluate treatment effectiveness, identify patients who need adjustments to care, and implement timely interventions.

Using remission data supports better symptom management, functional recovery, and overall patient outcomes.

Tips for Improving Performance on Depression Remission

- Use validated tools to monitor depressive symptoms. For this measure, use PHQ-9 routinely to guide treatment adjustments; measurement-based care is linked to higher remission rates.
- Adjust care plans based on patient response and progress.
- Clear workflow for follow-up to embed PHQ-0 screening into care plans and potential use of EHR (or other system) alerts for patients with initial scores >9. Use tools to track patients due for follow-up at 4-8 months.
- Ensure PHQ-9 results are entered in structures fields for accurate extraction into CSV template.
- Monitor compliance monthly and share performance with team.

Source:

1. National Committee for Quality Assurance (NCQA). *Depression Remission at 12 Months (HEDIS Measure).* Used to assess the proportion of patients with depression who achieve symptom remission, supporting evaluation of treatment effectiveness, identification of patients needing care adjustments, and improvement of clinical outcomes. ncqa/hedis/measures/depression-remission-at-12-months

DEATHS BY SUICIDE

Measure Description

The purpose of monitoring Deaths by Suicide is to track suicides among patients to monitor safety and identify risk trends. Tracking deaths by suicide enables clinicians and organizations to evaluate preventive strategies, identify gaps in care, and implement targeted interventions.

Proactive monitoring can improve patient safety, reduce risk, and guide quality improvement initiatives.

Tips for Improving Performance on Deaths by Suicide

- Perform regular suicide risk assessments for patients identified as at risk.
- Develop and implement individualized safety plans and crisis intervention strategies.
- Review and analyze cases to identify opportunities for improving suicide prevention and patient safety.

Source:

1. U.S. Department of Health and Human Services (HHS). *National Strategy for Suicide Prevention (2024)*. Federal guidance emphasizing the use of suicide mortality data to monitor risk trends, evaluate prevention efforts, and support quality improvement and patient safety initiatives. hhs. prevention-and-wellness/mental-health

SUCCESSFUL DISCHARGE

Measure Description

The purpose of monitoring successful discharges is to track the proportion of patients discharged after achieving treatment goals or completing care programs. Monitoring successful discharge helps clinicians evaluate the effectiveness of care, identify gaps, and support continuity of care post-discharge.

Using discharge data informs strategies to maintain outcomes and ensure patients continue to benefit from care interventions.

Tips for Improving Performance on Successful Discharges

- Set clear, measurable goals for each patient prior to discharge.
- Engage patients actively in treatment planning and goal setting.
- Provide ongoing support and follow-up after discharge.
- Monitor outcomes post-discharge to ensure sustainability.
- Organization should define "successful discharge" clearly. Develop a standard rubric and align definitions with recognized protocols.
- Ensure documentation accuracy by training staff to complete the "successful discharge" field correctly in the CSV template.
- Audit EHR records for missing or inconsistent discharge coding.
- Educate staff on intake, consent, and documentation processes to avoid missing releases or incomplete documentation.
- Conduct monthly reviews of discharge data and intervene quickly when success rates decline.

Sources:

1. Agency for Healthcare Research and Quality (AHRQ). *Re-Engineered Discharge (RED) Toolkit.* Guidance on monitoring discharge outcomes to evaluate care effectiveness, identify gaps in care transitions, and support continuity of care post-discharge. ahrq.patient-safety/toolkit/index
2. Pourat, N., et al. (2019). *Timely outpatient follow-up is associated with fewer hospital readmissions among patients with behavioral health conditions*. Journal of the American Board of Family Medicine, 32(3), 353–363. Timely Outpatient Follow-up Is Associated with Fewer Hospital Readmissions among Patients with Behavioral Health Conditions | American Board of Family Medicine

EMERGENCY DEPARTMENT UTILIZATION

Measure Description

The purpose of tracking Emergency Department (ED) Utilization is to track ED visits to identify potentially preventable visits and gaps in outpatient care. Monitoring ED utilization allows clinicians to identify high-risk patients, optimize care coordination, and implement interventions to reduce unnecessary visits.

Using this data supports timely access to care, improved outcomes, and more efficient resource utilization.

Note: This project tracks emergency department (ED) utilization for all visits, as well as a separate measure focused specifically on visits with a behavioral health diagnosis.

Tips for Improving Performance on Emergency Department Utilization

- Ensure adequate outpatient access to services
- Review clinical processes with patients for crisis plans prior to ED visit
- Monitor high-utilizer patients and implement targeted care coordination.
- For behavioral health-related ED visits, educate patients on mobile crisis teams or telehealth interventions to divert patients from ED, as applicable.
- Educate patients on appropriate use of the ED usage versus outpatient care.
- Develop integrated care plans accessible to both behavioral health and primary care teams. This can include chronic condition management, medication reconciliation, and preventive care reminders.

Source:

1. National Committee for Quality Assurance (NCQA). Emergency Department Utilization (EDU) Measure. Used to assess emergency department visit patterns and identify potentially preventable utilization and gaps in outpatient care coordination. ncqa.hedis/measures/emergency-department-utilization