



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0008

Corresponding Measures:

De.2. Measure Title: Experience of Care and Health Outcomes (ECHO) Survey

Co.1.1. Measure Steward: Agency for Healthcare Research and Quality

De.3. Brief Description of Measure: The ECHO is a survey that includes 5 multiple item measures and 12 single item measures:

Multiple Item Measures:

Getting treatment quickly

- Get treatment as soon as wanted when it was needed right away

- Get appointments as soon as wanted

- Get professional help by telephone

How well clinicians communicate

- Clinicians listen carefully

- Clinicians explain things in an understandable way

- Clinicians show respect

- Clinicians spend enough time

- Feel safe with clinicians

- Patient involved as much as wanted in treatment

Perceived improvement

- Compare ability to deal with daily problems to 1 year ago

- Compare ability to deal with social situations to 1 year ago

- Compare ability to accomplish things to 1 year ago

- Compare ability to deal with symptoms or problems to 1 year ago

Getting treatment and information from the plan

- Getting new clinician

- Delays in treatment while wait for plan approval

- Getting necessary treatment

- Understanding information about treatment in booklets or on the web

- Getting help when calling customer service

- Filling out paperwork

Informed about treatment options

- Told about self-help or consumer run programs

- Told about different treatments that are available for condition

Single Item Measures:

- Overall rating of counseling and treatment (MCO and MBHO)

- Overall rating of the health plan (MCO only)

- Wait more than 15 minutes past appointment time to see clinician

- Told about medication side effects

- Talk about including family & friends in treatment

- Given as much information as wanted about how to manage condition
- Given information about rights as a patient
- Patient feels that he or she could refuse a specific type of treatment
- Was information revealed that should have been kept private
- Cultural competence -Care responsive to language, race, religious, ethnic
- Amount helped by treatment
- Plan provides information about how to get treatment after benefits used up

The measures are based on reports of care experiences over the previous six months from adult (18 years of age or older) patients receiving behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages their treatment and health outcomes.

Each measure score is the mean of the responses to the survey questions from patients receiving care at a particular health plan or managed behavioral health organization

More detail can be found at: <http://www.ahrq.gov/cahps/surveys-guidance/echo/about/survey-measures.html>

1b.1. Developer Rationale: Donabedian and others have suggested that evaluating the process of care is one of the most direct ways to assess quality of care (Cleary, 2016). More recently, it has been suggested that one of eight ways that federal agencies can remove barriers to the delivery of effective behavioral care is measurement at the client, provider, organization, and population levels (Karakus, Ghose, et al. 2016). The ECHO Survey assesses patient experiences with behavioral health services in such areas as getting treatment quickly, communication with clinicians, and information about treatment options. In moving away from global satisfaction questions, toward reports about specific well-defined aspects of care, the ECHO Survey more directly assesses quality of care than measures of "satisfaction".

The quality of behavioral health care is of significant concern because mental illnesses and alcohol and substance abuse impose substantial burdens on patients, employers, and the health care system. Payors and regulators are interested in assessing quality by comparing the experiences of patients receiving care from different health care organizations. A fundamental goal of CAHPS instruments is to provide evidence that can be used to improve health care and this was a major reason for developing the ECHO measures:

Shaul and colleagues noted that surveys such as the ECHO can identify aspects of the plan and treatment that are improvement priorities. Use of these data is likely to extend beyond the behavioral health plan to consumers, purchasers, regulators and policymakers, particularly since NCQA is encouraging behavioral health plans to use a similar survey for accreditation purposes.

To facilitate the use of such measures to stimulate quality improvement efforts, the CAHPS team reviewed the literature on strategies for improving aspects of care assessed in CAHPS surveys and developed: "The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience", which can be seen at:

<http://www.ahrq.gov/cahps/quality-improvement/improvement-guide/improvement-guide.html>:

Cleary, P. D. (2016). Evolving Concepts of Patient-Centered Care and the Assessment of Patient Care Experiences: Optimism and Opposition. *Journal of health politics, policy and law*, 3620881.

Karakus, M., Ghose, S. S., Goldman, H. H., Moran, G., & Hogan, M. F. (2016). "Big Eight" Recommendations for Improving the Effectiveness of the US Behavioral Health Care System. *Psychiatric Services*, appi-ps.

Shaul JA, Eisen SV, Stringfellow VL, Clarridge BR, Hermann RC, Nelson D, Anderson E, Kubrin AI, Leff HS, Cleary PD. Use of consumer ratings for quality improvement in behavioral health insurance plans. *Jt Comm J of Qual Imp*; 2001; 27: 216-229.

S.4. Numerator Statement: No changes from original specification: The ECHO survey measures patient-centered care by asking about patient experiences with behavioral health care (mental health and substance abuse treatment) and the organizations that provide or manage the person's treatment and health outcomes.

The survey and instructions are available at:

[www.qualityforum.org/pdf/ambulatory/txECHOALL\(onepager&specs&survey\)03-23-07.pdf](http://www.qualityforum.org/pdf/ambulatory/txECHOALL(onepager&specs&survey)03-23-07.pdf)

Measure developer/instrument web site: www.cahps.ahrq.gov/content/products/ECHO/PROD_ECHO_MBHO.asp?p=1021&s=214
The composite measures' component items can be found on the document titled "Reporting Measures for the ECHO Survey 3.0" (Document No. 209 – 8/31/06) available for download at <http://www.ahrq.gov/cahps/surveys-guidance/echo/instructions/index.html>
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S.6. Denominator Statement: All survey respondents, or for selected items, all respondents who respond appropriately to screening questions.

S.8. Denominator Exclusions: No changes: Patients who received behavioral health services only in primary care settings (e.g. psychotropic medications from their primary care physician) are not included.

De.1. Measure Type: Outcome: PRO-PM

S.17. Data Source: Instrument-Based Data

S.20. Level of Analysis: Health Plan

IF Endorsement Maintenance – Original Endorsement Date: Jul 01, 2007 **Most Recent Endorsement Date:** Jul 01, 2007

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[NQF_evidence_attachment_12-27-2016-636192980306805249.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

No

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Donabedian and others have suggested that evaluating the process of care is one of the most direct ways to assess quality of care (Cleary, 2016). More recently, it has been suggested that one of eight ways that federal agencies can remove barriers to the delivery of effective behavioral care is measurement at the client, provider, organization, and population levels (Karakus, Ghose, et al.2016).

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Shaul JA, Eisen SV, Stringfellow VL, Clarridge BR, Hermann RC, Nelson D, Anderson E, Kubrin AI, Leff HS, Cleary PD. Use of consumer ratings for quality improvement in behavioral health insurance plans. *Jt Comm J of Qual Imp*; 2001; 27: 216-229.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

The CAHPS consortium does not compile or monitor performance data from ECHO users. Thus, it has limited information related to performance scores on the ECHO instrument.

Below are selected published studies describing the development and psychometric characteristics of the CABHS instrument, which was developed prior to the ECHO, and the subsequent ECHO instrument.

Shaul JA, Eisen SV, Stringfellow VL, Clarridge BR, Hermann RC, Nelson D, Anderson E, Kubrin AI, Leff HS, Cleary PD. Use of consumer ratings for quality improvement in behavioral health insurance plans. *Jt Comm J of Qual Imp*; 2001; 27: 216-229.

In 1998 and 1999, data were collected from five groups of adult patients in commercial health plans and five groups of adult patients in public assistance health plans with services received through four organizations, one of three MBHOs or a health system. Patients who received behavioral health care services during the previous year were mailed the CABHS survey. Non-respondents were contacted by telephone to complete the survey.

Response rates ranged from 49% to 65% for commercial patient groups and from 36% to 51% for public assistance patients. Getting treatment promptly from clinicians and aspects of care most influenced by health plan policies and operations, such as access to treatment and plan administrative services, received the least positive responses, whereas questions about communication received the most positive responses. In addition, questions about access and plan related aspects of quality showed the most inter-plan variability. Three of the organizations in this study focused quality improvement efforts on access to treatment.

Eisen, S.V., B. Clarridge, V. Stringfellow, J.A. Shaul, and P.D. Cleary. "Toward a National Report Card: Measuring Consumer Experiences with Behavioral Health Services. In B. Dickey and L. Sederer (Eds.), *Improving Mental Health Care: Commitment to*

Quality. Washington, DC: APA Press, 2001. Chapter 9;115-134.

The CABHS survey was field tested with two groups of mental health consumers: commercially insured individuals (N=200), and Medicaid enrollees (N=300). Both groups were members of an HMO for which the behavioral health component was managed by an external managed behavioral health care organization. The survey was conducted by a survey research center that was independent of the HMO and the managed care organization.

Survey response rates reached an acceptable level (63%) for commercially insured consumers who were reachable by telephone. Response rates to mailed surveys alone were about 32%, highlighting the importance of telephone follow-up. A large percentage of consumers, particularly Medicaid enrollees, were not reachable by phone (55%). Of those reached by telephone, 57% participated in the survey.

The majority of respondents were female (80%), between the ages of 25 and 44 (61%) and were high school graduates (82%). Forty-nine percent were commercially insured; 51% were Medicaid beneficiaries. Almost two-thirds (64%) were Caucasian, 19% were Black or African-American, and 17% were members of other racial groups. Overall health was reported to be “fair” or “poor” by 27% of the sample. Mental health was reported to be “fair” or “poor” by 34% of the sample. Respondents did not differ significantly from non-respondents in terms of age or sex.

Questions regarding behavioral health and substance abuse service use indicated that 86% reported receiving treatment for mental illness, personal or family problems and 76% of them reported taking prescription medications as part of their treatment. Nine percent of the sample reported receiving services for alcohol abuse and 7% reported receiving services for drug abuse. Ten percent of respondents reported having received inpatient care.

Overall, responses to survey questions evaluating the care received suggested relatively positive experiences. Clinician-consumer interaction was rated more favorably than access to care. The highest rated aspects of care were items indicating clinician and office staff respect for consumers, frequency with which consumers felt listened to by clinicians, and clinicians’ explanation of things in ways that consumers could understand. Least favorable ratings concerned accessibility to help in the evenings and on weekends.

Among questions about administrative burden and global evaluation of the insurance plan, responses were most favorable to the question about paperwork; this result was expected since all participants in this field test were HMO members for whom no paperwork was required. Respondents gave the least favorable responses to a question about handling of phone calls to the plan without a long wait. Overall evaluation of the plan (8.33 on a 10-point scale where 10 is the most positive rating) was almost identical to the overall evaluation of services (8.24).

One of the goals of the CABHS survey was to compare consumer experiences with different health plans. The field test was able to identify perceived differences between the two plans assessed (i.e., commercial plan and Medicaid). Consumers enrolled in the commercial plan rated timeliness of help on weekdays, evenings and weekends more highly than did those in the Medicaid plan. In addition, commercial plan members more often reported that they were told they could refuse treatment they did not want (87%) compared to Medicaid plan members (67%). On the other hand, Medicaid enrollees rated their health plan more highly overall than did consumers in the commercial plan (mean global rating of plan=8.80 for the Medicaid plan and 7.84 for the commercial plan, where 10 is the highest rating). Reported differences between the health plans were not associated with differences between the groups in demographic variables or health status of enrollees (Eisen et al. 1999).

Eisen SV, Shaul JA, Leff HS, Stringfellow V, Clarridge BR, Cleary PD. Toward a national consumer survey: Evaluation of the CABHS and MHSIP Instruments. *J Behav Health Serv & Res*; 2001; 28(3): 347-369.

This paper describes a study evaluating the Consumer Assessment of Behavioral Health Survey (CABHS) and the Mental Health Statistics Improvement Program (MHSIP) surveys. The purpose of the study was to provide data that could be used to develop recommendations for an improved instrument. Subjects were 3,443 adults in six behavioral health plans. The surveys did not differ significantly in response rate or consumer burden. Both surveys reliably assessed access to treatment and aspects of appropriateness and quality. The CABHS survey also reliably assessed features of the insurance plan, and the MHSIP survey reliably assessed treatment outcome. Analyses of comparable items suggested which survey items had greater validity. Results are discussed in terms of consistency with earlier research with these and other consumer surveys. Implications and recommendations for survey development, quality improvement and national policy initiatives to evaluate health plan performance are presented.

We do not have data over time for the ECHO but other student using HCAHPS indicate that other CAHPS surveys can detect important temporal trends:

Elliott MN, Lehrman WG, Goldstein EH, Giordano LA, Beckett MK, Cohea CW, Cleary PD. Hospital survey shows improvements in patient experience. *Health Aff*, 2010; 29(11): 2061-2067. PMID: 21041749.

The comparison of scores on the HCAHPS survey for hospitals that reported data in 2008 and 2009 shows that after only one year of public reporting, hospitals that participated in the first public reporting experienced modest but meaningful improvements on all measures except for doctor communication, with the biggest gains in discharge information, hospital quietness, and staff responsiveness

Elliott MN, Cohea CW, Lehrman WG, Goldstein E, Cleary PD, Giordano LA, Beckett MK, Zaslavsky AM. Accelerating improvement and narrowing gaps: Trends in patients' experiences with hospital care reflected in HCAHPS public reporting. *Health Serv Res*, 2015, 50 (6): 1850-67.

HCAHPS scores increased by 2.8 percentage points from 2008 to 2011 in the most positive response category. Among the middle 95 percent of hospitals, changes ranged from a 5.1 percent decrease to a 10.2 percent gain overall. The greatest improvement was in for-profit and larger (200 or more beds) hospitals. Five years after HCAHPS public reporting began, meaningful improvement of patients' hospital care experiences continues, especially among initially low-scoring hospitals, reducing some gaps among hospitals.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

The Epidemiologic Catchment Area (ECA) study and the National Comorbidity Survey (NCS) indicate that approximately 30% of the adult US general population ages 15-54 met diagnostic criteria for at least one mental disorder in the past 12 months (Regier, Kaelber et al. 1998). These surveys also found low rates of treatment of mental illness, for example the NCS found that only 13.3% of persons with a psychiatric problem used outpatient health care services for that problem in the past 12 months (Kessler, Zhao et al. 1999).

Few validated measures of mental health care are available for use (Shield, Campbell et al. 2003). Such measures are needed to indicate where variations in care exist and to help improve care where quality is found to be lacking (Seddon, Marshall et al. 2001). Researchers have shown that there are gaps between existing measures for mental health quality of care and the needs of consumers, providers, and policy makers (Hermann, Leff et al. 2000). A recent review of mental health quality measures found that only 12% have been assessed for reliability and 3% for validity (Hermann, Leff et al. 2000).

Variation in quality:

Studies have shown considerable geographic variation in quality of mental health services (Shield, Campbell et al. 2003). Another study suggest plan coverage is a source of variation in quality noting that compared to those without depressive symptoms the disadvantage was larger in Medicare Advantage than in Fee-For-Service for those with depressive symptoms (Martino, Elliott et al. 2016). In addition, studies using the ECHO Survey point to differences in mental health care quality as perceived by patients. In one study using the ECHO Survey, of 47 ECHO Survey questions tested, analysis of variance found statistically significant differences between the 12 health plans studied for all but 8 items (Shaul, Eisen et al. 2001).

Significant opportunity for improvement:

The variation in quality and population differences described in section 1b.2 and in the articles cited below, indicate that there are significant opportunities to reduce disparities in access to services and treatment by geography, race, and age.

Abel G, Mavaddat N, Elliott MN, et al. Primary care experience of people with longstanding psychological problems: evidence from a national UK survey. *Int Rev Psychiatry* 2011 Jan;23(1): 9-Feb.

Bell, C. C. and H. Mehta (1980). "The misdiagnosis of black patients with manic depressive illness." *J Natl Med Assoc* 72(2): 141-5.

Blazer, D. G., C. F. Hybels, et al. (2000). "Marked differences in antidepressant use by race in an elderly community sample: 1986-1996." *Am J Psychiatry* 157(7): 1089-94.

Borowsky, S. J., L. V. Rubenstein, et al. (2000). "Who is at risk of nondetection of mental health problems in primary care?" J Gen Intern Med 15(6): 381-8.

Conner, K. O., Copeland, V. C., Grote, N. K., Koeske, G., Rosen, D., Reynolds, C. F., & Brown, C. (2010). Mental health treatment seeking among older adults with depression: the impact of stigma and race. The American Journal of Geriatric Psychiatry, 18(6), 531-543.

Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. Health services research, 49(1), 206-229.

German, P. S., S. Shapiro, et al. (1985). "Mental health of the elderly: use of health and mental health services." J Am Geriatr Soc 33(4): 246-52.

Hall, L. L. and L. M. Flynn (1997). "NAMI'S managed care report card. National Alliance for the Mentally Ill." Eval Rev 21(3): 352-6.

Hermann, R. C., H. S. Leff, et al. (2000). "Quality measures for mental health care: results from a national inventory." Med Care Res Rev 57 Suppl 2: 136-54.

Kales, H. C., F. C. Blow, et al. (2000). "Race, psychiatric diagnosis, and mental health care utilization in older patients." Am J Geriatr Psychiatry 8(4): 301-9.

Kessler, R. C., S. Zhao, et al. (1999). "Past-year use of outpatient services for psychiatric problems in the National Comorbidity Survey." Am J Psychiatry 156(1): 115-23.

Martino SC, Elliott MN, Haviland AM, et al. Comparing the Health Care Experiences of Medicare Beneficiaries with and without Depressive Symptoms in Medicare Managed Care versus Fee-for-Service. Health Serv Res 2016 June;51(3): 1002-20.

Padgett, D. K., C. Patrick, et al. (1994). "Ethnicity and the use of outpatient mental health services in a national insured population." Am J Public Health 84(2): 222-6.

Regier, D. A., C. T. Kaelber, et al. (1998). "Limitations of diagnostic criteria and assessment instruments for mental disorders. Implications for research and policy." Arch Gen Psychiatry 55(2): 109-15.

Ross, E. C. (1997). "Managed behavioral health care premises, accountable systems of care, and AMBHA'S perms. American Managed Behavioral Healthcare Association." Eval Rev 21(3): 318-21.

Seddon, M. E., M. N. Marshall, et al. (2001). "Systematic review of studies of quality of clinical care in general practice in the UK, Australia and New Zealand." Qual Health Care 10(3): 152-8.

Shaul, J. A., S. V. Eisen, et al. (2001). Experiences of Care and Health Outcomes (ECHO) Survey Field Test Report: Survey Evaluation (unpublished report). Boston, MA.

Shield, T., S. Campbell, et al. (2003). "Quality indicators for primary care mental health services." Qual Saf Health Care 12(2): 100-6.

Sirey, J. A., B. S. Meyers, et al. (1999). "Predictors of antidepressant prescription and early use among depressed outpatients." Am J Psychiatry 156(5): 690-6.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

The CAHPS Consortium does not collect or compile data from CAHPS surveys, including the ECHO, so it does not have direct data on disparities.

Leff and colleagues, however, used ECHO survey data to examine the relationship between cultural factors and quality of care.

Measurement of patient satisfaction is now considered essential for providing patient centered care and is an important tool for addressing health care disparities. However, little is known about how ethnically and racially diverse (ERD) groups differ in how they perceive quality, and widely used instruments for measuring perceived quality give little attention to cultural elements of care. Leff and colleagues, however, examined the relationship between the culturally determined beliefs and expectations of four ERD groups (African Americans, Latinos, Portuguese-speakers, and Haitians, total N = 160) and the technical quality of treatment for depression provided in four “culturally-specific” primary care clinics. Using data from the Experiences of Care and Health Outcomes survey, chart reviews and focus groups, the study addressed a set of questions related to the psychometric properties of perceived care measures and the technical quality of care. The groups differed in preferred cultural elements except all preferred inclusion of religion. They did not differ in overall perceived quality. Technical quality was higher for Portuguese and Haitians than for African Americans and Latinos.

Martino et al., in a study of adults who received behavioral health services and who completed the ECHO Survey, found that commercial insurance coverage was associated with better general and mental health, on average, than Medicaid insured (3.44 versus 2.80 for general health, $P < .001$, and 3.35 versus 2.89 for mental health, $P < .001$).

Leff, H. S., Chow, C., Wieman, D. A., Ostrow, L., Cortés, D. E., & Harris, T. (2016). Measurement of Perceived and Technical Quality of Care for Depression in Racially and Ethnically Diverse Groups. *Journal of Immigrant and Minority Health*, 1-9.

Martino SC, Elliott MN, Haviland AM, et al. Comparing the Health Care Experiences of Medicare Beneficiaries with and without Depressive Symptoms in Medicare Managed Care versus Fee-for-Service. *Health Serv Res* 2016 June;51(3): 1002-20.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Quality of mental health services differs by a variety of demographic characteristics. In the 2009 English GP Patient Survey, 5.7% of 2,163,456 respondents reported that they had a long-standing psychological or emotional condition. In an unadjusted regression model, respondents with long-standing emotional or psychological conditions rated their experiences worse than people without such problems, with scores which were up to 3 percentage points lower on individual survey items. However, after controlling for age, gender, ethnicity, deprivation and self-reported general health, people with long-standing psychological or emotional problems had slightly higher scores on 16 out of the 18 survey items, though with the equivalent of less than 2 percentage points difference for most items (Abel, Mavaddat, et al. 2011).

Regarding the diagnosis and treatment of mental illness race appears to be an important determinant. Doctors are less likely to identify blacks as depressed (Bell and Mehta 1980; Borowsky, Rubenstein et al. 2000) or to prescribe anti-depressant medications for blacks, compared to whites (Sirey, Meyers et al. 1999; Blazer, Hybels et al. 2000). Also, in general, blacks are less likely to use mental health services compared to whites, even when similarly insured (Padgett, Patrick et al. 1994; Kales, Blow et al. 2000).) and blacks and Latinos had shorter episodes of care and fewer psychotropic drug fills (Cook, Zuvekas, et al. 2014).

In addition, older adults are less likely to be treated for mental illness from specialty providers compared to younger adults (German, Shapiro et al. 1985) and depressed older adults perceived a high level of public stigma and were not likely to be currently engaged in or seek mental health treatment (Conner, Copeland, et al. 2010).

(see 1b.3 for references)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.***

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the

Quality Data Model (QDM).
<p>De.5. Subject/Topic Area (check all the areas that apply): Behavioral Health</p> <p>De.6. Non-Condition Specific(check all the areas that apply):</p> <p>De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any): Adults</p>
<p>S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.) http://www.ahrq.gov/cahps/surveys-guidance/echo/index.html</p> <p>S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications) This is not an eMeasure Attachment:</p> <p>S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff) No data dictionary Attachment:</p> <p>S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available. Attachment:</p> <p>S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.</p> <p>S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2. Yes</p> <p>S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons. The ECHO has been updated with minor wording changes so that it is consistent with the family of CAHPS surveys. As part of this process, several focus groups were conducted and some terminology was updated to be more consistent with widely understood words and phrases.</p> <p>S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure. <i>IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).</i> No changes form original specification: The ECHO survey measures patient-centered care by asking about patient experiences with behavioral health care (mental health and substance abuse treatment) and the organizations that provide or manage the person's treatment and health outcomes.</p> <p>The survey and instructions are available at: www.qualityforum.org/pdf/ambulatory/txECHOALL(onepager&specs&survey)03-23-07.pdf Measure developer/instrument web site: www.cahps.ahrq.gov/content/products/ECHO/PROD_ECHO_MBHO.asp?p=1021&s=214</p>

The composite measures' component items can be found on the document titled "Reporting Measures for the ECHO Survey 3.0" (Document No. 209 – 8/31/06) available for download at <http://www.ahrq.gov/cahps/surveys-guidance/echo/instructions/index.html> No changes from original specification: The ECHO survey measures patient-centered care by asking about patient experiences with behavioral health care (mental health and substance abuse treatment) and the organizations that provide or manage the person's treatment and health outcomes.

The survey and instructions are available at:

[www.qualityforum.org/pdf/ambulatory/txECHOALL\(onepager&specs&survey\)03-23-07.pdf](http://www.qualityforum.org/pdf/ambulatory/txECHOALL(onepager&specs&survey)03-23-07.pdf)

Measure developer/instrument web site: www.cahps.ahrq.gov/content/products/ECHO/PROD_ECHO_MBHO.asp?p=1021&s=214

The composite measures' component items can be found on the document titled "Reporting Measures for the ECHO Survey 3.0" (Document No. 209 – 8/31/06) available for download at <http://www.ahrq.gov/cahps/surveys-guidance/echo/instructions/index.html>

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

No changes: Responses from all survey respondents, or for selected items, all respondents who respond appropriately to screening questions.

Eligible respondents are health plan or MBHO patients who have been continuously reenrolled for the past 12 months, 18 years or older, with diagnostic or procedural code in administrative records.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All survey respondents, or for selected items, all respondents who respond appropriately to screening questions.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

No changes: The denominator is the number of survey respondents in a health plan or managed behavioral healthcare organization (MBHO).

Eligible respondents are health plan or MBHO patients who have been continuously reenrolled for the past 12 months, 18 years or older, with diagnostic or procedural code in administrative records.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

No changes: Patients who received behavioral health services only in primary care settings (e.g. psychotropic medications from their primary care physician) are not included.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

Patients who received behavioral health services only in primary care settings (e.g. psychotropic medications from their primary care physician) in the preceding 12 months are not included.

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

<p>S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment) Statistical risk model If other:</p>
<p>S.12. Type of score: Continuous variable, e.g. average If other:</p> <p>S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score) Better quality = Higher score</p> <p>S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.) The score for each multi-item measure is the adjusted average of the responses to composite items. The score for single item measures is the adjusted average score to that item for all patients in a given unit (e.g., plan). Adjustments are made using the CAHPS Macro which estimates a regression model in which all the plans are "absorbed" or fixed effects and a linear regression model is used to estimate adjusted plan scores after adjusting for self-reported mental health status, self-reported general health status, alcohol/drug treatment, age, education, and race/ethnicity.</p>
<p>S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.) If an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. The sample should be a random sample of eligible patients and needs to be large enough to yield 411 completed surveys per health care organization, a cost-effective method shown to produce statistically valid survey comparisons. Proxy respondents are not allowed.</p> <p>S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.) Specify calculation of response rates to be reported with performance measure results. Guidance provided on the web site page specified in 5.1</p>
<p>S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED). If other, please describe in S.18. Instrument-Based Data</p> <p>S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.) If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration. Available at: http://www.ahrq.gov/cahps/surveys-guidance/echo/instructions/index.html</p> <p>S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1) Available at measure-specific web page URL identified in S.1</p> <p>S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED) Health Plan</p> <p>S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED) Outpatient Services If other:</p>
<p>S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)</p>

2. Validity – See attached Measure Testing Submission Form

[NQF_testing_attachment_12-27-2016.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

Yes - Updated information required during the SDS Trial Period is included

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Other

If other: [Survey measures](#)

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

No data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

ECHO is based on patient reported survey data. The CAHPS consortium is doing research on using patient portals to collect such data and currently is conducting a study in a large practice in Massachusetts of such an approach. If that study is successful, we probably will do further research on collecting patient reported data through patient portals. One barrier to doing this, however, is that many organizations providing behavioral health services do not have patient portals and/or the data collected electronically is subject to protections that make it difficult to use such information for assessing the quality of patient centered care. The consortium continues to study this issue however.

Another approach to collecting patient-reported data that the CAHPS Consortium is actively studying is the use of electronic devices (e.g., PDAs/Smartphones, tablets). Unfortunately, these approaches have not been refined to the point that the data collected is adequately representative of the patient population to which inferences are to be made.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

ECHO data collection follows established CAHPS survey protocols:

<http://www.ahrq.gov/cahps/surveys-guidance/echo/index.html>

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

ECHO surveys and survey materials, including the MACRO for analyses are publicly available at no cost on the AHRQ Web Site.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Use Unknown	

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

The CAHPS Consortium makes surveys, including the ECHO surveys, available to the public for use but does not systematically track use.

We have three indications, however, of on-going use, downloads from the CAHPS-ECHO Web Site, ECHO survey web page visits, and

requests for technical assistance. Westat serves as a public resource for CAHPS users and one of its functions is to answer requests about specific instruments. To provide support for our application for maintenance of the ECHO endorsement, we compiled selective data on these two indicators.

Westat examined external requests for technical assistance specifically related to the ECHO surveys over the past two years. In 2015 they received 83 inquiries and as of December 15, 2016 they had received 33 inquiries in 2016, for a total of 116 in the past two years.

In 2015, there were approximately 250 ECHO web page visits a month. In 2016, the number of ECHO web page visits rose fairly steadily from about 250 a month to 650 a month by the end of the year.

In the last six months of 2015 there were approximately 40 downloads a month of ECHO surveys and in 2016 the number of instrument downloads a month varied between about 60 and 120 a month.

These numbers of downloads and inquiries likely represent only a small subset of the number of organizations and entities (e.g. state Medicaid programs) using ECHO, but at least they indicate on-going interest in use.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

The CAHPS Consortium makes surveys, including the ECHO surveys, available to the public for use but does not systematically track use.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

See response to 4b.

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

See response to 4b.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

See response to 4b.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

See response to 4b.

4a2.2.2. Summarize the feedback obtained from those being measured.

NA

4a2.2.3. Summarize the feedback obtained from other users

NA

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

NA

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

The CAHPS Consortium makes surveys, including the ECHO surveys, available to the public for use but does not systematically track use. We have anecdotal information that states and plans are using ECHO data to stimulate and monitor improvement, but we do not systematically compile such data.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

None

4b2.2. Please explain any unexpected benefits from implementation of this measure.

None

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

N/A

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

[Available at measure-specific web page URL identified in S.1 Attachment:](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [Agency for Healthcare Research and Quality](#)

Co.2 Point of Contact: [Caren, Ginsberg](#), caren.ginsberg@ahrq.hhs.gov, 301-427-1894-

Co.3 Measure Developer if different from Measure Steward:

Co.4 Point of Contact:

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

The ECHO Development Group comprised representatives from NCQA, NCQA's Behavioral Health Measurement Advisory Panel, the CAHPS consortium, the MHSIP development group, the Human Services Research Institute, the Center for Mental Health Services, the Forum on Performance Measures for Behavioral Health and Related Service Systems, the Washington Circle Group, the American Managed Behavioral Healthcare Association (AMBHA), and the National Alliance for the Mentally Ill participated in the development of the ECHO survey. Consumers, clinicians and behavioral health policy experts were also members of the survey development team. Consumers played several important roles in the development of the ECHO survey. They provided feedback about the content and design of the instrument, participated in focus groups and one-on-one interviews, and were part of the survey's development team. The information provided by consumers about the content and design of the ECHO survey has been crucial to the survey's ability to ask about concepts that are important to consumers for the evaluation of their behavioral health treatment and for which they are the best or only source of information.

Individuals and members of groups that contributed to the development of the ECHO measures.

Thomas M. Achenbach, Ph.D.
University of Vermont
Burlington, VT

Brian V. Abbott
Texas A&M University
College Station, TX

Ross B. Andelman, M.D.

Contra Costa Children's Mental Health Services
Concord, CA

Robert P. Archer, Ph.D.
Eastern Virginia Medical School
Norfolk, VA

C. Clifford Attkisson, Ph.D.
University of California, San Francisco
San Francisco, CA

Steven E. Bailey
University of Texas - Houston Health Sciences Center
Houston, TX

Thomas Beers, Ph.D.
Kaiser Permanente San Diego Chemical Dependency Program
San Diego, CA

Albert J. Bellanger
Harvard Medical School
Cambridge, MA

Larry E. Beutler, Ph.D.
Pacific Graduate School of Psychology
Palo Alto, CA

Phillip J Brantley, Ph.D.
Pennington Biomedical Research Center
Baton Rouge, LA

Gary M. Burlingame
Brigham Young University
Provo, UT

James N. Butcher, Ph.D.
University of Minnesota
Minneapolis, MN

David L. Carlston, Ph.D.
Ohio University
Athens, OH

Antonio Cepeda-Benito, M.D.
Texas A&M University
College Station, TX

Dianne L. Chambless, Ph.D.
University of Pennsylvania
Philadelphia, PA

James A. Ciarlo, Ph.D.
University of Denver
Denver, CO

Paul D. Cleary, Ph.D.
Harvard Medical School
Boston, MA

James R. Clopton, Ph.D.
Texas Tech University
Lubbock, TX

John D. Cone, Ph.D.
Alliant International University
San Diego, CA

C. Keith Conners, Ph.D.
Duke University
Durham, NC

Jonathan C. Cox
Brigham Young University
Provo, UT

William J. Culpepper, M.S.
University of Maryland
Baltimore, Maryland

Constance J. Dahlberg
Alliant International University
San Diego, CA

Allen S. Daniels, Ed.D.
Alliance Behavioral Care
University of Cincinnati
The American Managed Behavioral Healthcare Association
Cincinnati, OH

Edwin de Beurs
Leiden University

Leonard R. Derogatis, Ph.D.
University of Maryland
Baltimore, MD

Kathy Dowell
Ohio University
Athens, OH

Gareth R. Dutton, M.A.
Louisiana State University
Baton Rouge, LA

William W. Eaton, Ph.D.
Johns Hopkins University
Baltimore, MD

Susan V. Eisen, Ph.D.

Edith Nourse Rogers Memorial Veterans Hospital
Boston University
Boston, MA

Jeffery N. Epstein, Ph.D.
Duke University
Durham, NC

Alex Espadas
University of Texas - Houston Health Sciences Center
Houston, TX

Laura E. Evison, CNM, MSN
University of Maryland
Baltimore, MD

Kya Fawley
Northwestern University
Chicago, IL

Maureen Fitzpatrick, CRNP, MSN
University of Maryland
Baltimore, MD

Jenny Fleming
University of California, Santa Barbara
Santa Barbara, CA

Michael B. Frisch, Ph.D.
Baylor University
Waco, TX

Anthony B. Gerard, PhD.
Western Psychological Services
Los Angeles, CA

Sona Gevorkian
Massachusetts General Hospital
Boston, MA

David H. Gleaves
Texas A&M University
College Station, TX

Pamela Greenberg, MPP
The American Managed Behavioral Healthcare Association

Roger L. Greene, Ph.D.
Pacific Graduate School of Psychology
Palo Alto, CA

Thomas K. Greenfield, Ph.D.
University of California, San Francisco
San Francisco, CA

Ann T. Gregersen
Brigham Young University
Provo, UT

Grant R. Grissom, Ph.D.
Polaris Health Directions, Inc.
Langhorne, PA

Seth D. Grossman, M.A., M.S.
IASPP
Carlos Albizu University
Miami, FL

Kurt Hahlweg
Technische Universitaet Braunschweig
Braunschweig, Germany

Steven R. Hahn, M.D.
Albert Einstein College of Medicine
Jacobi Medical Center
Bronx, NY

Ashley Hanson
University of Alabama
Tuscaloosa, AL

Nancy M. Hatcher
University of Georgia
Athens, GA

Derek Hatfield
Ohio University
Athens, OH

Eric J. Hawkins
Brigham Young University
Provo, UT

Jena Helgeson
Northwestern University
Chicago, IL

Kay Hodges, Ph.D.
Eastern Michigan University
Ann Arbor, MN

Elizabeth A. Irvin
Services Research Group, Inc.
Simmons College

Gary Jeager, M.D.
Kaiser Permanente Harbor City Chemical Dependency Program
Harbor City, CA

R. W. Kamphaus, Ph.D.

University of Georgia
Athens, GA

Jennifer Karpe
University of Alabama
Tuscaloosa, AL

Sangwon Kim
University of Georgia
Athens, GA

Scott H. Kollins, Ph.D.
Duke University
Durham, NC

Kenneth A. Kobak
Dean Foundation for Health Research and Education
Research Training Associates
Madison, WI

Teresa L. Kramer, Ph.D.
Centers for Mental Healthcare Research
University of Arkansas for Medical Sciences
Little Rock, AR

Kurt Kroenke, M.D.
Regenstrief Institute for Health Care
Indiana University School of Medicine
Indianapolis, IN

Samuel E. Krug, Ph.D.
MetriTech, Inc.
Champaign, IL

David Lachar, Ph.D.
University of Texas - Houston Health Sciences Center
Houston, TX

Michael J. Lambert, Ph.D.
Brigham Young University
Provo, UT

Jeanne M. Langraf, M.A.
HealthAct
Boston, MA

William W. Latimer
Johns Hopkins University
Baltimore, MD

Jean-Philippe Laurenceau
Texas A&M University
College Station, TX

John S. Lyons, Ph.D.

Northwestern University
Chicago, IL

Mary Malik
University of California, Santa Barbara
Santa Barbara, CA

John S. March, M.D.
Duke University Medical Center
Durham, NC

Mark E. Maruish, Ph.D.
Ingenix Pharmaceutical Services
Eden Prairie, MN

Sarah E. Meagher, M.S.
University of Miami
Miami, FL

Gregorio Melendez, Ph.D.
Ohio University
Athens, OH

Theodore Millon, Ph.D., D.Sc.
IASPP
Miami, FL

Carla Moleiro, Ph.D.
University of California, Santa Barbara
Santa Barbara, CA

Leslie C. Morey, Ph.D.
Texas A&M University
College Station, TX

Carles Muntaner

Jack A. Naglieri, Ph.D.
George Mason University
Fairfax, VA

Charles Negy
University of Central Florida

Frederick L. Newman, Ph.D.
Florida International University
Miami, FL

Sharon-Lise T. Normand
Harvard Medical School
Cambridge, MA

Benjamin M. Ogles
Ohio University
Athens, OH

Ashley E. Owen
University of South Florida
Tampa, FL

James D. A. Parker, Ph.D.
Trent University
Ontario, Canada

Julia N. Perry

Steven I. Pfeiffer, Ph.D.

James O. Prochaska, Ph.D.
University of Rhode Island
Kingston, RI

Janice M. Prochaska, Ph.D.
Pro-Change Behavior Systems, Inc.

Leslie A. Rescorla,
Bryn Mawr College

Eric C. Reheiser
University of South Florida
Tampa, FL

Cecil R. Reynolds, Ph.D.
Texas A&M University
College Station, TX

William M. Reynolds
Humboldt State University

James M. Robbins, Ph.D.
Centers for Mental Healthcare Research
University of Arkansas for Medical Sciences
Little Rock, AR

Abram B. Rosenblatt, Ph.D.
University of California, San Francisco
San Francisco, CA

Douglas Rugh
Florida International University
Miami, FL

Scott Sangsland, M.A.
Kaiser Permanente,
Southern California Permanente Medical Group

Forrest Scoggin, Ph.D.
University of Alabama
Tuscaloosa, AL

James A. Shaul, MHA
Harvard Medical School
Boston, MA

Gill Sitarenios, Ph.D.
Multi-Health Systems, Inc
Toronto, ON, Canada

Corey Smith

G. Richard Smith, M.D.
University of Arkansas for Medical Sciences
Little Rock, AR

Douglas K. Snyder, Ph.D.
Texas A&M University
College Station, TX

Charles D. Spielberger, Ph.D.
University of South Florida
Tampa, FL

Robert L. Spitzer, M.D.
New York State Psychiatric Institute
Columbia University
New York, NY

Steven Stein, Ph.D.
Multi-Health Systems, Inc
Toronto, ON, Canada

Randy Stinchfield, Ph.D.
University of Minnesota
Minneapolis, MN

Sumner J. Sydeman
Northern Arizona University
Flagstaff, AZ

Elana Sydney, M.D.
Albert Einstein College of Medicine
Jacobi Medical Center
Bronx, NY

Hani Talebi
University of California, Santa Barbara
Santa Barbara, CA

Manuel J. Tejeda
Barry University

Allen Tien

John E. Ware, Jr., Ph.D.
Tufts Medical School

QualityMetric, Inc.
Lincoln, RI

Irving B. Weiner, Ph.D.
University of South Florida
Tampa, FL

M. Gawain Wells
Brigham Young University
Provo, UT

Douglas Welsh
University of Alabama
Tuscaloosa, AL

Janet B. W. Williams, D.S.W.
New York State Psychiatric Institute
Columbia University
New York, NY

Kimberly A. Wilson
Stanford University
Palo Alto, CA

Ken C. Winters, Ph.D.
University of Minnesota
Minneapolis, MN

Stephen E. Wong, Ph.D.
Florida International University
Miami, FL

Karen B. Wood, M.A.
Louisiana State University
Baton Rouge, LA

Michele Ybarra

Daniels AS, Shaul JA, Greenberg P, Cleary PD. "The Experience of Care and Health Outcomes Survey (ECHO): A Consumer Survey to Collect Ratings of Behavioral Health Care Treatment, Outcomes and Plans." In: M.E. Maruish (Ed), The Use of Psychological Testing for Treatment Planning and Outcomes Assessment. Third Edition. Vol. 3 Instruments for Adults. Fairfax, VA: Lawrence Erlbaum Assoc., 2004. Chapter 29, 839-866.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision:

Ad.4 What is your frequency for review/update of this measure? As needed as determined by major CAHPS revisions and changes in behavioral health standards

Ad.5 When is the next scheduled review/update for this measure? 03, 2017

Ad.6 Copyright statement: AHRQ holds the Trademark to ECHO

Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: The organization affiliation of Caren Ginsberg should be the Agency for Healthcare Research and Quality, not CMS. She should be listed as the Steward (I could not change these settings on-line; Paul).

