



## Optum Adult Wellness Assessment <sup>1</sup> Frequently Asked Questions

### General Questions about the Adult Wellness Assessment

**Q: What is the Wellness Assessment?**

A: The Adult Wellness Assessment (WA) is a brief, psychometrically-tested, patient self-report instrument that measures the following;

- Global Distress (depression, anxiety, low self-efficacy, and impaired functioning associated with psychological and emotional distress)
- General health and medical comorbidity
- Workplace functioning (absenteeism and presenteeism)
- Chemical dependency risk

**Q: Why did Optum develop the Wellness Assessment?**

A: There is compelling research showing that the integration of outcomes measurement into clinical practice is associated with better clinical outcomes. As a result, Optum wanted to promote patient-centered, outcomes-informed treatment and needed to provide clinicians with a patient self-report outcomes measure.

When developing the Wellness Assessment (WA), Optum had clear objectives in mind:

- The tool needed to be reliable and valid.
- The tool needed to be brief and easily administered. While lengthier instruments may provide more precision in clinical application, such as diagnostic support, they are far too burdensome for patients to routinely complete during the course of their treatment.
- The tool needed to be applicable to the broadest spectrum of outpatients possible.
- The tool needed to capture a patient's status on multiple dimensions, including health and workplace.
- The tool needed to be sensitive to change; providing accurate, reliable measure of progress over time.
- The tool needed to be free of licensing restrictions so that clinicians could use the instruments widely.

---

<sup>1</sup> Although Optum has developed a Youth Wellness Assessment, this FAQ refers only to the Adult version of the Wellness Assessment.



While there were many instruments available in the market, none met all of the above requirements, so Optum elected to develop its own. Items from well-validated public domain scales (SCL-90, CAGEAID, SF-12) were utilized to develop the WA, and the current version shows a high degree of correspondence with other established measures found in the psychotherapy literature.

**Q: How was the Wellness Assessment developed?**

Initially developed in 1999, the Wellness Assessment (WA) was patterned after other well-validated public domain instruments, including subscales from measures such as the Symptom Checklist-90 (SCL-90R) and the Short Form Health Survey (SF-36). Its use in a managed behavioral health organization (MBHO) was tested in a NIMH-funded study (# 1 R43MH57614-01A1) on the effects of administering patient assessments and delivering feedback reports to clinicians. The current version of the WA is a shortened version of the original WA, and has undergone a number of psychometric analyses both internally and by an academic third-party. These analyses have been conducted to ensure the WA's psychometric integrity as an outcome tool and to affirm its use as an objective assessment tool with external credibility.

**Q: Does a brief instrument like the Wellness Assessment meet the essential requirements for an assessment tool? How does it compare to other available assessments?**

A: Clinical relevance, feasibility, and scientific soundness should inform the choice of an assessment tool. The Wellness Assessment (WA) shows strong clinical relevance by providing a measure of a patient's current emotional and psychological status, medical health, workplace productivity, and risk for chemical dependency, all in a single measure. The WA measure is brief, minimizing the burden to the patient completing it and to the clinician scoring it, making it feasible to administer at multiple points in the therapeutic process. The WA measure is meant to be used as a barometer that is indicative of general improvement, stability, and in some cases, increasing distress. It is also meant to capture other changes in health and workplace productivity that might be co-occurring. The WA measure is scientifically sound, having undergone extensive psychometric tests. These tests have established that the WA Global Distress scale shows strong reliability, meaning all of the items consistently measure the construct of distress. The tests have also demonstrated the WA has strong validity, meaning that the items contained in the WA measure function similarly to items included in established measures reported in the

psychotherapy outcomes research literature, including the PHQ-9 measure of depression, the OASIS measure of anxiety, the SF-12 measure of general health, and the HPQ measure of workplace productivity. Clinicians should feel confident in using the WA as an outcomes tool in their practice.

**Q: What assessment domains are included in the Wellness Assessment, and why?**

A: The Wellness Assessment (WA) was intentionally designed to be brief, offering respondents an opportunity to provide feedback on their general emotional and psychological status, medical health, workplace productivity, and risk for chemical dependency.

- Items included in the WA's primary scale, Global Distress, were developed and selected to capture broad areas (e.g., anxiety, depression, sleep, role function, etc.) in order to detect changes in global levels of emotional distress. Though the item content of the Global Distress scale reflects characteristics of major psychiatric disorders, it is not meant to be used as a substitute for more lengthy and comprehensive diagnostic self-report measures or clinician rating scales.
- Items measuring workplace functioning were included because of the impact behavioral health can have on a person's ability to function at work.
- Substance use and risk were included because it is often under-diagnosed if not assessed regularly.
- Health and medical comorbidity are addressed to help ensure the patient is receiving coordinated care as needed between medical and behavioral clinicians.

**Q: How do I know that the Wellness Assessment is an instrument that is scientifically sound?**

A: The Wellness Assessment (WA) has undergone a number of psychometric analyses, both internally and by an academic third-party. These have been done to ensure its psychometric integrity as an outcome tool and to affirm its use as an objective assessment tool with external credibility. Findings from a 2008 study confirmed the WA as a reliable and accurate assessment of global emotional and psychological distress. A recent study, conducted in 2010, concluded that the Adult WA had strong validity, meaning that the items contained in the WA measure function similarly to items included in established measures reported in the psychotherapy research literature. The technical psychometric reports on



the WA are available on ubhonline.com and in the reference library of ALERT Online.

**Q. How can brief instruments like the Wellness Assessment that capture a “snapshot” of my patient be useful clinically?**

A: The baseline Wellness Assessment (WA) “snapshot” provides information that can be used to flag risk, as well as to open a discussion in therapy. Although clinicians are asked to administer the WA at the first session and again between the third and fifth sessions, clinicians are encouraged to administer the WA more often through the course of treatment. Using ALERT Online, an interactive report available on ubhonline.com, clinicians can use the progress reports to evaluate patients’ progress in psychotherapy, monitor specific items that have changed (worsened/improved), and adjust treatment plans as needed. This can help the therapeutic alliance by showing the patients that their specific responses are being heard and addressed in therapy.

Multidimensional, patient-reported outcome instruments like the WA offer more flexibility in understanding treatment outcomes, as they allow the clinician to track changes across several aspects of importance to the patient, including general health status, social relationships, work/school status etc. For example, an individual who is experiencing severe clinical depression may at first report being more troubled by symptoms, as compared to relational concerns. As symptoms abate due to effective treatment, other concerns, perhaps unreported earlier, such as work productivity, relationships, and so forth may become more prominent. Comparing WA snapshots of the patient throughout the course of treatment allows these shifting concerns to be identified and addressed in treatment.

**Q: Does the Wellness Assessment adequately measure change over time?**

A: Yes, a third-party academic researcher analyzed the psychometric properties of the Wellness Assessment’s Global Distress scale, designed to measure depression, anxiety, low self-efficacy, and impaired functioning associated with psychological and emotional distress. Results indicated that the items of the Global Distress scale did sensitively reflect change over time.

**Q. Why does Optum rely on patient self-report rather than clinician-report?**

A: The use of patient-reported outcomes has been recognized as a valid tool in assessing patient experience and perceptions, as well as whether treatment for mental health and substance abuse disorders is effective and beneficial for specific patients. Patient-reported outcomes inform clinicians about the patients' experience of symptoms and areas of concern, their perspective on the treatment they receive, and their perception regarding the effectiveness of treatment. Perhaps the most important aspect of patient-reported outcomes is an emphasis on the role of the patient as the *consumer* of treatment – an active partner with the clinician in the treatment process. The role of the patient was underscored by the Institute of Medicine's (2001) emphasis on *patient-centered care* as one of the five critical components of quality care. Essentially, patient-centered care focuses on patient preferences and beliefs regarding care needs and their involvement in treatment planning. Patient-reported outcomes provide a foundation for patient-centered care that helps to ensure that care is relevant to the patient's concerns, as well as to provide an opportunity to engage patients in the treatment process.

**Q. What if my patients exaggerate or minimize their responses on the Wellness Assessment in order to either protect their privacy or ensure authorization for services?**

A: By reviewing patients' Wellness Assessment (WA) responses with them during treatment, the clinician has the opportunity to identify areas where their verbal description of symptoms and current functioning does not seem to match their WA responses. The clinician can then open a discussion with the patient about these issues.

**Q. How do I measure more targeted outcomes for my patients with specific disorders such as PTSD?**

A: The Wellness Assessment (WA) is designed to be used initially at a patient's first or second appointment, when the diagnosis may not yet be determined. It is also designed to measure global levels of distress, functioning, general health, and workplace productivity, all of which may be impacted by the specific disorder a patient has. For these reasons, regardless of the patient's diagnosis, the WA can be a useful tool that provides valuable clinical information at the beginning and throughout treatment, in addition to any other measures that may be used. However, when a patient has been diagnosed with a particular disorder, such as PTSD, it may be appropriate to also incorporate condition-specific measures that allow the measurement of more targeted outcomes.



## Questions about the Adult Wellness Assessment Validity Study

**Q: Why did Optum engage in a validity study of the Wellness Assessment?**

A: Previous internal and external analyses have shown the Wellness Assessment (WA) to be an instrument that has strong psychometric properties. This means that the measure is consistent and accurate in measuring what it was designed to measure. The purpose of the 2010 validity study was to build on those previous analyses by demonstrating that the WA can function as well as other “Gold Standard” measures that were designed to measure similar constructs and used widely by clinicians.

**Q: What does it mean when the study report says that the Wellness Assessment’s Global Distress Scale is reliable?**

A: Reliability measures the amount of internal consistency a scale has. In other words, if a scale has items measuring a particular construct, such as anxiety, then a person should answer all of the anxiety items in a similar way. If this occurs, it suggests a reliable scale - that all of the items consistently measure aspects of the same construct: anxiety. The most commonly used method of measuring reliability in the social sciences is Cronbach’s alpha ( $\alpha$ ). When  $\alpha = .70$  or higher, a scale is considered to have acceptable reliability. When  $\alpha = .80$  or higher, a scale is considered to have optimal reliability. In our study, the Wellness Assessment Global Distress Scale showed  $\alpha = .91$ , suggesting optimal reliability.

**Q: How did the researchers choose which “Gold Standard” measures to compare the Wellness Assessment to?**

A: The researchers reviewed and selected comparison “Gold Standard” measures that are used extensively in the field, cited often in the scientific literature, and designed to measure similar components as those included in the Wellness Assessment (psychological distress, workplace productivity, and general health).

**Q: What does it mean to say that the Wellness Assessment has strong construct validity?**

A: In demonstrating that the Wellness Assessment (WA) has strong construct validity, the study findings support the use of the WA by clinicians to draw accurate conclusions about their patients’ Global Distress, workplace productivity, and general health status. This also supports the WA’s ability





to function as well as several “Gold Standard” measures of similar constructs.

**Q: What does “correlation” mean in this study?**

A: A correlation in a psychometric study like this is a measure of association between two instruments: how well both instruments relate to each other, and the strength with which the two instruments are both measuring the same construct. When an instrument is compared to a “Gold Standard” already within the scientific and clinical literature, the correlation measures how well the intended instrument measures the same thing that the “Gold Standard” is measuring. If a correlation is below .39, the intended instrument is considered to have a low correlation and little correspondence to the “Gold Standard.” A moderate correlation would be between .40-.69. A high correlation is considered to be above .70, and suggests that both the intended instrument and the “Gold Standard” are measuring a similar construct. In this study, for example, the Global Distress scale of the Wellness Assessment had a high correlation ( $r = .81$ ) with the PHQ-9, a “Gold Standard” measure of Depression, suggesting that the Global Distress scale and the PHQ-9 are both measuring a similar construct: Depression.

**Q: How does the Wellness Assessment compare to “Gold Standard” measures of Depression, such as the PHQ-9?**

A: The Wellness Assessment (WA) has a Global Distress scale that is not designed as a diagnostic tool, but as a way to measure more global constructs representing the depression, anxiety, low self-efficacy, and impaired functioning associated with psychological and emotional distress. If the WA Global Distress Scale is a valid measure of these constructs, scores on the scale should correlate with (i.e. correspond to or relate to) scores on “Gold Standard” measures of similar constructs. This study shows that the Global Distress scale is very highly correlated ( $r = .81$ ) with the PHQ-9, a “Gold Standard” Depression measure, and the relationship is statistically significant ( $p < .001$ ). In other words, in this study, those individuals who had high scores on the Global Distress scale also scored highly on the PHQ-9, and the likelihood is less than 1 in 1000 that this strong relationship occurred by chance. In addition, this study found similarly high correlations between the Global Distress Scale and other “Gold Standard” measures of related constructs, including the OASIS measure of Anxiety, the SF-12 mental health items, and the General Health Questionnaire (a general mental health screener often used in primary care). This lends further evidence that the Global Distress scale functions well as a measure of these constructs.

**Q: How does the Wellness Assessment compare to “Gold Standard” measures of general physical health status such as the SF-12?**

A: If the physical health questions on the Wellness Assessment (WA) are a valid measure of general physical health constructs, scores on those items should correlate with (i.e. correspond to or relate to) scores on “Gold Standard” measures of similar constructs. This study shows that the WA items designed to measure physical health were very highly correlated with the physical health items of the SF-12, a “Gold Standard” measure. In fact, a single item on the WA that asks about general health was found to be nearly perfectly correlated ( $r = .93$ ) with the single general health item on the SF-12, meaning that if a person scored high on the WA general health item, they nearly always scored high on the SF-12. The relationship between the two items was also statistically significant ( $p < .001$ ), meaning that the strong relationship has a less than 1 in 1000 likelihood of occurring by chance. Additional support for the WA as a tool for measuring physical health were findings of high correlations (strong correspondence) between other WA health items (# of chronic conditions reported, # of visits to the doctor in the last 6 months) and SF-12 general health and physical health items.

**Q: How does the Wellness Assessment compare to “Gold Standard” measures of productivity such as the HPQ?**

A: If the productivity questions on the Wellness Assessment (WA) are a valid measure of absenteeism (# days missing from work) and presenteeism (# of days cut back from work), scores on the scale should correlate with (i.e. correspond to or relate to) scores on “Gold Standard” measures of similar constructs. This study shows that the WA item designed to measure absenteeism was highly correlated ( $r = .85$ ) with the HPQ absenteeism item, meaning that the # of days patients indicated they were unable to work on the WA corresponded highly with the number of days they indicated they missed work on the HPQ. A moderate correlation ( $r = .45$ ) was also seen between the WA presenteeism item and the HPQ presenteeism item. Both correlations were statistically significant at the  $p < .001$  level, meaning the relationship has a less than 1 in 1000 likelihood of occurring by chance.

**Q: How valid is the Wellness Assessment measure of alcohol and drug use?**

A: The Wellness Assessment (WA) includes a 3-item substance use scale that is made up of items taken directly from a “Gold Standard” measure of substance use, the CAGE-AID (Brown & Rounds, 1995). In this validity study, the WA substance use scale was therefore not compared back to





the “Gold Standard” measure from which it was created. Instead, the scale was compared to another measure of substance use within the WA, an item that asks the patient to indicate how many drinks of alcohol they have had in the past week. Results of this study show that the WA substance abuse scale was moderately correlated ( $r = .57$ ) with the # of drinks item, and the correlation was statistically significant at the  $p < .001$  level, meaning the relationship has a less than 1 in 1000 likelihood of occurring by chance. A stronger correlation would not be expected, given that the 3-item scale is about both alcohol and drug use, and the drinks item only asks about alcohol use. Furthermore, the 3-item scale asks about use in the last month, whereas the # of drinks item asks about the past week.

**Q: So what do the validity study findings mean for a clinician using the Wellness Assessment?**

**A:** The last 10 years of research on the Wellness Assessment (WA) have provided us with very good evidence of the psychometric integrity of the instrument. The Global Distress scale of the WA is reliable, and measures what it is intended to measure: depression, anxiety, low self-efficacy, and impaired functioning. This latest study confirms that the WA has construct validity, and accurately measures constructs of depression, anxiety, physical health, workplace productivity and substance use. Clinicians can use the WA and be confident that the instrument is measuring what it is intended to measure, and functions as well as other measures of similar constructs.