Quality and Outcomes in Behavioral Health

Stacy DiStefano
Chief Strategy Officer, Inperium Inc | Advisory Board Member, OPEN MINDS
Metrics Should Align With Goals & Priorities

- Improve Consumer Health
- Promote Integrated Care
- Improve Access
- Improve Consumer Quality Of Life & Outcomes
- Improve Affordability
Follow-up after hospitalization for mental illness

Diabetes screening for people with Schizophrenia using an antipsychotic

Antidepressant medication management

Community Tenure

Depression monitoring via PHQ-9

Patient Reported Outcomes

Involvement of family/significant other

Initiation/engagement of alcohol and other drugs

Diabetes care – blood sugar controlled

Adherence to antipsychotic medication for people with schizophrenia

Use of depression screening and follow-up

Risk adjusted ALOS

Readmission rates

Patient or consumer satisfaction

PCP Engagement

Access to care measures
<table>
<thead>
<tr>
<th>Questionnaire</th>
<th>What it Measures</th>
<th>Visits Administered</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Anxiety Disorder (GAD)-7</td>
<td>Anxiety Screen</td>
<td>Initial and Follow-up</td>
</tr>
<tr>
<td>Patient Health Questionnaire (PHQ)-9</td>
<td>Depression Screen</td>
<td>Initial and Follow-up</td>
</tr>
<tr>
<td>Life Events Checklist (LEC)-5</td>
<td>Screen for potentially traumatic life events</td>
<td>Initial</td>
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<tr>
<td>PTSD Checklist – Civilian Version (PCL-C)</td>
<td>Post Traumatic Stress Disorder screen</td>
<td>Initial</td>
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<tr>
<td>Quality of Life Enjoyment and Satisfaction Questionnaire (Q-LES-Q-SF)</td>
<td>Screen for degree of enjoyment/satisfaction in daily life</td>
<td>Initial</td>
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<tr>
<td>Sheehan Disability Scale</td>
<td>Assess functional impairment in areas of work/school, social, family life</td>
<td>Initial</td>
</tr>
<tr>
<td>The Pittsburgh Sleep Quality Index (PSQI)</td>
<td>Assess sleep quality and disturbances over last month</td>
<td>Initial</td>
</tr>
<tr>
<td>PROMIS</td>
<td>Patient reported outcomes tool measuring general health and physical function</td>
<td>Initial</td>
</tr>
<tr>
<td>Columbia-Suicide Severity Rating Scale (C-SSRS)</td>
<td>Suicide assessment screen</td>
<td>Initial</td>
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<tr>
<td>AUDIT-C</td>
<td>Screen for high-risk alcohol use</td>
<td>Initial</td>
</tr>
</tbody>
</table>
### Three Types of Outcome Reporting

<table>
<thead>
<tr>
<th>Process Measures</th>
<th>Outcome Measures</th>
<th>Social Determinants Of Health Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>These typically illustrate provider or consumer adherence to care improvement processes and are substitutes when outcomes may be difficult to calculate.</td>
<td>These are quantitative outcomes that demonstrate whether or not a targeted goal was achieved.</td>
<td>Many behavioral health conditions contribute directly to deficits in social determinants of health. Measurements of social determinant outcomes can illustrate high quality behavioral health outcomes.</td>
</tr>
<tr>
<td>Scheduling appointments for 7- and 30-day follow-up after hospitalization for mental illness</td>
<td>Actual percentage for 7- and 30-day readmissions</td>
<td>Employment status</td>
</tr>
<tr>
<td>Treatment initiation and engagement benchmarks for substance use disorder</td>
<td>Actual percentage of “kept appointments” for 7- and 30-day follow-up after hospitalization for mental illness</td>
<td>Housing status</td>
</tr>
<tr>
<td>Notification of inpatient admission</td>
<td></td>
<td>Education status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality of life</td>
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<tr>
<td></td>
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<td>Independent living</td>
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</table>
The Intersection Of Value-Based Reimbursement (VBR) & Social Determinants Of Health (SDOH)

- **VBR** – Ties reimbursement to quality and efficiency measures
  - Facilitates the achievement of the triple aim—improving population health, reducing the costs of health care and improving individual member outcomes
  - Supports provider engagement and payer/provider collaboration
  - Rewards provider performance on agreed upon measures of quality and utilization

- **SDOH** – Environmental factors that influence a population’s health and functioning (e.g., socio-economic status, transportation, age)
  - Provide important detail that can guide interventions to achieve VBR goals
  - Increase understanding of population needs
  - Move VBR beyond easy-to-access measures that hold greater meaning
The Net Promoter Score (NPS) is a measure of the willingness of consumers to recommend an organization’s products or services, usually obtained through continual surveying of consumer base.

- **Index ranging from -100 to 100**
- **Items score on a range from 0 to 10**
- **Used to measure consumer overall satisfaction to products, services, and loyalty to organization brand**
- **Calculated by subtracting the percentage of detractors (those who score the organization poorly) from promoters (those who score the organization highly)**
Overwhelmed? HOPE Can Be Found By:

- Establishing a clear and simple goal
  - Improve psychiatry access, reduce ER visit, housing retention—pick 2 to start

- Working together
  - Bring payer & provider together to solve payer pain points and achieve an outcome improvement for the consumer. Get on the same page.

- Establish regular structures to monitor and use a continuous improvement cycle
  - Most of these fail because the “deal is inked” but no one is tracking the measures closely. It’s the old adage—what is measured gets managed. Get full staff buy-in and communicate!
### Example: Nebraska Domains and Key Metrics

<table>
<thead>
<tr>
<th>Access &amp; Engagement</th>
<th>Integration</th>
<th>Quality Outcomes</th>
<th>Consumer Health</th>
<th>Affordability &amp; Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Improve access to behavioral health prescribers.</td>
<td>2.1. Improve PCP coordination</td>
<td>3.1 Increase the % of consumers in stable housing</td>
<td>4.1 Improve food security</td>
<td>5.1 Increase community tenure</td>
</tr>
<tr>
<td>1.2 Improve access to culturally sensitive care.</td>
<td>2.2 Improve screening of diabetes</td>
<td>3.2 Increase the % of consumers in integrated employment</td>
<td>4.2 For individuals with diabetes, assure annual retinal eye exam</td>
<td>5.2 Reduce readmission rate</td>
</tr>
<tr>
<td>1.3 Improve access to Medication Assisted Treatment (MAT)</td>
<td>2.3 Improve consumer engagement in weight management programs for those identified as obese</td>
<td>3.3 Increase % of consumers with reliable clinical improvement based on outcome scales</td>
<td>4.3 For individuals with schizophrenia, increase screening for diabetes</td>
<td>5.3 Reduce ER visits</td>
</tr>
<tr>
<td>1.4 Increase utilization of MAT providers</td>
<td></td>
<td>3.4 Improve 7-day HEDIS followup measure</td>
<td>4.4 For individuals taking anti-psychotic medications with diagnosis of bipolar or schizophrenia, increase diabetes screening</td>
<td>5.4 Improve medication adherence for individuals taking:</td>
</tr>
<tr>
<td>1.5 Improve followup after initial diagnosis of substance use disorder</td>
<td></td>
<td></td>
<td></td>
<td>a) anti-psychotic medication</td>
</tr>
<tr>
<td>1.6 % who responded that I, not staff, decided my treatment goals</td>
<td></td>
<td></td>
<td></td>
<td>b) anti-depressant medication</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>c) Diabetes medication</td>
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<tr>
<td></td>
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<td></td>
<td>d) Cholesterol medication</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>e) Hypertension medication</td>
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### Key Metrics

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<tr>
<td>1.1 % of consumers seen within 14 days of request for BH prescriptive services</td>
<td>2.1 % of consumers with an annual PCP visit</td>
<td>3.1 % of consumers with stable housing as measured through consumer survey</td>
<td>4.1 % of consumers with access to nutritional food within 30 miles radius and/or % of consumers educated re: access to nutritional food</td>
<td>5.1 % of total community days for individuals with MHSA diagnosis</td>
</tr>
<tr>
<td>1.2 % consumers who respond positively to consumer question re: culturally sensitive care (baseline 85.6%)</td>
<td>2.2 % of consumers screened for diabetes</td>
<td>3.2 % of consumers in integrated employment based on consumer survey</td>
<td>4.2 % of consumers with diabetes that have a retinal screening</td>
<td>5.2 % of individuals readmitted to same or higher level of care within 30 days</td>
</tr>
<tr>
<td>1.3 % of consumers access to MAT program within 30 miles</td>
<td>2.3 % of consumers identified as obese that are engaged in weight management program</td>
<td>3.3 % of consumers with positive clinical progress based on member reported outcome instrument OR % agree services improved quality of life (consumer survey (79.4% baseline))</td>
<td>4.3 % of consumers with schizophrenia diagnosis that are screened for diabetes</td>
<td>5.3 # of Emergency Department visits</td>
</tr>
<tr>
<td>1.4 % of consumers with 90 days or greater engagement in MAT</td>
<td></td>
<td>3.4 % of claims that show outpatient followup after inpatient discharge occurred within 7 days</td>
<td>4.4 % of consumers taking anti-psychotic medications for bipolar or schizophrenia diagnosis that are screened for diabetes</td>
<td>5.4 Medication adherence based on pharmacy data that shows adherence or medication gaps for:</td>
</tr>
<tr>
<td>1.5 % of consumers who are engaged in SUD program within 14 days of initial diagnosis</td>
<td></td>
<td></td>
<td></td>
<td>a) anti-psychotic medications</td>
</tr>
<tr>
<td>1.6 % of consumers who respond positively to consumer question re: “I decided my treatment goals”</td>
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<td>b) anti-depressant medications</td>
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# Nebraska Key Metrics in Key Domains: Access, Quality and Integration

## Access & Engagement
- Improve access and utilization of behavioral health prescribers
- Improve access and utilization of Medication Assisted Treatment

## Quality & Affordability
- Increase the percentage of consumers in stable housing
- Increase the percentage of consumers in integrated employment
- Increase community tenure
- Improve consumer-reported outcome results
- Improve NPS (I would recommend this agency to a friend or family member)
- Improve 7-day HEDIS measure

## Integration/Social Determinants of Health
- Improve PCP coordination (enrolled members have 1 PCP visit annually)
- Improve screening for diabetes and adherence to treatment plan
- Improve screening for obesity and access to nutritional options (e.g., address food insecurity)
Independent Monitoring For Quality – National Core Indicators

Choice & Control

- Always carry ID: Statewide 52%, Administrative Entity 56%
- Have a key to get into house: Statewide 33%, Administrative Entity 32%
- Choose where they live: Statewide 49%, Administrative Entity 56%
- Choose what they do during the day: Statewide 71%, Administrative Entity 75%
- Vote: Statewide 28%, Administrative Entity 28%

Statewide vs. Administrative Entity
Housing
- Rental Subsidy provided to participants of the Iowa RIST & ACT programs from County Funds to secure the basic need of safe stable housing for individuals of the program. Six months rent payments continue if hospitalized to facilitate return to housing.

Supportive Community Living
- Life skills, tenancy support services, and community integration component of the program to help individuals learn and develop skills needed to maintain independent living and integrate into the community of their choosing. Consumer satisfaction tracked by independent contractor.
Iowa Program Census Year 2

- 37 Individuals supported total since beginning of program
- 26 Participants in the current program census (full census)
  - 2 participant deaths due to chronic health conditions
  - 5 discharged to lower level of supports
  - 4 discharged to higher levels of care
Iowa Example: Program Outcomes

- **Housing Retention**
  - 94% of participants retained stable housing
    - 2 of 37 participants have been evicted or had leases terminated
      - 85-90% - national trend for housing first programs (Pathways National).

- **Hospitalization**
  - 30% some inpatient days (1 day - 30 days)
  - 70% of participants supported have not had a psychiatric hospitalization since working with the team over past 2 years
An Intentional Move Beyond FFS and Counting Units

35% of Payers are capturing and leveraging SDoH to help guide interventions and improve population health outcomes

93% of health plans (both Commercial, Medicaid and Medicare) have implemented pay for performance reimbursement models
Examples of APMs that Focus on Outcomes

- Move away from counting units and creating workflows around authorizations.
- If program staff is spending time talking to payer staff on “coordination” then not enough focus is on the consumer.
- Whole person care requires whole person funding.
Reimbursement Types: Pay For Performance

**Definition:** Providers are financially rewarded for meeting pre-established targets for delivery of healthcare services

**Pros**
- Incentivizes behavior change
- Lead to improvement of quality measures
- Encourage more efficient coordination

**Cons**
- Provider only focused on care that affects measures, and ignore other factors - "manage to metric" or "cherry pick" member
- Incentive may not be large enough to promote behavior change
- Provider could see overall reduction in revenue if unable to fill vacancy
- Difficult to evaluate causality v. random fluctuation

**Pay For Performance Example**
- “ABC” Health Plan pays an escalator of up to 6% for rev code 124 (acute inpatient level of care) based on achievement of HEDIS 7-day ambulatory follow up
- “ABC” Plan pays a 1 time bonus of $50,000 for achievement of key performance measures included assuring consumer compliance with annual dentist visit
Reimbursement Types: Case Rate or Bundled Rate

**Definition:** A flat payment for a group of procedures and/or services

**Pros**
- May decrease need for authorization and concurrent review
- Controls cost per episode
- Incentivizes fewer re-admissions
- Can bundle multiple services and promote innovation

**Cons**
- Incentivizes shifting treatment to other settings or codes
- Increase oversight to manage quality
- Increases risk to providers
- Potential for double payment if member switches provider
- Encourages discharge once member passes breakeven point
- Incentivizes admissions
- Need to make many assumptions, e.g., service mix, license mix, etc
- Requires system to support

**Case Rate Or Bundle Rate Example**

- “ABC” Health Plan pays a monthly rate of $1,200 for Medication Assisted Treatment (MAT) to include medication management, counseling services, and lab services associated with treatment, excluding medication costs.
- “XYZ” Health Plan pays a case rate of $7,000 for acute inpatient episode to include all services (e.g., physician fees, labs, etc.) for a single treatment episode. A readmission warranty includes a 10% withhold for any case that is readmitted within 90 days of treatment.
- “EFG” Health Plan pays a tiered case rate of $800 for day 1 of treatment, $600 for days 3-5, and $200 for Days 6 and 7 with no payment after day 7 for acute inpatient treatment.
Reimbursement Types: Shared Savings & Shared Risk

**Definition:** Provider and payer share in the healthcare savings pool generated by performance improvement (e.g., reduced behavioral costs or total cost of care)

**Pros**
- Offer a reward split among those contributing to the success (e.g., payer supports analytics and member assignment and provider implements interventions to reduce costs)
- Shared risk is a variation in which the provider is “at risk” for the service costs
- Good step toward capitation if successful

**Cons**
- “Shared” is not always a 50/50 share
- Achievement may result in little room for ongoing improvement—need to develop go-forward model of sustainability

**Shared Savings & Shared Risk Example**
- A Core Service Agency (CSA) offers a full continuum of care and has been assigned 500 seriously and emotionally disturbed (SED) children to manage with a goal of improving community tenure and reducing out-of-state foster care placement. Achievement of pre-defined target measures (using baseline year of data) will result in the Plan and the CSA splitting the savings (generated from reduced higher level of care costs) 50/50
- Variation – CSA is at risk for the membership and splits any achievement with the Plan, but must pay all services and provide transparency into service utilization and costs
Reimbursement Types: Capitation

**Definition:** A set payment for each enrolled person assigned to that physician or group of physicians, whether or not that person seeks care, per period of time

**Pros**
- Rewards groups, and in turn those groups’ individual physicians, who deliver cost-efficient care
- Costs stable and predictable
- No billing

**Cons**
- Assignment can be challenging in behavioral health environment
- Payers concerned that under-treatment might occur
- Dependent on marketplace factors and a group’s negotiating power
- May result in increased oversight by payer
- Regulatory hurdles
- Requires system to support

**Capitation Example**
- An outpatient provider is paid a per member per month (PMPM) to support the care coordination of an assigned cohort of 500 individuals that meet the state definition of severe and persistently mentally ill (SPMI). The provider can earn a bonus on top of the PMPM if key performance measures are achieved.
Key Components Of Performance-Based Contracts

Entry Level Criteria

- Submit claims electronically with fast turn around time and/or have data sharing capabilities
- Participate in review and intervention discussion (e.g. once a month)
- Adhere to current managed care requirements and clinical guidelines

Measures

- Balance of Quality and Cost/Efficiency Measures with Social Determinants of Health tracking
- Emphasis on outcome vs treatment process measures
- Examples: PCP visit in past 12 months, #/% employed in integrated program, wages earned over 2 week in paid community job, national core indicators (NCI)

Rewards

- Annual escalator
- Bonus payment
- Prorated based on performance to capped amount
Questions?