## Agenda

BEHAVIORAL HEALTH AS A QUALITY PRIORITY

INTRODUCTION TO A BEHAVIORAL HEALTH QUALITY FRAMEWORK

PANEL REFLECTIONS ON BEHAVIORAL HEALTH QUALITY FRAMEWORK

MODERATED PANEL DISCUSSION AND AUDIENCE QUESTIONS

CONCLUSION

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# Speakers

**Panelists**

Mary Applegate, MD
*Med. Director, OH Medicaid*

Rhonda Robinson Beale, MD
*Senior VP and CMO, United Health*

Gail Edelsohn, MD, MSPH, MBE
*Senior Med. Director, CCBH*

Tammy Allan, LCSW
*BH Director, Hill Country, CA*

Brianne Masselli,
*Consumer Advocate*

**NCQA Staff**

Peggy O'Kane, MHA
*President*

Serene Olin, PhD
*Assistant VP, Research*

Lauren Niles, MPH
*Senior Research Associate*

Andy Reynolds
*Assistant VP, Communications & External Relations*

# *Behavioral Health as a Quality Priority*

Serene Olin, PhD
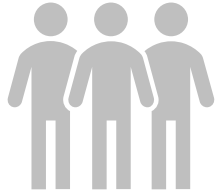*Assistant VP, Research, NCQA*

# Introduction to A Behavioral Health Quality Framework

*A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care*

**LAUREN NILES,  MPH, SR. RESEARCH ASSOCIATE, PERFORMANCE MEASUREMENT**

**SERENE OLIN, PHD, ASSISTANT VP, RESEARCH AND ANALYSIS**

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# Behavioral Health (BH) is a Key Driver of Overall Health

**Behavioral health (BH)\* conditions are a leading cause of disease burden in the United States**, yet there are significant gaps in treatment – especially within communities of color.

Although individuals with BH conditions account for **more than half of all health care spending**, BH services account for **only 4.4% of this cost**.

National efforts are evolving to pay for value, rather than volume.

**Quality measures** are urgently needed to guide value-based payment models to support high quality care that is equitable and coordinated care.

*\*Behavioral health (BH) includes mental health and substance use disorders*

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# Getting to Whole Person Care:  Role of Quality Measures

*Understanding the Challenges*

**What** are we measuring in Behavioral Health?

Environmental Scan:

- Examined **publicly-available quality performance measures** used in active federal accountability programs

- Synthesized measure landscape to **identify gaps and opportunities** to improve whole person care

What is the **impact** of measurement?

Key Stakeholder Interviews:

- Interviewed entities at different levels of health care delivery system in five exemplar states:
  - California
  - Louisiana
  - Colorado
  - Washington
  - Pennsylvania

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# Behavioral Health Quality Measure Landscape

*Abundant measurement, reliance on non-standard measures, few BHI measures*

**39 active federal reporting programs** focused on delivery of health care services require reporting of <u>over 1400 measures/metrics</u>

### Insight 1
Programs include mix of BH and PH and "cross-cutting" measures
*"Whole person" care*

### Insight 2
Reliance on **nonstandard** performance measures and metrics, especially in BH

### Insight 3
Few BH measures are consistently used across federal programs

*35 standardized BH measures mostly rely on administrative claims, focus on diagnoses and narrow care processes*

### Insight 4
Programs focused on BHI often do not have standard ways to capture key aspects of care

*"Home-grown" metrics for cost, care coordination, care experience and outcomes*

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# What is Impact of Current Measure Reporting?

*Stakeholder insights from the BH care delivery system:*

### Insight 1

BH **care** supported through a complex funding streams with disparate reporting requirements

### Insight 2

Measures are seen as rudimentary and narrow; not useful for improving care delivery

### Insight 3

Reporting burden limit available resources to focus on measuring what matters

### Insight 4

BHI viewed as key to addressing access and stigma, but lack clarity on **WHO** is accountable and **HOW** to measure quality of integration.

### Insight 5

**Large-scale solutions** and **incentives** needed to improve BH data.

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# "Measuring what matters" -- Differs by Stakeholders

*Stakeholders at different levels have unique and unmet quality measurement needs*

| | Measure Category | State | Managed Care | Facility |
|---|---|---|---|---|
| **OUTCOMES** | BH symptoms and functioning improvement (i.e., measurement-based care) | X | X | X |
| | Patient goal attainment | | X | X |
| | Patient experience | | X | X |
| | Social outcomes (e.g., kindergarten readiness, crime rate, employment rate) | X | | |
| | BH integration- outcomes and effectiveness | X | X | |
| | Cost | X | X | |
| | Equity in BH outcomes | X | X | X |
| **PROCESSES** | Social service coordination (e.g., linkage to social service agency) | | X | X |
| | Health care coordination/referral success | | X | X |
| | Evidence based treatment (e.g., Fidelity to Cognitive Processing Therapy model) | X | | X |
| | Patient goal setting | X | X | X |
| | BH integration-processes (e.g., data sharing, warm-handoffs) | | X | X |
| | Equity (e.g., equitable access to BH care) | X | X | X |

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# Behavioral Health Quality Framework*

*Connecting the dots across the delivery system*
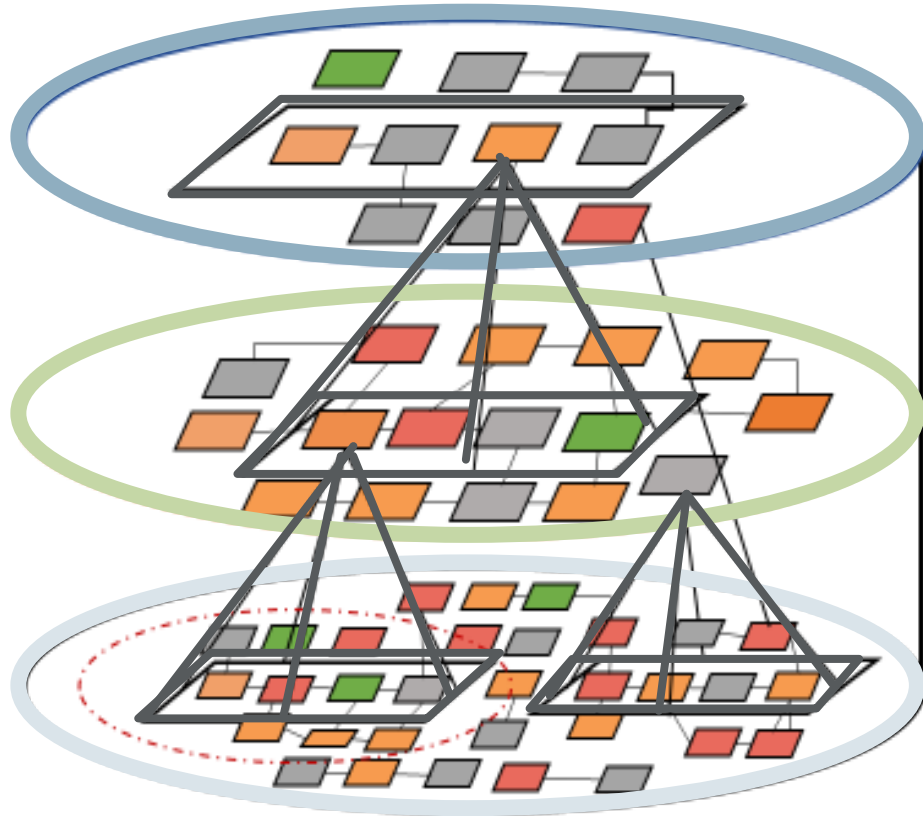


**State & Federal:** *Macro Level*
Set priorities and direct resources through regulations and financial support

**Managed Care:** *Meso Level*
Manage delivery of evidence-based care
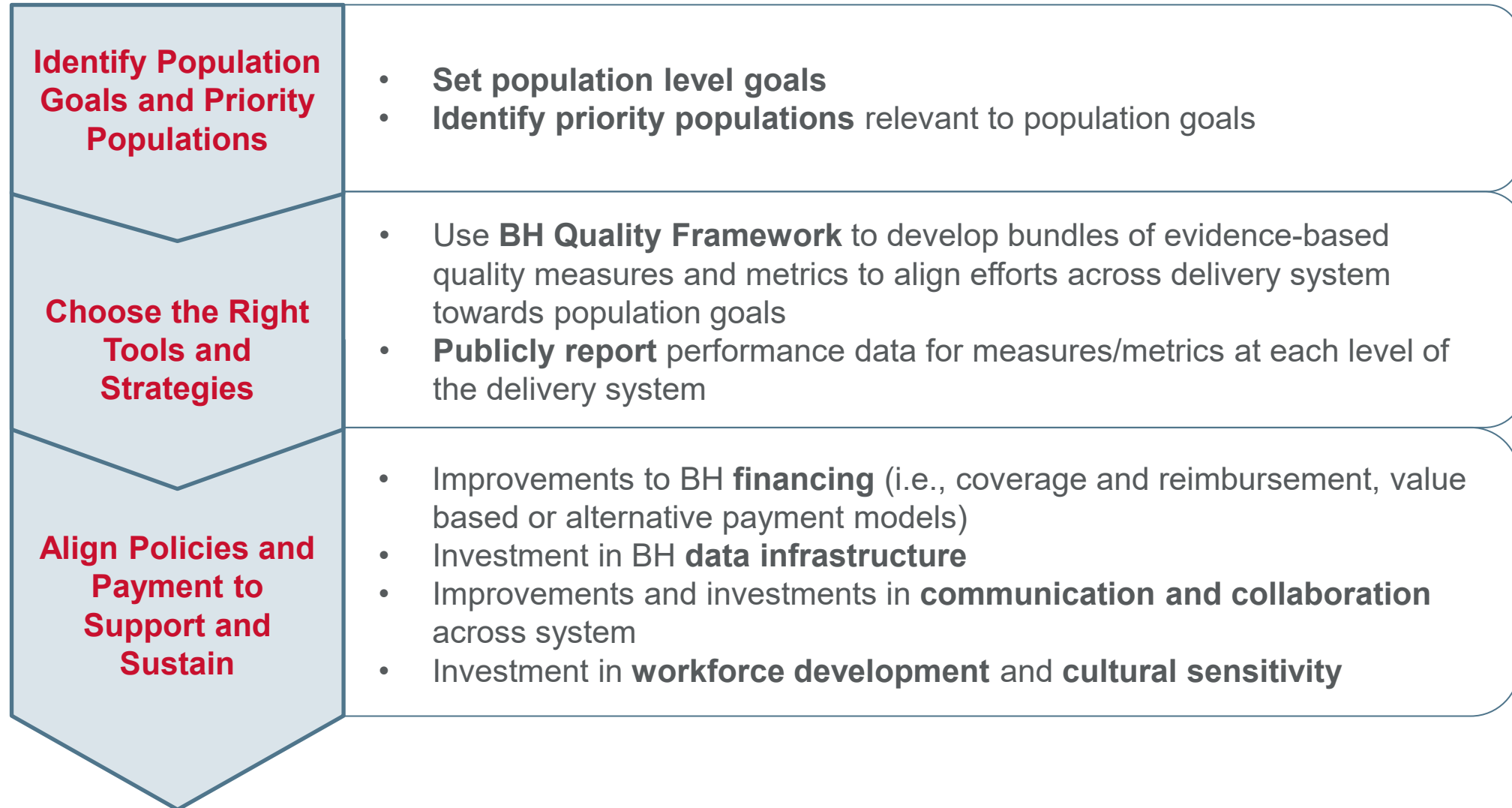
**Facility/Provider:** *Micro Level*
Provide evidence-based treatment and services to support whole-person care

**A measurement framework to focus reporting on what matters at each level of the delivery system**

# Quality Framework for Whole Person BH Care

*Proposed roadmap for applying the BH Quality Framework*

**Identify Population Goals and Priority Populations**

- **Set population level goals**
- **Identify priority populations** relevant to population goals

**Choose the Right Tools and Strategies**

- Use **BH Quality Framework** to develop bundles of evidence-based quality measures and metrics to align efforts across delivery system towards population goals
- **Publicly report** performance data for measures/metrics at each level of the delivery system

**Align Policies and Payment to Support and Sustain**

- Improvements to BH **financing** (i.e., coverage and reimbursement, value based or alternative payment models)
- Investment in BH **data infrastructure**
- Improvements and investments in **communication and collaboration** across system
- Investment in **workforce development** and **cultural sensitivity**

# Putting the Framework into Action:

*An illustrative example: Addressing the national opioid crisis*

## Step 1: Identify Population Goals and Priority Populations

- **Population Health Goal:**
  - Reduce opioid-related overdose and mortality rates

- **Relevant populations:**
  - Individuals diagnosed with opioid use disorder
  - Individuals who have experienced an adverse opioid related drug event
  - Individuals who rely on, or may be exposed to, opioid analgesics to manage pain

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# Step 2: Choose the right tools and strategies

*Align measure bundles across levels to drive forward population goals*

**Measure Bundle for Population Goal:** *Reducing Opioid-Related Mortality*

Purposeful data/Information exchange across system

| Federal & State | **Outcome**: Opioid-related death |
| | **Process**: Follow-up post emergency department for OUD |
| | **Structure**: Prior authorization for MOUD, reimbursement for telehealth |
| **Managed Care** | **Outcome:** Repeat opioid overdose/poisoning events |
| | **Process**: Treatment continuity, care coordination for high-risk members |
| | **Structure:** BH network adequacy, coverage of non-opioid pain therapy |
| | Member experience |
| **Facility/ Provider** | **Outcome**: Treatment dropout/show rates |
| | **Process:** Access to MOUD, treatment engagement, preventive and chronic care management for patients with OUD, care coordination |
| | **Structure:** Waivered providers, telehealth infrastructure, care team communication infrastructure |
| | Patient experience |

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# Step 3: Align Policies and Payment to Sustain

*Prioritizing key system supports*

**$**

Improvement to BH financing (i.e., coverage and reimbursement for important aspects of BH care, value based or alternative payment models to support BH care delivery)

Investment in BH data infrastructure (i.e., standards, exchange, storage)

System-wide communication and collaboration for

1) population health goals *and* 2) meaningful quality measures

Invest in workforce training in cultural sensitivity

# Panel Reflections

*Reactions to the Behavioral Health Quality Framework from Stakeholders Across the Delivery System*

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# State Medicaid Organization: Ohio

*State Medicaid Perspective*



Mary Applegate, MD
*Medical Director, OH Medicaid*

**Role:** Medical Director, Ohio Department of Medicaid

**Who is the Ohio Dept of Medicaid responsible for?** Over 3 million Ohioans, **almost half** of whom have a behavioral health diagnosis

**Role of Quality Measures in Efforts:**

- Monitoring utilization of services and quality of care
- Aligning efforts across physical <u>and</u> behavioral health systems
- Designing quality improvement efforts to continuously improve health outcomes
- Setting the stage for value-based contracting as part of population health management

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# Reflection on BH Quality Framework

*State Medicaid Organization Perspective*

## 1. How does this Framework resonate given my role/responsibility in health system?

It allows for the designation of different roles and responsibilities by different entities so that an entire patient journey toward better health can be planned. This is the foundation of population health management
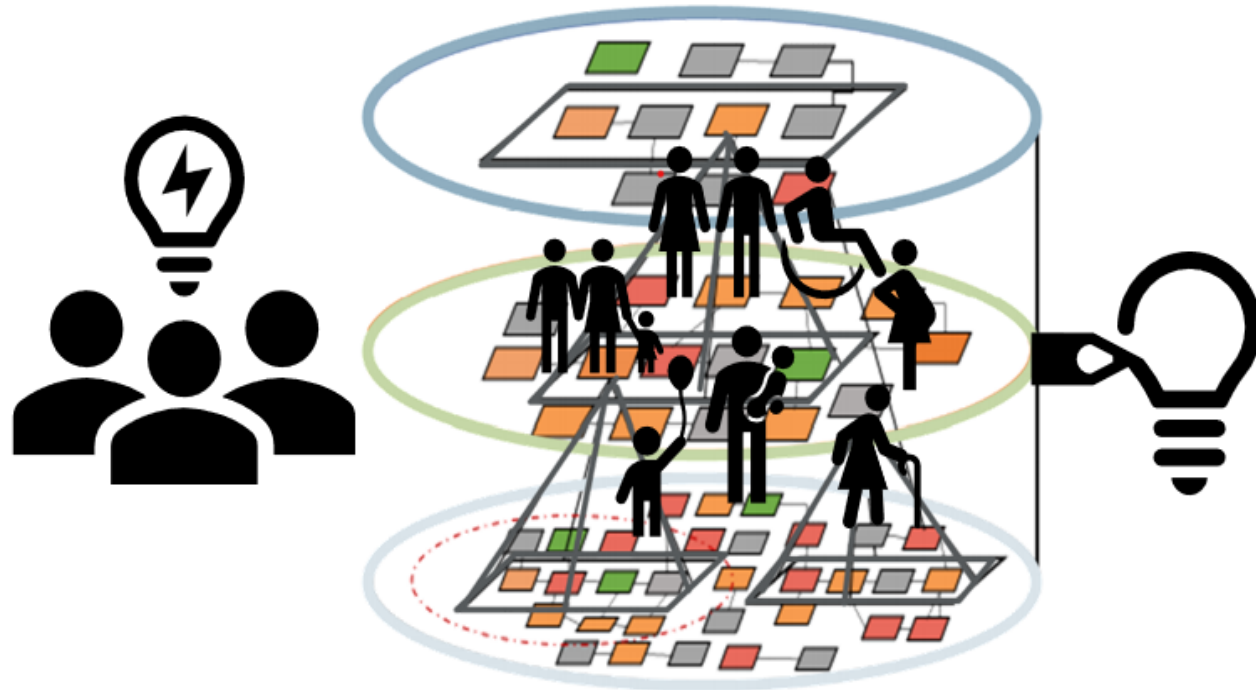
## 2. What is missing from the Framework?

There is an additional layer of all of the **people** cared for in the health system. Not only are they the subjects of the measures that aim to convey degrees of quality in care, the patients can actively influence every level of the system.
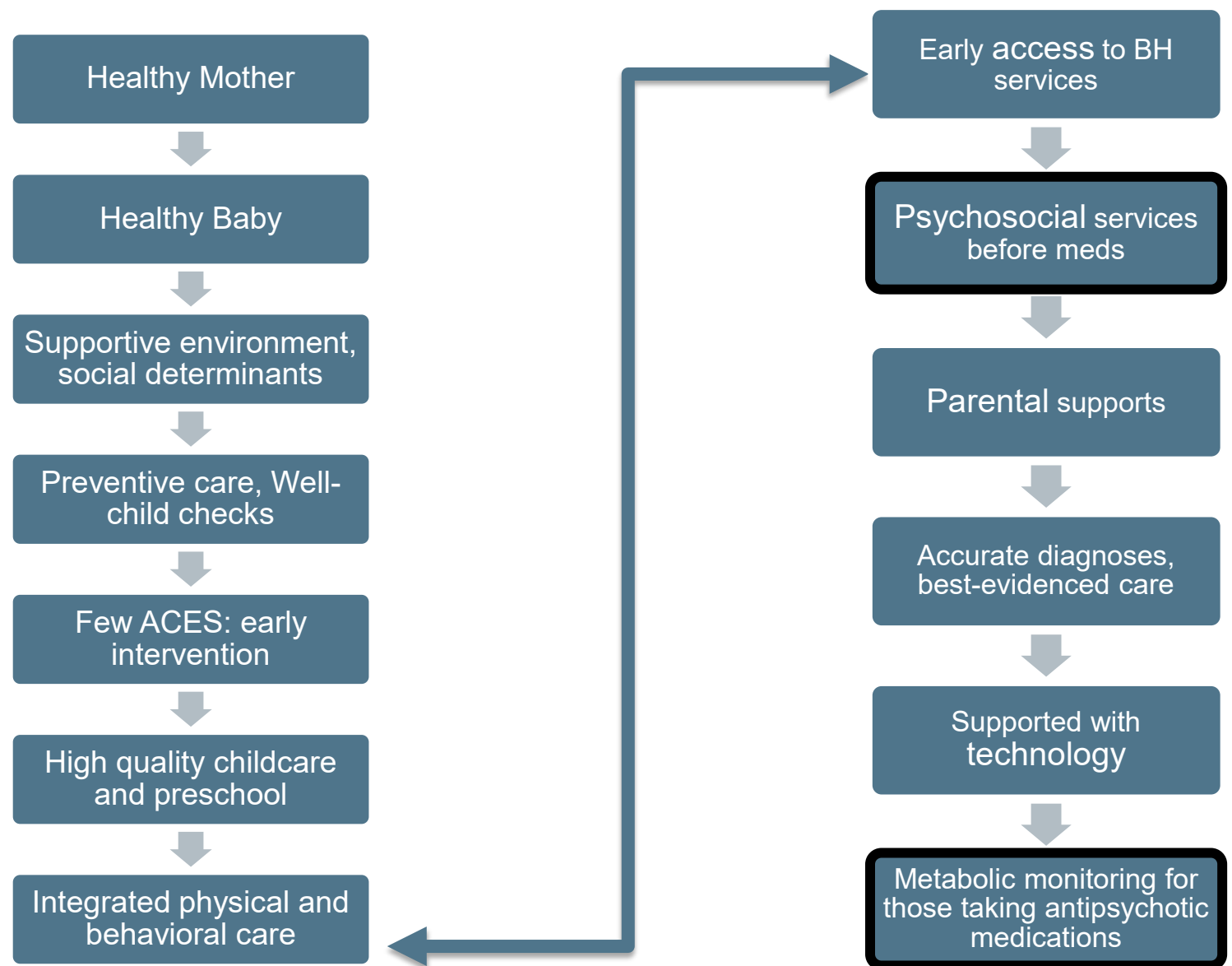
# Aligning Measures and Payment for Better Outcomes

*State Medicaid Organization Perspective*

**Actively Partnering with Members, Families, Communities, and Providers to Design Person-Centered Care**

# Context of Measures: "Life course" Population Health Perspective



Healthy Mother

Healthy Baby

Supportive environment, social determinants

Preventive care, Well-child checks

Few ACES: early intervention

High quality childcare and preschool

Integrated physical and behavioral care

Early access to BH services

Psychosocial services before meds

Parental supports

Accurate diagnoses, best-evidenced care

Supported with technology

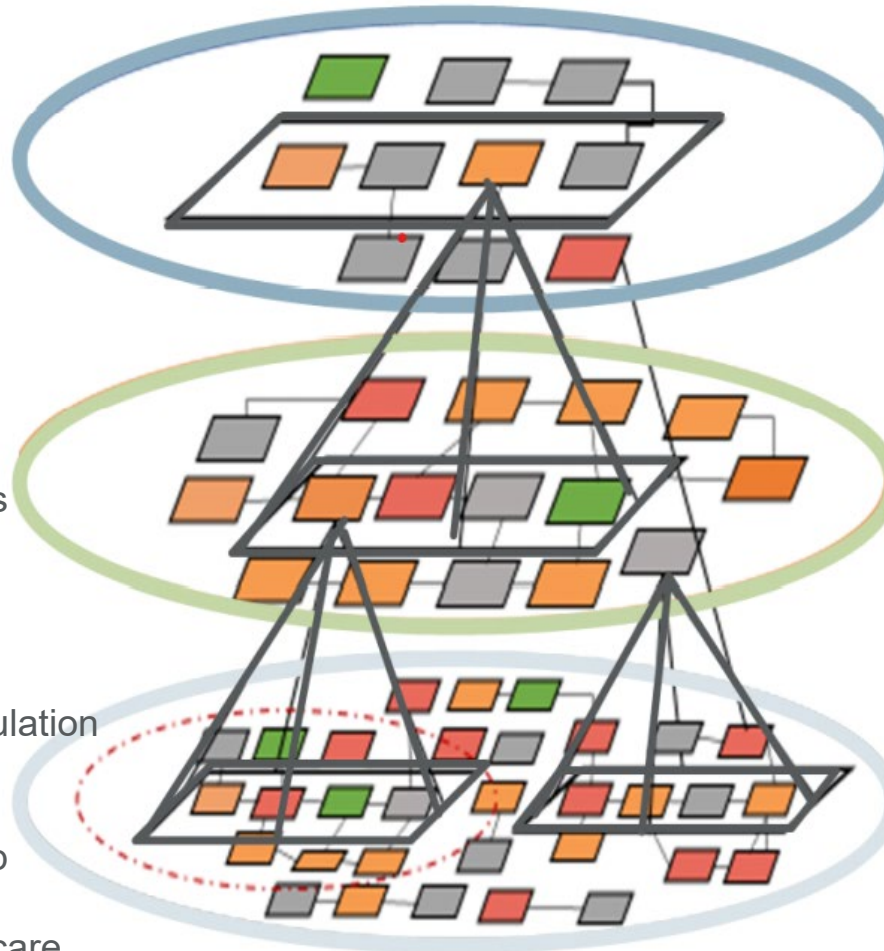Metabolic monitoring for those taking antipsychotic medications

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# Mutually Beneficial Roles & Responsibilities

*State Medicaid Organization Perspective*

Funding/other
Resources
Ensure access
Building social &
environmental
infrastructure

School performance,
BH IP Hospitalization
Suicide/Overdose rates

Access to BH services,
Provider network
Access to medications
Telehealth & QI supports
Value-based payment
options
Community investment

School measures, IP
Psychosocial care &
metabolic measures
stratified
by race/ethnicity/foster/
geography

Managing health of population
(access for all?)
Following best practice
Continuity of relationship
Integration of care/
Connectivity to primary care
Treating all with respect
Community activism
Cross agency collaboration
(Child-serving agencies/schools/health)

First-Line Psychosocial
Care
Metabolic Monitoring

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# Managed Health Care: United Health Group
*Managed Care Organization Perspective*

Rhonda Robinson Beale, MD
*Senior VP and CMO, United Health*

**UnitedHealth Group:** Provides Medical, Pharmacy and Behavioral Health through:
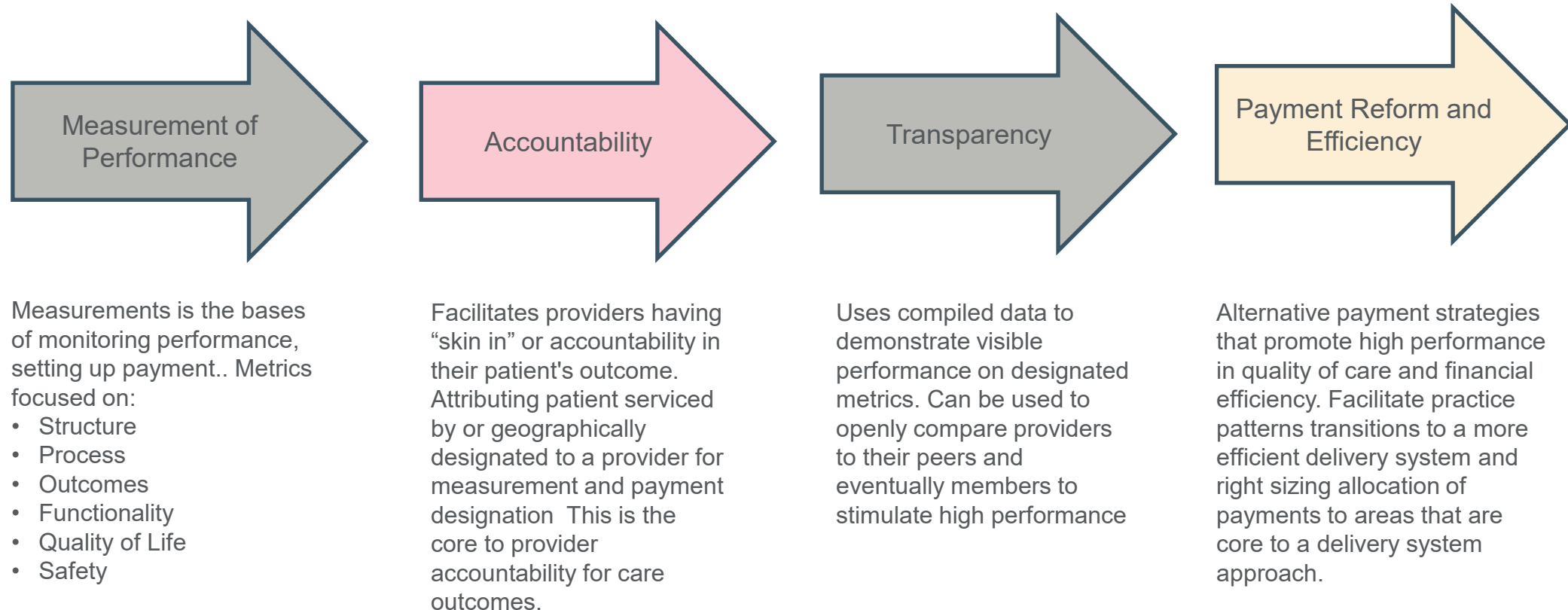
**Health care coverage:** ~137 million people in over 130 counties for Commercial, Medicaid, Medicare and Exchange segments.

**Direct care** to over 3.6 million through owned or high investment in provider care delivery systems engaged in value-based arrangements,

**Data Analytics:** Data warehouse access to over 20 years of health care utilization data points, 74 million EHRs, and ability for extensive analytics (i.e., ML, AI) and research through collaborations with academic centers.

# Managed Health Care: United Health Group

## *Core Levers Used to Drive the Practice Change*

**Measurement of Performance** → **Accountability** → **Transparency** → **Payment Reform and Efficiency**

Measurements is the bases of monitoring performance, setting up payment.. Metrics focused on:
- Structure
- Process
- Outcomes
- Functionality
- Quality of Life
- Safety

Facilitates providers having "skin in" or accountability in their patient's outcome. Attributing patient serviced by or geographically designated to a provider for measurement and payment designation This is the core to provider accountability for care outcomes.

Uses compiled data to demonstrate visible performance on designated metrics. Can be used to openly compare providers to their peers and eventually members to stimulate high performance

Alternative payment strategies that promote high performance in quality of care and financial efficiency. Facilitate practice patterns transitions to a more efficient delivery system and right sizing allocation of payments to areas that are core to a delivery system approach.

These four capabilities are the basic levers used to implement change from a traditional clinical practice to a functional system of care.

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# Reflection on BH Quality Framework
*Managed Care Organization Perspective*

**1. How does this framework fit in with my role/responsibilities at my organization?**

**A. <u>Population Goals/Priority Populations:</u>**

Building accountability into the network system:

- Designating the denominator and numerator
- Support operationalizing attribution
  - Active, passive, joint
- Essential population management elements for network systems
  - Threshold population volume needed to allow operationalization
  - Consolidation points for data – patient centered tracking
  - Outreach capabilities/build customer loyalty

# Reflection on BH Quality Framework (continued)
*Managed Care Organization Perspective*

**B. <u>Right Tools and Strategies</u>:**

- Support Transparency
  - Patient centered
  - Provider comparisons

- Rapid cycle data turn around
  - At least monthly
  - Claims verses encounters
    - Eligibility systems
    - Visa-like transaction

- Practitioner consolidation
  - MSOs and Aggregators

- Success based on outcomes

# Reflection on BH Quality Framework (continued)
*Managed Care Organization Perspective*

C. <u>**Align Policies and Payment**</u>

- Provider centered requirements/policies
- Payment method "Get what you pay for"
  - Capitalization of transformation
    - F4S – grants/philanthropic
    - Supplemental payments
      - PMPM
      - Case rates
      - Shared savings
    - Capitation

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# Reflection on BH Quality Framework (continued)

*Managed Care Organization Perspective*

**2. What is *missing* from the Framework?**

Commercial/Employer Perspective

- Population goal – functionality/productivity
- Absence of Governmental Influences
  - Eligibility for grants/pilots
  - State rules do not apply to ERISA
- Employer Collaboratives as an Influencer/Stakeholder
- Central Accountable Entity for Behavioral Health System Framing and Policies

# Community Care Behavioral Health Organization

*Managed Behavioral Health Care Perspective*

Gail Edelsohn, MD, MSPH, MBE
*Senior Med. Director, CCBH*

**Role:** Senior Medical Director, Quality

**Community Care Behavioral Health Organization:** > 1 million Medicaid members, nearly 2/3 PA's counties; UPMC Insurance Services Division; carve out

- PA Medicaid HealthChoices model- state contracts for BH services with county human service organizations, county human services partner with MBHO
- Invested local county oversights with control and resources that promotes BH integration with human services systems and physical health payors

**Role of Quality Measures in Efforts:**

- Drive contract level and organization-wide workplans
- Across network provider performance benchmarked reviewed by level of care, shared with provider; outliers trigger specific quality improvement activities
- Aligning efforts across physical and behavioral health system
- Foster accountability through incorporation into VBP contracts
- Inform and prioritize Care Management Interventions

UPMC | COMMUNITY CARE
Behavioral Health Organization

# Reflection on BH Quality Framework
*Managed Behavioral Healthcare Organization Perspective*

1. **How does this Framework resonate given my role/responsibility in health system?**

   - Aligns with identifying population goals and prioritizing populations
   - Connecting the dots across levels of delivery system; Community Care *includes county level (what matters and reporting)*
   - Facilitates creation of bundles of evidence-based measures and metrics
   - Aligns with BH financing (value based), communication, collaboration
   - Supports standardization of measures and streamlining large and at times inconsistent set of measures
   - Identifies need for BH data exchange across providers and MCOs

2. **What is missing from the Framework?**

   - Member/person voice, other systems/stakeholders impacting whole person care; inclusion of SDOH in framework
   - Proactively shape the work re: equity, disparities, systemic, institutionalized & structural racism, to develop common standardized measures; Multicultural Distinction helpful, but more structure would be appreciated
   - Acknowledge lack of consensus, assumptions re: some widely collected measures; opportunity to re-evaluate, invite input, would enhance likelihood of success of the framework

UPMC COMMUNITY CARE Behavioral Health Organization

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# Using measures and data to improve care equity

*Managed Behavioral Healthcare Organization Perspective*

## How could measures be better used to improve the work you can do?

- More fully integrated into operations
- Select and integrate measures within VBPs
- Align measures with utilization review (i.e. gold card for certain thresholds)
- Having measures serve more as focus for CM activities, quality follow up, less utilization review

## How would you use data or evidence to improve care equity ?

- Utilization rates of specific treatment services and classes of psychotropic medication stratifying by race, ethnicity, gender, diagnostic group, geographic location to identify disparities
- Include Medicaid categories as well as race, ethnicity, gender, age regarding pediatric polypharmacy and antipsychotic pediatric prescribing to identify disparities
- Utilize data on prescriber type, high volume prescribers to design interventions

## What do you need to improve care ?

- Adequate access; question current metrics (geo, ratios); wait time in ED, shared metric to drive network development

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# Improving care and promoting accountability

*Managed Behavioral Healthcare Organization Perspective*

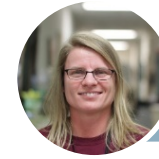**What do you need to improve care?**

- Real time, validated cross systems, human service data to include substance use

- Evidence based treatment in the network; how to verify provider proficiency to deliver EBPs and maintain capacity?

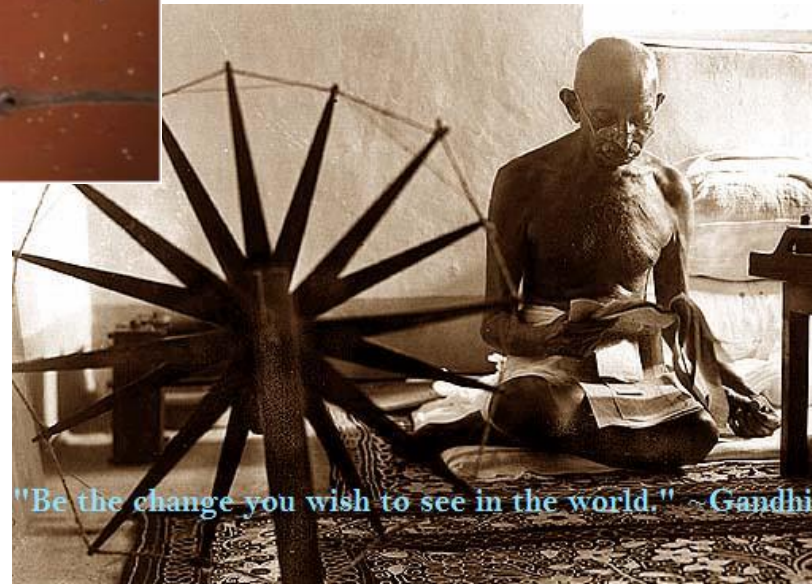**From accountability levels above and below?**

- At county level, BH system partners with other social systems with opportunities to support programmatic and financial integration of SDOH into whole person health
- Effective clinical and quality management can produce re-investment funds to expand, develop services and supports to meet needs of local communities
- Alignment with the state around ASAM criteria, monitoring, expectations
- Exchange of information between MH and SUD providers and MBHO; state regulations limits SUD information shared; providers receive mixed messages

UPMC | COMMUNITY CARE
Behavioral Health Organization

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# Hill Country Health and Wellness Center

Tammy Allan, LCSW
BH Director, Hill Country, CA

*Provider Perspective*

# Hill Country Health and Wellness Center

*Provider Perspective*

Started as frontier clinic in far northern CA; opened in 1985 by a small group of friends, FQHC status since 2005

Whole person care approach from the very beginning

Grass roots energy and effort still exists, fueled by social work and nursing ethics

Three fully integrated (BHI) clinic sites, rural and small city, with billable and non-billable services; integration includes on-demand access to behavioral health consultants, case managers, recovery coaches and rapid access to psychiatry

Co-located specialty BH, multiple complex care programs, BH in frontier schools; 365 urgent mental health and addiction resource center (walk-in); 365 mobile crisis outreach team; wellness center and teen center; housing

Medicaid, Medicare, private insurance, MHSA, and patchwork of grants and partnerships – all with own metrics and desired outcomes



From infancy through old age, we are partners in health care, understanding that health is a wonderful and complex state of being that is affected by body, mind, and spirit.
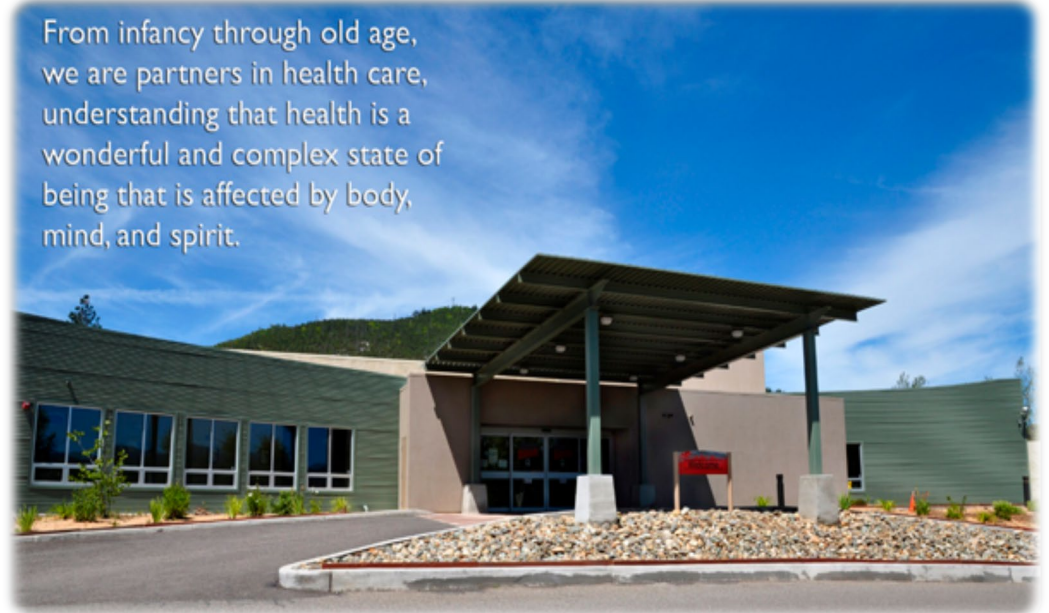
*Our Mission:*
*With kindness, Hill Country Health and Wellness Center works in partnership with our patients and community, providing to everyone the health care services, education and support needed to live whole, healthy and satisfying lives.*

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# Reflection on BH Quality Framework

*Provider Perspective*

1.  **How does this Framework resonate given my role/responsibility in health system?**

    - **Many positive changes in health care policy over past two decades** have enabled major breakthroughs for BH in the real world, with abundant opportunities for innovation and improvement.

    - **Current quality measurement strategies need improvement**; facilities rely heavily on *program-specific metrics* and *non-standardized quality measures*. These are not transferable and are often viewed as minimally useful by providers.

    - **Strain exists as facilities rely on multiple funding streams** to provide appropriate and critical services and there are *unique reporting requirements* for each funding source. This becomes absurdly complicated, burdensome and stymies innovation and quality care.

    - **Excessive reporting and documentation demands become demoralizing.** Whole Person approaches are effective and rewarding, but also demanding and often heart wrenching. When you have limited time to help turn a tragedy into a triumph, demands (e.g., data collection) that impede direct work may be resisted.

# Reflection on BH Quality Framework

*Provider Perspective*

2.  **What is *missing* from the Framework?**

    • **Integrated BH care model and SDOH are still new concepts** in most settings and some systems are more ambivalent about change than others.  The combination of mental health care and addiction care under one umbrella is still in infancy in many places.  Increased promotion at macro and meso levels may be influential.

    • **Investments in infrastructure and training are necessary**.  Behavioral Health electronic health records systems lag behind health care for purposes of data mining.  Additionally, most health care EHR systems do not integrate behavioral health well and do not address SDOH. Funds to upgrade or modify current EHR systems.

    • **Protection of certain health information makes collaborative care more challenging** and causes great variation in how BHI is implemented.  This has been and will continue to be a complicated hurdle.

# Actions Re: Social Determinants of Health & Equity

*Provider Perspective*

- Provide **training** to all staff regarding **Social Determinants of Health, ACEs, trauma-informed care, mental-health informed care, and addiction-informed care**.  It is important to understand what motivates behavior and affects judgment, our own and others'

- **Use EHR to identify and outreach to vulnerable populations** based upon socioeconomic status, household composition, minority status, housing type, access to transportation, food, etc

- **Include SDOH-related risk factors** in primary health and specialty care assessments and treatment/care plans.  (Comprehensive psychosocial assessments have been a standard part of mental health evaluations, but these have been increasingly substituted with more data friendly screening tools, which often do not elicit sufficient information regarding social and environmental variables)

# Consumer Advocate

*Consumer Perspective*



Brianne Masselli, Consumer Advocate

**Role in healthcare system:** A consumer advocate

**Role of Quality Measures in Efforts:** From consumer perspective—quality measures should assess products, processes, and outcomes that are co-designed by consumers with lived-experience.

# Reflection on Behavioral Health Quality Framework

*Consumer Perspective*

**Engagement**
- Impact of trauma
- Acknowledgement of illness
- Consent & buy-in

**Access**
- Low barrier
- Co-location
- Right time & right fit

**Quality**
- Defining quality & measures
- User/patient experience
- Hopefulness, self-determination, well-being, social connectedness, and autonomy

# Reflection on Behavioral Health Quality Framework

*Consumer Perspective*

**Levels of Engagement**: Direct Care, Organizational, and Policy

**Continuum of Engagement**: Consultation, Involvement, Partnership, and Shared Decision Making

**Experience-Based Co-Design:** Discrete products, care process, or structural outcomes, and ultimately leading to improved quality of care.

**Example:** Youth engagement in selecting Evidence Based Practices

Andy Reynolds, *Assistant VP, Communications & External Relations, NCQA*

*Moderated Panel Discussion & Audience Questions*

**PLEASE SUBMIT YOUR QUESTIONS IN THE Q&A WINDOW**

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