Behavioral Health Performance & Clinical Quality Measures

May 28, 2019
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About NYeC

• New York eHealth Collaborative (NYeC, pronounced “nice”) is a non-profit organization, working in partnership with the New York State Department of Health as the designated entity to improve healthcare through health information exchange (HIE) across the state. NYeC leads the advancement of the Statewide Health Information Network for New York (SHIN-NY), which connects seven regional networks, or Qualified Entities (QEs), allowing participating healthcare professionals, with patient consent, to quickly access electronic health information and securely exchange data with any other participant in the state.

• Health Care Advisory Professional Services (HAPs) team provides technical assistance to stakeholders in implementing technologies and processes to improve healthcare delivery in New York State.
Opportunities for PAT Movement

• TCPI Change Package – 2.4. Optimal Use of Health Information Technology (HIT)
  • Innovate for access (PAT Milestone 17)

• Other PAT Milestones affected by this work
  • Share information through technology (PAT Milestone 10)
  • Use technology supporting evidence (PAT Milestone 1)
  • Use technology for partnerships (PAT milestone 9)
  • Drive efficiency through technology (PAT Milestone 1, Milestone 18, Milestone 22)
In our webinar series to date we have learned about:

- how the usage of Health IT and Electronic Health Records (EHR) have been shown to improve care in a behavioral health setting
- how an EHR can be leveraged in healthcare and help us to understand our performance and achieve integration of services
- optimization of specific patient workflows and processes on an EHR at an organization enables the capture of that information and reporting on that data
- utilizing EHR dashboards lets an organization see changes in their quality measures and where there are opportunities for improvement

In this session we will focus on these Behavioral Health performance measures, and we welcome Dr. Thomas Smith, CMIO of NYS OMH, who helped develop the set of behavioral health measures that is in use today. Through his talk we expect to better understand the derivation of these measures, and how they are representative of your organization’s performance.
Behavioral Health Performance and Clinical Quality Measures

Thomas E. Smith, M.D.
Chief Medical Officer, NYS Office of Mental Health
Special Lecturer, Columbia University Department of Psychiatry
Takeaways from this Webinar

• Understand why it is important to measure processes and outcomes;
• Comprehend which measures are used to assess quality of health care (patient experience, cost, structure, process, and outcomes);
• Appreciate which behavioral health measure sets are used in New York State and the strengths and weaknesses of these measure sets;
• Recognize the relationship between measuring quality and how that relates to value-based payment arrangements; and
• Comprehend how an agency creates and manages their value proposition as relates to performance measures as part of a larger system, and in their relationship with payers.
Why Do We Measure Quality and Performance?

1. Research and monitor systems, providers, and populations

2. Internal Quality Improvement
   a. To support point-of-care decision making
   b. For provider continuous quality improvement projects
   c. Managed care organization performance improvement

3. Accountability
   a. Public reporting
   b. Value-based payment
Accountability: Initial Studies of Financial Incentives for Quality in Primary Care, 1990-2005

1. Large primary care practices

2. Bonus payments for hitting targets related to immunizations, cancer screening, HbA1c monitoring in diabetics, and tobacco cessation education.

3. Positive but modest effects on quality of care for some primary outcome measures.¹-³ Multiple studies found no effect on quality of care.

4. Reasons for lack of consistent robust effects of P4P:
   a. Selection bias because programs were voluntary
   b. Incentives were low (under 5% of capitated rates)
   c. Volume of individuals in arrangement was often low for providers
   d. Confusion about paying for performance vs. paying for improvement
   e. Intrinsic vs. extrinsic motivation

¹Rosenthal et al, Early Experience With Pay-for-Performance From Concept to Practice, JAMA 2005; 294:1788-1793
³Scott et al, The effect of financial incentives on the quality of health care provided by primary care physicians (Review), Cochrane Database of Systematic Reviews 2011; Issue 9, Art. No.: CD008451
Health Care Spending as a Percentage of GDP, 1980-2013

- US (17.1%)
- FR (11.6%)
- SWE (11.5%)
- GER (11.2%)
- NETH (11.1%)
- SWIZ (11.1%)
- DEN (11.1%)
- NZ (11.0%)
- CAN (10.7%)
- JAP (10.2%)
- NOR (9.4%)
- AUS (9.4%)*
- UK (8.8%)

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

*Source: OECD Health Data 2015.
But U.S. Health Care Outcomes are Average at Best
## Comparing Health Care Quality and Spending Indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
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<td><strong>Health Expenditures/Capita, 2011</strong></td>
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<td>$4,522</td>
<td>$4,118</td>
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<td>$5,643</td>
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Notes: * Includes ties. ** Expenditures shown in US PPP (purchasing power parity); Australian $ data are from 2010.

Leading to Focus on Quality of Health Care


The First National Hospital Quality Reporting Programs

- **2002 Hospital Quality Alliance**: American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges launched the **Hospital Quality Alliance**, a national public–private collaboration to encourage hospitals to collect and report quality data.

- CMS linked participation in the program to the annual Medicare payment updates; participating hospitals reported data on at least 10 quality measures.

- **2003 CMS Premier Hospital Quality Incentive Demonstration**: 26 hospitals used quality-benchmarking database in a multi-year pay-for-performance program with 33 quality measures.
Federal Government Ramps up Focus on Quality

- **2005 Deficit Reduction Act**: Congress requires CMS to develop a plan for hospital “value based purchasing” by 2009
- **2008: Mental Health Parity and Addiction Equity Act** (MHPAEA)
- **2009: HITECH Act** for Health Information Technology for Economic and Clinical Health
- **2010: Affordable Care Act** required DHHS to “establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.”
Federal Programs Resulting from Legislation

- Key programs authorized by legislation:
  - Pay-for-Value programs for hospitals and physicians
  - Physician and Hospital Quality Reporting Systems (pay for reporting)
  - Value-based modifier
- Bundled payments
- Meaningful use for Electronic Health Records (EHRs)
- Accountable Care Organizations (ACOs):
  - 2012: Medicare Shared Savings and Pioneer Programs
  - 2017: Shared Savings Tracks 1, 2, or 3
  - Up to 90% of all Medicare fee-for-service payments tied to quality or value by 2018
Accountable Care Model

Effect of adjusting the target budget on the amount of shared savings

$ per bundle or member

Adjusted target budget
Baseline
Actual Performance

Amount of Shared Savings With Adjusted
Medicare Accountable Care Organizations

480 Shared Savings Program ACOs in 50 states (plus Washington, D.C. & Puerto Rico) are providing care to 9.0 million beneficiaries in 2017.

Number of ACOs in the area.
NOTE: This area may cover organizations serving beneficiaries across multiple states.
ACOs and Behavioral Health

• 2014: 84% of ACOs had behavioral health in their contract but only 14% had integrated behavioral health into primary care.

• Pioneer ACOs decreased inpatient mental health spending but did not improve outpatient and emergency department utilization and spending, readmissions, or continuity of care.


Realizing the Impact of Behavioral Health Conditions on Health Care Costs and Outcomes

Ten medical conditions with the highest estimated spending in 2013

- Mental disorders
- Heart conditions
- Trauma
- Cancer
- Pulmonary conditions
- Osteoarthritis
- Normal birth
- Diabetes
- Kidney disease
- Hypertension

New York State: a disproportionate amount of total cost of care and hospital visits can be attributed to the BH population

**Overview**

- Medicaid members diagnosed with BH account for **20.9** percent of the overall Medicaid population in NYS
- The average length of stay (LOS) per admission for BH Medicaid users is **30** percent longer than the overall Medicaid population's LOS
- Per member per month (PMPM) costs for Medicaid Members with BH diagnosis is **2.6** times higher than the overall Medicaid population

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**Medicaid members diagnosed with BH**

- Medicaid members diagnosed with BH account for 32% of Medicaid Primary Care Physicians (PCP) visits
  - Total PCP Visits from Medicaid Members: **17.24 million**
  - Medicaid members diagnosed with BH: **5.51 million**

- Medicaid members diagnosed with BH account for 45.1% of all ED Visits
  - Total ED visits from Medicaid Members: **3.14 million**
  - Medicaid members diagnosed with BH: **1.42 million**

- Medicaid members diagnosed with BH account for 60% of the total cost of care
  - Total Medicaid Cost of Care: **$48.05 billion**
  - Medicaid members diagnosed with BH: **$28.82 billion**

- Medicaid members diagnosed with BH account for 53.5% of admissions
  - Total Medicaid Admissions: **1.09 million**
  - Medicaid members diagnosed with BH: **0.58 million**

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ACOs and Behavioral Health

2016 survey of 69 Medicare ACOs: 43 had a behavioral health initiative (integration, co-location, care coordination, embedded social work, or improvements in the behavioral health referral network)\(^1\)

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Behavioral Health (BH) Performance Measures
<table>
<thead>
<tr>
<th>Measure</th>
<th>State Category</th>
<th>Classification</th>
<th>BH Category</th>
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<tbody>
<tr>
<td>Preventive Care and Screening: Screening for Clinical Depression and</td>
<td>1</td>
<td>P4R</td>
<td>Depression &amp; Anxiety</td>
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<tr>
<td>Follow-Up Plan</td>
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<td>Antidepressant Medication Management - Effective Acute Phase</td>
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<td>Depression &amp; Anxiety</td>
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<tr>
<td>Treatment &amp; Effective Continuation Phase Treatment</td>
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</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation</td>
<td>1</td>
<td>P4P</td>
<td>SUD</td>
</tr>
<tr>
<td>Intervention*</td>
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<tr>
<td>Diabetes Screening for People With Schizophrenia or Bipolar Disorder</td>
<td>1</td>
<td>P4P</td>
<td>Bipolar</td>
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<tr>
<td>Who Are Using Antipsychotic Medications*</td>
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<td>Initiation and Engagement of Alcohol and other Drug Abuse Dependence</td>
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<td>P4P</td>
<td>SUD</td>
</tr>
<tr>
<td>Treatment (IET)*</td>
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<tr>
<td>Continuity of Care from Inpatient Detox to Lower Level of Care*</td>
<td>2</td>
<td>P4R</td>
<td>SUD</td>
</tr>
<tr>
<td>Continuity of Care from Inpatient Rehabilitation for Alcohol and Other</td>
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<td>P4P</td>
<td>SUD</td>
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<td>Drug Abuse or Dependence Treatment to Lower Level of Care*</td>
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<td>Follow-Up After Emergency Department Visit for Alcohol and Other Drug</td>
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<td>SUD</td>
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<tr>
<td>Dependence Ages 13+</td>
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<tr>
<td>Follow-Up After Emergency Department Visit for Mental Illness Ages 6+</td>
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<td>P4R</td>
<td>Depression &amp; Anxiety</td>
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</tbody>
</table>

* Measure overlaps with HARP Measure Set
## 2018 Behavioral Health Measures Included in the HARP Quality Measure Measure Set

<table>
<thead>
<tr>
<th>Measure</th>
<th>State Category</th>
<th>Classification</th>
<th>BH Category</th>
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<tr>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
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<td>Follow-up After Hospitalization for Mental Illness (within 7 and 30 days)</td>
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<td>SUD</td>
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<tr>
<td>Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</td>
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<td>Continuity of Care from Inpatient Detox to Lower Level of Care</td>
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<td>P4P</td>
<td>SUD</td>
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<tr>
<td>Continuity of Care from Inpatient Rehabilitation for Alcohol and Other Drug Abuse or Dependence Treatment to Lower Level of Care</td>
<td>1</td>
<td>P4P</td>
<td>SUD</td>
</tr>
<tr>
<td>Follow-Up After Emergency Department Visit for Alcohol or Other Drug Dependence</td>
<td>1</td>
<td>P4P</td>
<td>SUD</td>
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<tr>
<td>Follow-Up After Emergency Department Visit for Mental Illness</td>
<td>1</td>
<td>P4P</td>
<td>Depression &amp; Anxiety</td>
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<td>Continuing Engagement in Treatment (CET) Alcohol and Other Drug Dependence</td>
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<td>Initiation of Pharmacotherapy upon New Episode of Opioid Dependence</td>
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<tr>
<td>Initiation of Pharmacotherapy upon New Episode of Alcohol Abuse or Dependence</td>
<td>2</td>
<td>P4R</td>
<td>SUD</td>
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</table>

* Measure overlaps with Tobacco use measure in IPC Measure Set*
Current State of Behavioral Health Performance (BH) Measurement

• Few endorsed measures of key BH processes and outcomes such as:
  o Control of core symptoms of psychiatric illnesses
  o Engagement and retention in care
  o Establishment of family/community supports
  o Access to recovery-oriented services
  o Personal and public safety

• Many currently endorsed measures address quality of care for medical co-morbidities—diabetes or cardiovascular disease—seen in a minority of individuals with BH conditions

• Other than depression, few measures capture processes or outcomes directly related to care for the BH condition
Moving Forward

• Efforts develop and implement new BH performance/quality measures
  o NYS VBP Clinical Advisory Groups (CAGs)
  o NYS OMH BH Integrated Performance Measurement Center
  o APA Registry: PsychPRO

• Key issues
  o New measures of functioning and recovery
  o Measuring processes vs. outcomes
  o Stratifying existing measures
  o Measuring integrated care
  o E-measures
NYS Office of Mental Health/Columbia University BH Integrated Performance Measurement Center Priority Focus Areas

1. **Data Infrastructure**: Use information from EHRs, Qualified Entities, and other administrative databases to support BH performance measurement.

2. **Functioning and recovery**: Develop and test measures of functioning and recovery.

3. **Integrated Care**: Identify measurement strategies that best incentivize integrated (medical - behavioral health) care.
## 2018 Behavioral Health Measures Included in the HARP Quality Measure Set (cont.)

<table>
<thead>
<tr>
<th>Measure</th>
<th>State Category</th>
<th>Classification</th>
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<tbody>
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<td>Maintenance of Stable or Improved Housing Status</td>
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<td>Percentage of Members Enrolled in a Health Home</td>
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<td>Use of Pharmacotherapy for Alcohol Abuse or Dependence</td>
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<td>Use of Pharmacotherapy for Opioid Dependence</td>
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<td>P4R</td>
<td>SUD</td>
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Functional Outcomes

Individuals with SMI have low rates of participation in work/education activities

Current Employment Status

N=16,103*

- Employed (N=994): 6%
- Unemployed, seeking employment (N=3,199): 20%
- Unemployed, not seeking employment (N=11,910): 74%

* Data were not available for 18 individuals
Housing Indicators for SMI in NYS Medicaid Program

Number and Percentage Who Live Alone or Were Homeless
N=15,988*

- Live Alone (N=6,096): 38%
- Homeless (shelter or street) (N=974): 6%

* Data were not available for 133 individuals
Criminal Justice Indicators for SMI in NYS Medicaid Program

Number and Percentage Who Were Arrested or Incarcerated
N=16,107*

- Arrested with charges (N=7,703)
  - Within the past year: 6%
  - More than 1 year ago: 42%

- Incarcerated (jail or prison with overnight stay) (N=6,816)
  - Within the past year: 4%
  - More than 1 year ago: 38%

* Data were not available for 14 individuals
Life Events within the Last Year and More than One Year Ago

N=16,097*

- Lived in war zone or area of violent conflict... 6% Total, 31% More than 1 year ago
- Victim of sexual assault or abuse 6% Total, 27% More than 1 year ago
- Victim of crime (e.g. robbery, exclude assault) 6% Total, 29% More than 1 year ago
- Review hearing (e.g. forensic, certification, capacity...) 6% Total, 40% More than 1 year ago
- Victim of physical assault or abuse 3% Total, 42% More than 1 year ago
- Parental abuse of alcohol or drugs 3% Total, 29% More than 1 year ago
- Major loss of income or serious economic hardship... 3% Total, 40% More than 1 year ago
- Immigration, including refuge status 3% Total, 48% More than 1 year ago
- Victim of emotional abuse 3% Total, 44% More than 1 year ago
- Failed or dropped out of education 3% Total, 53% More than 1 year ago
- Distressed about health of another person 3% Total, 30% More than 1 year ago
- Witnessed severe accident, disaster, terrorism,... 3% Total, 39% More than 1 year ago
- Death of a close family member or friend 19% Total, 39% More than 1 year ago
- Child custody issues 19% Total, 39% More than 1 year ago
- Conflict-laden or severed relationship (include divorce) 19% Total, 39% More than 1 year ago
- Serious accident or physical impairment 19% Total, 39% More than 1 year ago

* Data were not available for 24 individuals
Perception of Care

Most individuals with SMI members feel involved in their treatment

**Percentage Responding Usually or Always**

n=168

<table>
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<tr>
<th>Question</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>How often did BH providers listen carefully to you?</td>
<td>85%</td>
</tr>
<tr>
<td>How often were you involved as much as you wanted in your treatment?</td>
<td>83%</td>
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</table>
Perception of Care
But many feel unable to set priorities and pursue interests

Percentage Responding Usually or Always
n=172

- I am able to set my own goals in life: 65%
- I am able to do things that I want to do: 62%
>40,000 individuals commit suicide in the United States each year; frequency of suicides in populations of patients attributed to VBP arrangements will be too low to allow for opportunities to demonstrate improvement.

Ongoing public debate about whether having a serious mental illness increases the risk of committing violent acts but these are also extremely rare events.

Calculating and publishing violence rates would reinforce stigmas and false stereotypes.

It is clear that individuals with behavioral health conditions are less likely to be suicidal or involved in violent episodes when they are engaged in care and/or adhering to prescribed medications.

Process measures of engagement and retention in care should therefore be employed until more relevant outcome measures are available. Examples:

- Frequency of visits with community-based behavioral health providers following discharge from an inpatient program or following identification of a new substance use disorder
- Completion of risk assessments
- Medication adherence
Conclusions/Next Steps for Clinicians and BH Clinics
Efforts to Promote Value and Efficiency in Health Care are Here to Stay
What Can You Do?

• Understand where your practice or agency fits in the larger system of care
• Know the oversight and payment authorities’ priorities for the system of care
• Develop your **Value Proposition:**
  - What is your expertise?
  - Align some (not all!) of your agency’s priorities and strengths with the system priorities
  - Implement tracking and reporting of key agency practices that align with the system priorities
  - Have summary reports ready for external audiences—brag about what you do well!
Examples of System-Level Priorities in VBP Arrangements

1. **Shift the locus of care:** Improve care transitions; offer prevention, early intervention, and crisis services; decrease inpatient admission and ED visit rates.

2. **Promote Integrated Care:** strategies to incentivize integrated (medical - behavioral health) care.

3. **Improve functioning and recovery:** Increase the numbers of individuals returning to work or school; decrease criminal justice contacts; promote individuals’ pathways to recovery.
What Should a Community-Based Organization Measure?

1. **Shift the locus of care:** Don’t need to measure readmission rates, but consider tracking adherence to your agency’s relevant Policies & Procedures, e.g.:
   a. Check-ins with all clients within 7 days of discharge from hospital or emergency department to check symptoms, reconcile medications, and review aftercare appointments
   b. Outreach to clients who fail to attend visits
   c. Enrollment in a Health Home, and regular communications with HH Care Manager
What Should a Psychiatrist or Community-Based Organization Measure?

1. **Shift the locus of care**

2. **Promote Integrated Care:** Don’t have to measure blood sugar and cholesterol, but consider tracking:
   a. Attendance at annual primary care appointments/wellness appointments
   b. Monthly medication reconciliation for both psychotropic and general medical medications
   c. Regular reviews (e.g., monthly or more when in crisis) of safety plans for individuals with depression or history of suicidal thinking/behavior
What Should a Psychiatrist or Community-Based Organization Measure?

1. Shift the locus of care
2. Promote Integrated Care
3. Improve functioning and recovery: Identify key elements of your vision/approach to care and measure adherence to related Policies & Procedures. Examples include rates of clients with:
   a. Complete, comprehensive Plans of Care
   b. Personalized recovery goals
   c. Housing stability
   d. Involvement with justice system
Summary

• Measurement-based care and quality monitoring are increasingly important elements of agency and practitioner practices

• Value-based payment models will replace fee-for-service

• BH performance measurement has lagged but is rapidly catching up

• Get comfortable with measurement strategies and programs

• Advocate for development and use of measures that matter most to us and our clients
Questions?
Measuring care through the monitoring of behavioral health measures is essential for tracking and reporting performance.

Development and usage of measures that matter most to us and our clients (Advisory Groups).

Behavioral health measures are found in:
- 2018 Integrated Primary Care Quality Measure Set
- 2018 HARP Quality Measure Set
- **13 Behavioral Health Quality Measures - the focus of the CTN**

Ensure that your organization captures these measures through the optimal use of Health Information Technology.

This enables opportunities for PAT movement and PAT movement means positive change, which is our goal.
## Care Transitions Network Clinical Quality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>National Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause 30 Day Readmission Rate Following MH Inpatient Discharge</td>
<td>NYS</td>
</tr>
<tr>
<td>30-MH Readmission</td>
<td>NYS</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness, 7 Days</td>
<td>HEDIS v2016</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness, 30 Days</td>
<td>NQF 1932</td>
</tr>
<tr>
<td>Adherence to Antipsychotic Medications (PDC) for People with Schizophrenia</td>
<td>NQF 1927</td>
</tr>
<tr>
<td>Adherence to Mood Stabilizers for People with Bipolar I Disorder</td>
<td>NQF 004 MU 137v4 PQRS 305</td>
</tr>
<tr>
<td>Use of Antipsychotic Drug Clozapine for Schizophrenia</td>
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# Care Transitions Network
## Clinical Quality Measures

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</tr>
<tr>
<td>Use of Multiple Concurrent Antipsychotics</td>
<td>HEDIS v2016</td>
</tr>
<tr>
<td>Diabetes Screening for People with Schizophrenia or Bipolar I Disorder</td>
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</tr>
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<td></td>
</tr>
<tr>
<td>14-Day Initiation and Engagement of Alcohol and Other Drug (AOD)</td>
<td>NQF 004</td>
</tr>
<tr>
<td>Dependence Treatment</td>
<td>MU 137v4</td>
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Services Provided by NYeC

• HIT Webinar Series
  1. Health IT 101 for Behavioral Health Providers
  2. EHR Optimization & Workflow Redesign for Behavioral Health Providers
  3. Behavioral Health Performance Measures
  4. Quality Improvement and Value Based Care
  5. Patient Access and Use of Patient Portals
  6. Health Information Exchange for Behavioral Health Providers

• Office Hours
• Vendor Workgroups
• RHIO Toolkit
• Learning Management System
Learning Collaborative Opportunities

• **Vendor Workgroup Sessions**
  • Come collaborate with other organizations utilizing your EHR and learn best practices on how to optimize your system
    • Dates:
      • 10e11 – May 29, 2019 2 pm – 3 pm
      • Foothold – May 31, 2019 2 pm – 3 pm
      • Cerner – June 3, 2019 2 pm – 3 pm
      • Netsmart – June 6, 2019 2 pm – 3 pm
      • Accumedic – June 10, 2019 2 pm – 3 pm

• **1:1 Consulting**
  • Receive personalized technical assistance and attention to your Health Information Technology (HIT) needs
    • If interested, please contact the Care Transitions Network via email at CareTransitions@TheNationalCouncil.org to be linked with NYeC’s expert team on how to optimize your HIT
Learning Collaborative Opportunities

• Upcoming Webinars
  • Dates:
    • Webinar #4 – Quality Improvement and Value Based Care: Tuesday, June 18, 2019 from 12 PM – 1 PM
    • Webinar #5 – Patient Access and Use of Patient Portals: Tuesday, July 16, 2019 from 12 PM – 1 PM
    • Webinar #6 – Interoperability and Connecting to the RHIO and Utilizing the SHIN-NY: Tuesday, July 30, 2019 from 12 PM to 1 PM

• Learning Management System Organizations may access the LMS library of resource material by sending an email to CareTransitions@TheNationalCouncil.org
Questions?
Thank you!

www.CareTransitionsNetwork.org
CareTransitions@TheNationalCouncil.org

The project described was supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

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