Restructuring Behavioral Healthcare:

Performance Standards to Promote Good Care at a Reasonable Cost

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I. Principles

Good care is accessible, acceptable, and appropriate.

The goal of good care is good outcomes

Accessible Care

Accessible =

Available to you in your community

Acceptable Care

Acceptable =
Offered in such a manner that you choose to participate

Appropriate Care

Appropriate = Doing the right thing:

- *Evidence based/informed*
- *Individualized*
- *Implemented correctly*
- *Timely*

Good Outcomes

- Recovery, resiliency
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Good Outcomes *(cont.)*

- Disease-specific recovery measures plus "return to good functioning"
- "No bad outcome" can be a proxy for "good outcome"
- Influenced by factors in addition to proximal treatment

Reasonable Cost

- When you don't know what the right amount is, a clue that your spending may be off is if you lead the pack (or bring up the rear)
- Payment systems need to recognize that some people cost more to treat than others and compensate accordingly

Reasonable Cost *(cont.)*

Payment system should:

- Minimize potential for adverse selection
- Create incentives to titrate treatment to insure that costs are reasonable for circumstances at hand (want to avoid incentives to under- or over-treat)

Government's Job Includes Knowing Whether It's Getting Good Value for Taxpayer Dollars

Knowing whether we are getting good value for our health care dollars requires tracking accessibility, acceptability, appropriateness, outcomes, and cost

Provide Information to Support Clear and Accountable Leadership

- As patients, we want treatments that are the best bets for recovery
- As payers, we want health expenditures to stretch as far as possible, produce good value, and be spent on effective treatments

Hence, it is reasonable to ask administrators at BHOs, MCOs, hospitals, state or local government, or unit chiefs:

- *"How do you insure that your practitioners are using best practices and achieving the desired results?"*

and

- *"How do you know that this is true?"*

II. Performance Monitoring & Measurement

Why we need performance monitoring:

- When squeezed, the toothpaste doesn't always come out of the front of the tube
- Effective monitoring improves care and reduces waste (allows identification and elimination of those holes in the sides of the tube)

What Makes a Good Measure?

- Good proxy for concept (=valid measure)
- Creates incentives for good care
- Meaningful to clients, clinicians and other stakeholders
- Straightforward & reliably measured

Goal=Fair Compensation for Complexity

Strategies:

- Risk adjusted case rates so that payment aligns with need
- Incentivize integration of care to address comorbidities
- Offer outlier protection
- Shared risk, shared savings
- Data transparency

III. Examples of Performance Measures Reflecting these Principles

Potential Performance Standards

- Phase I (before risk bearing)

Access and Engagement in Care

Performance expectation:

Individuals who have been ill enough to be hospitalized will be engaged in appropriate follow up services promptly upon discharge.

Access and Engagement in Care *(cont.)*

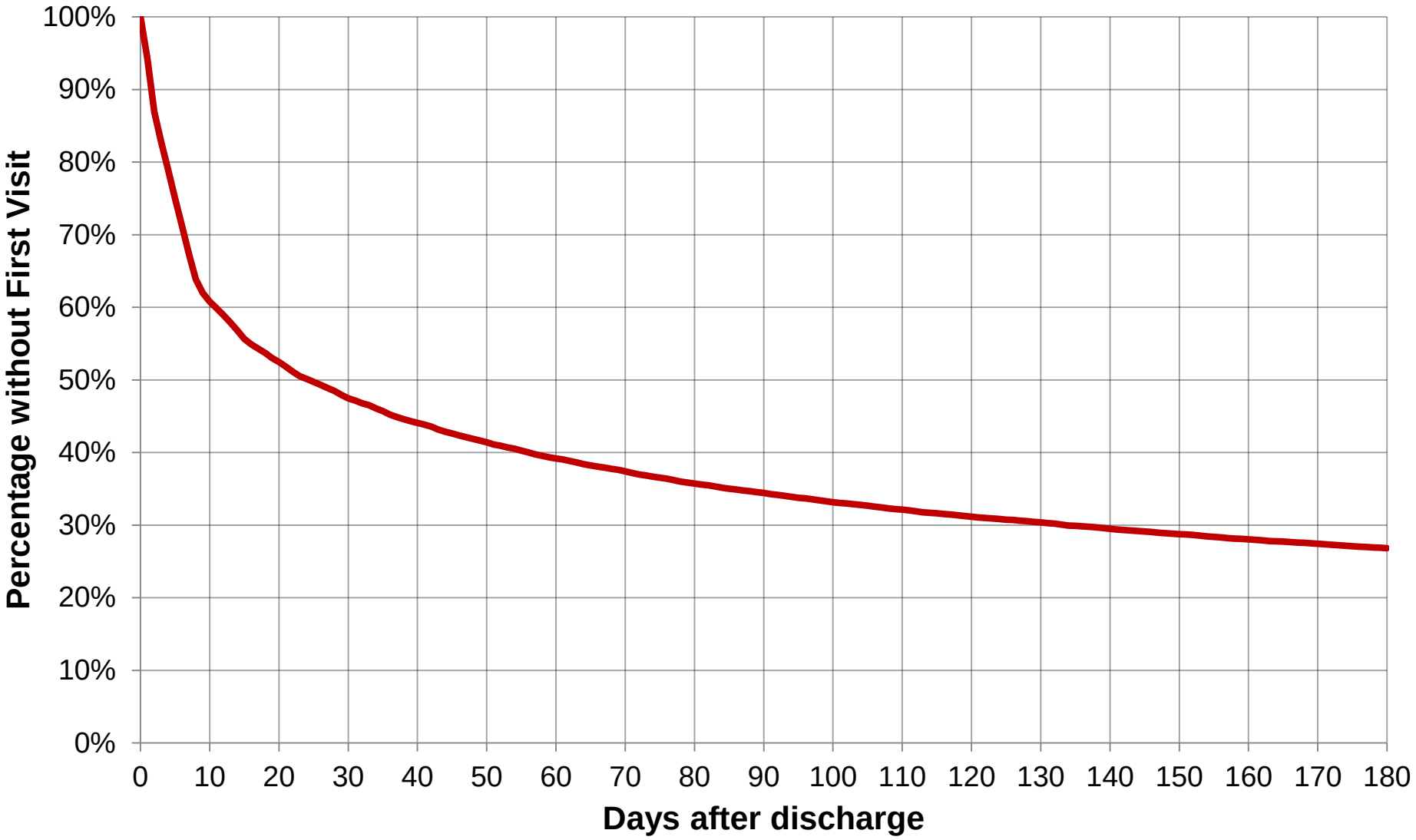
Metrics

1) X% of individuals discharged from a mental health hospitalization will have an outpatient visit within Y days of discharge.
2) X% of individuals discharged from a detox programs will have a visit in a non-crisis service within 30 days of discharge.
3) X% of individuals discharged from inpatient rehab will have a non-crisis visit in a lower level of care within 30 days of discharge.

Time from Discharge from Psychiatric Hospitalization to Outpatient Mental Health Treatment

Statewide - Age 21 and Over (N=25014)

(Includes only individuals with continuous Medicaid eligibility for 180 days post disch



Data Source: NYSOMH Office of Performance Measurement and Evaluation

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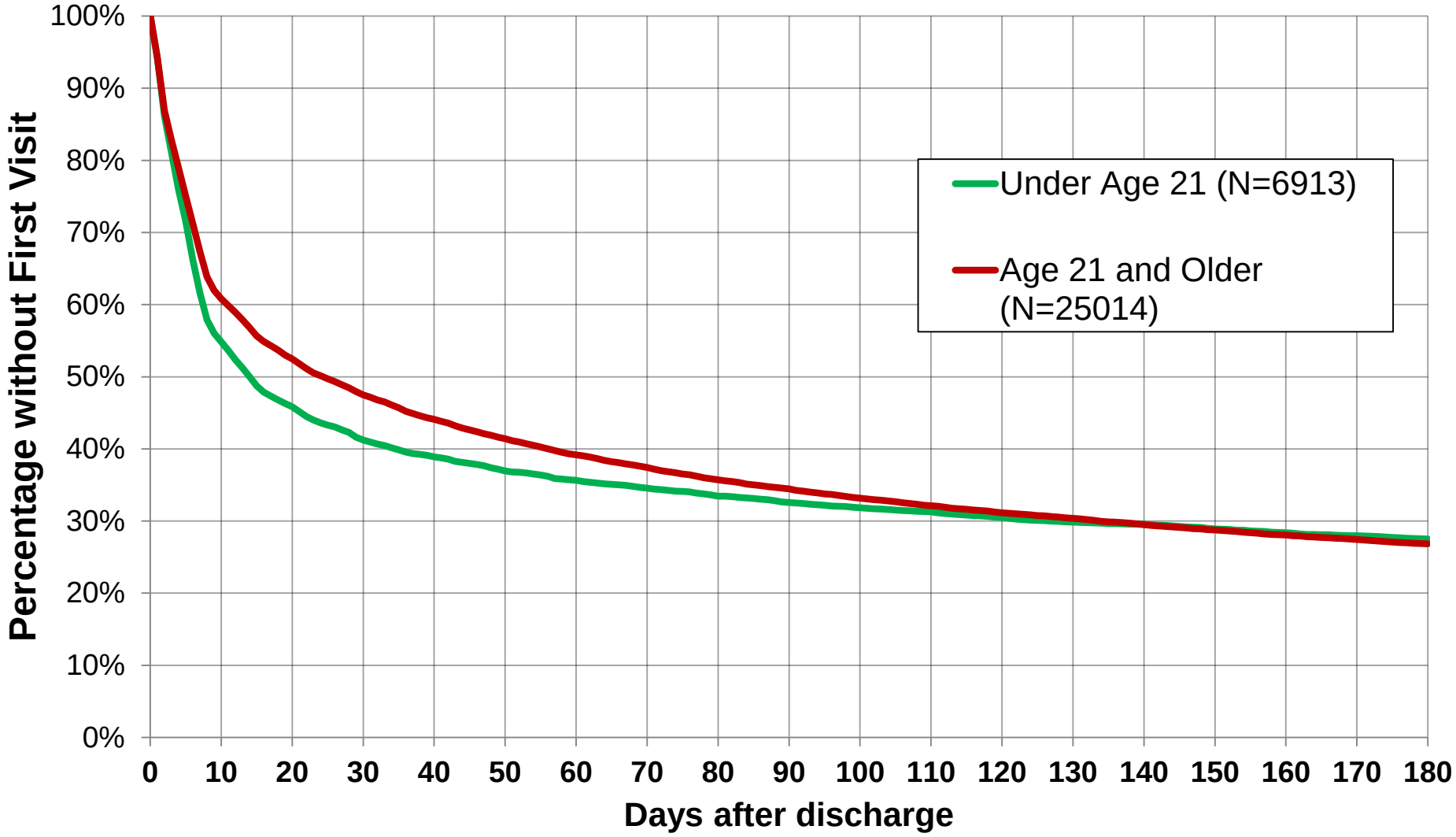


Data Source: NYSOMH Office of Performance Measurement and Evaluation

Access and Engagement in Care *(cont.)*

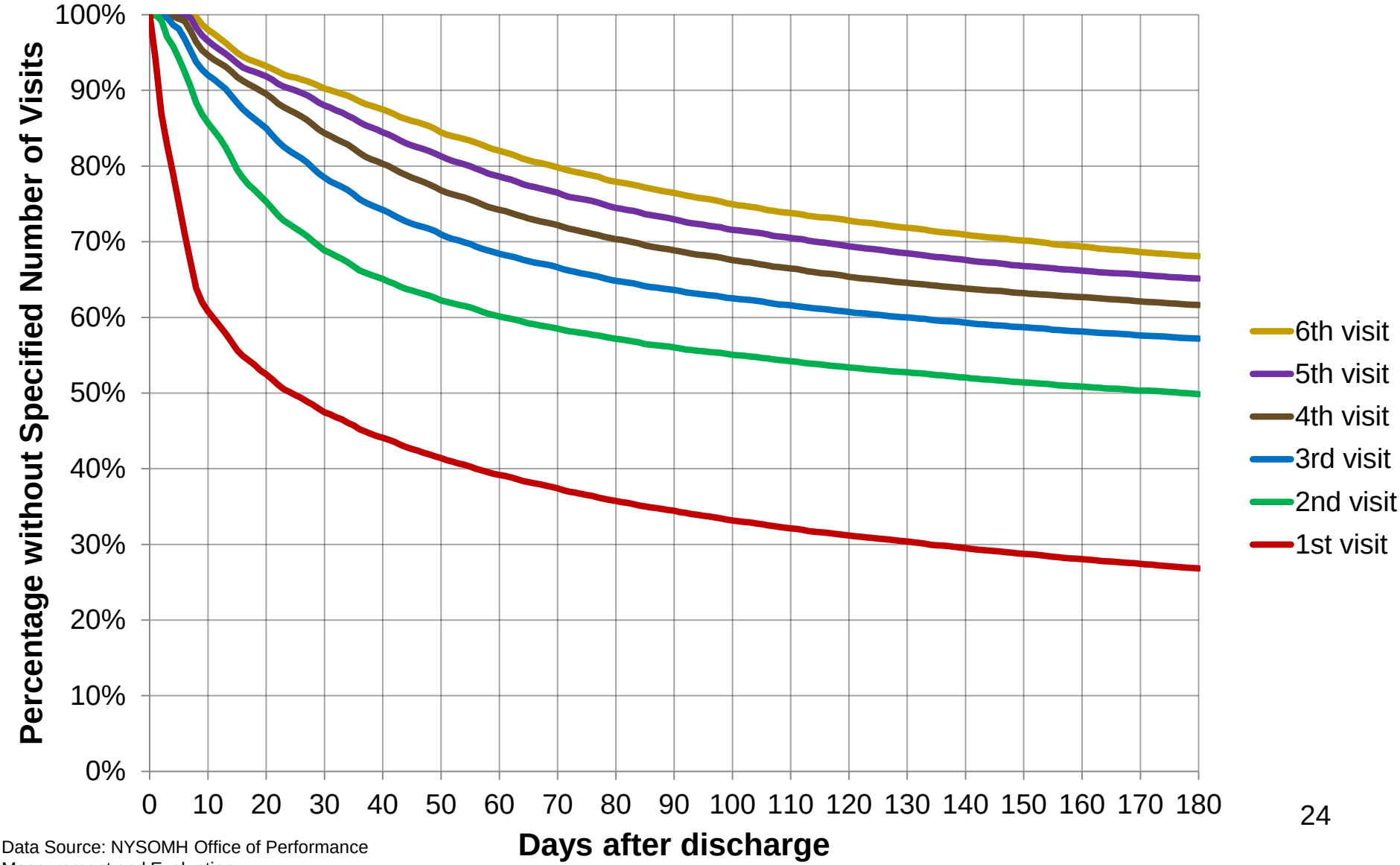
Metrics

4) X% of individuals discharged from a mental health hospitalization have a second outpatient visit within Y days of discharge.
5) X% of patients who have an outpatient visit within 30 days of discharge from detox or inpatient will have a follow-up appointment within Y days of discharge.
6) N% of those discharged complete 6 outpatient visits within Y months

Time from Discharge from Psychiatric Hospitalization to Outpatient Mental Health Treatment (2009)

Same Outpatient Service Provider, Statewide, Age 21 and Older (N=25014)

(Includes only individuals with continuous Med

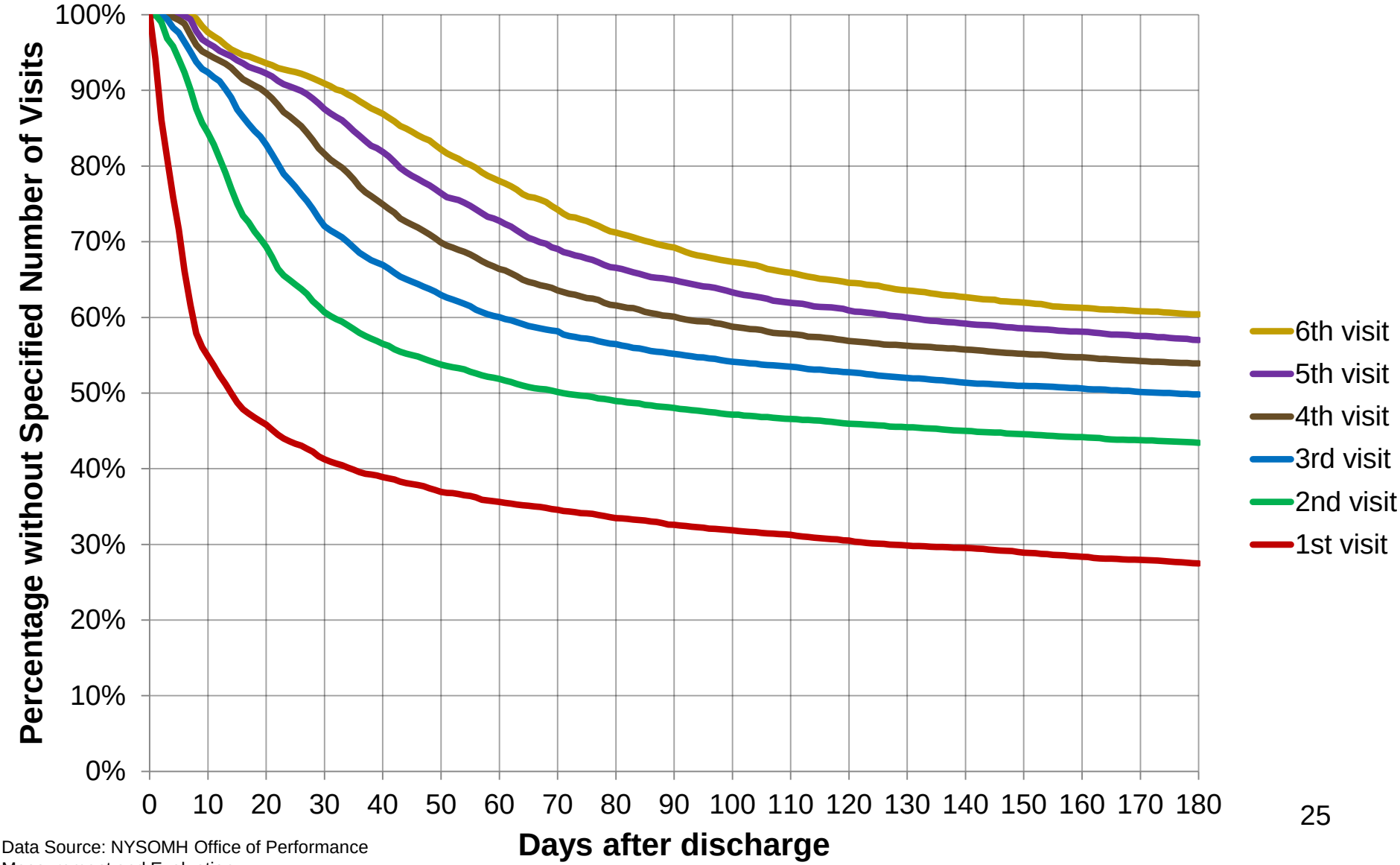


Data Source: NYSOMH Office of Performance Measurement and Evaluation

Time from Discharge from Psychiatric Hospitalization to Outpatient Mental Health Treatment (2009)

Same Outpatient Service Provider, Statewide, Under Age 21 (N=6913)

(Includes only individuals with continuous Medicaid



Data Source: NYSOMH Office of Performance Measurement and Evaluation

Access

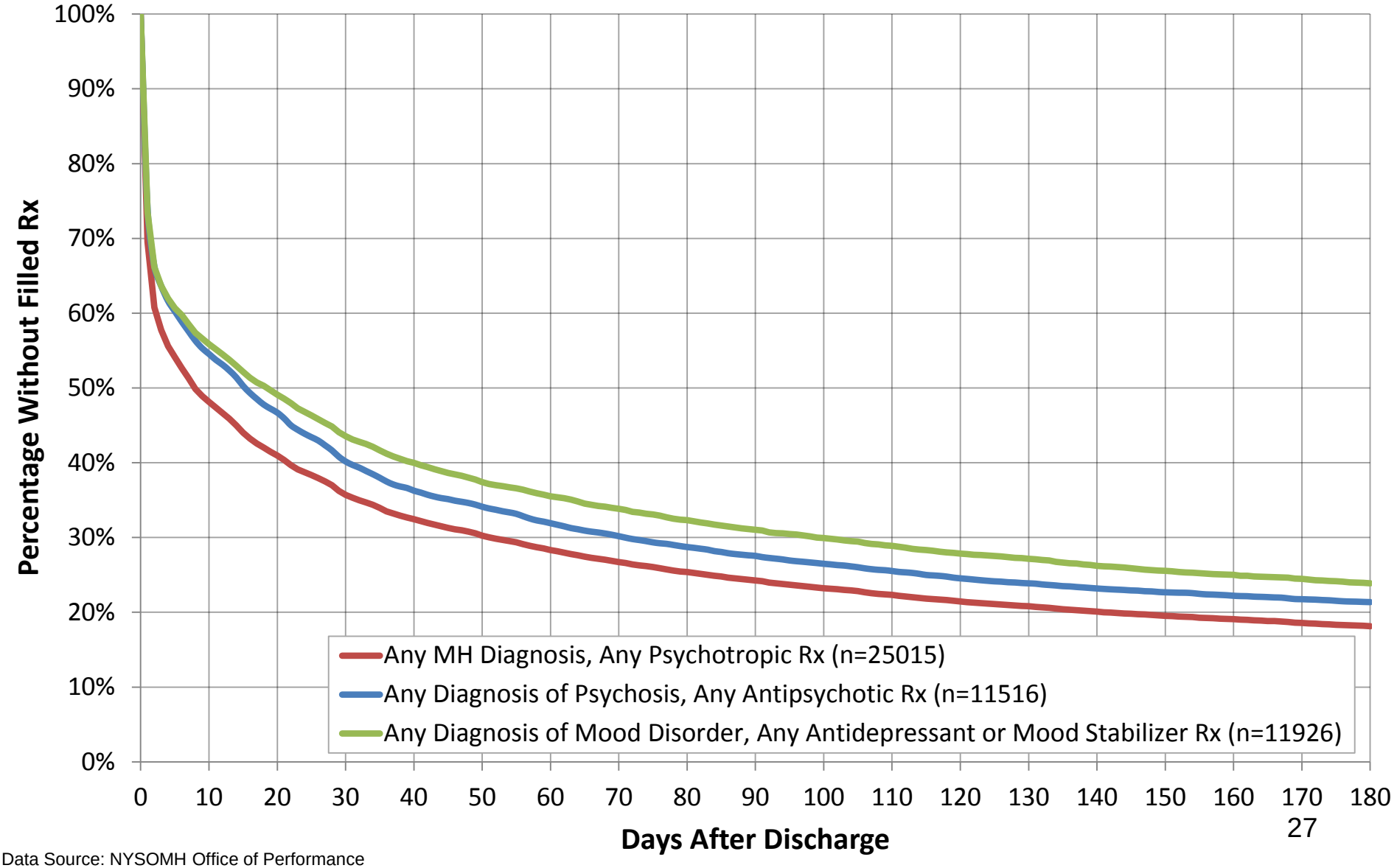
Performance expectation: *Almost all individuals who were ill enough to have had a psychiatric hospitalization should receive pharmacotherapy post discharge.*

Metric

- X% of adults discharged from a mental health hospitalization will fill a psychotropic script within 30 days of discharge and Y% of such adults will refill that prescription or a new psychotropic prescription within 100 days of discharge.

Time from Discharge from Psychiatric Hospitalization to Filling a Psychotropic Prescription (2009)

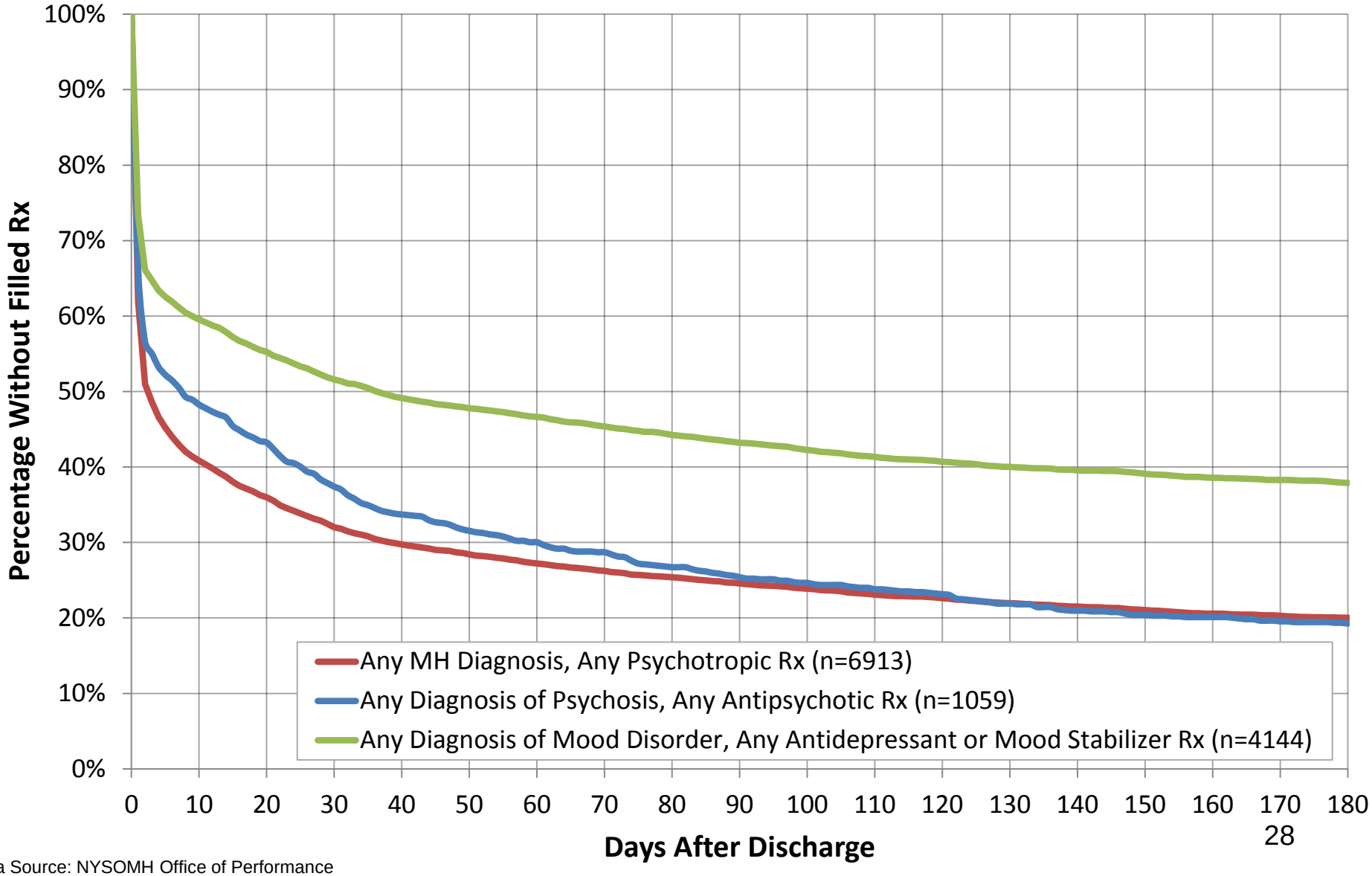
(By Diagnosis and Associated Type of Medication, Age 21 and Older)



Data Source: NYSOMH Office of Performance Measurement and Evaluation

Time from Discharge from Psychiatric Hospitalization to Filling a Psychotropic Prescription (2009)

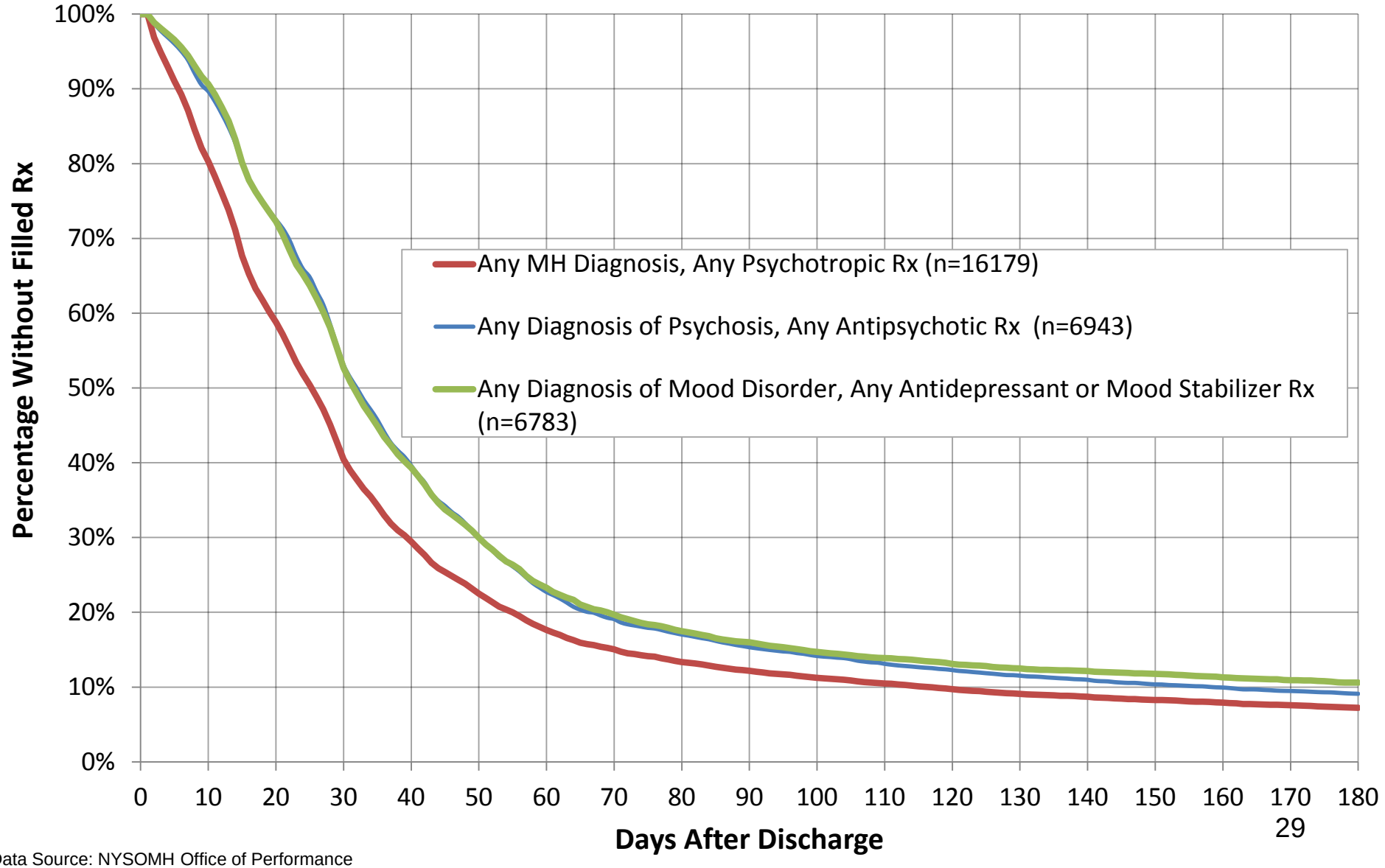
(By Diagnosis and Associated Type of Medication, under Age 21)



Data Source: NYSOMH Office of Performance Measurement and Evaluation

Time from Discharge to Filling 2nd Psychotropic Prescription Where First Rx was Filled within 30 Days of Discharge (2009)

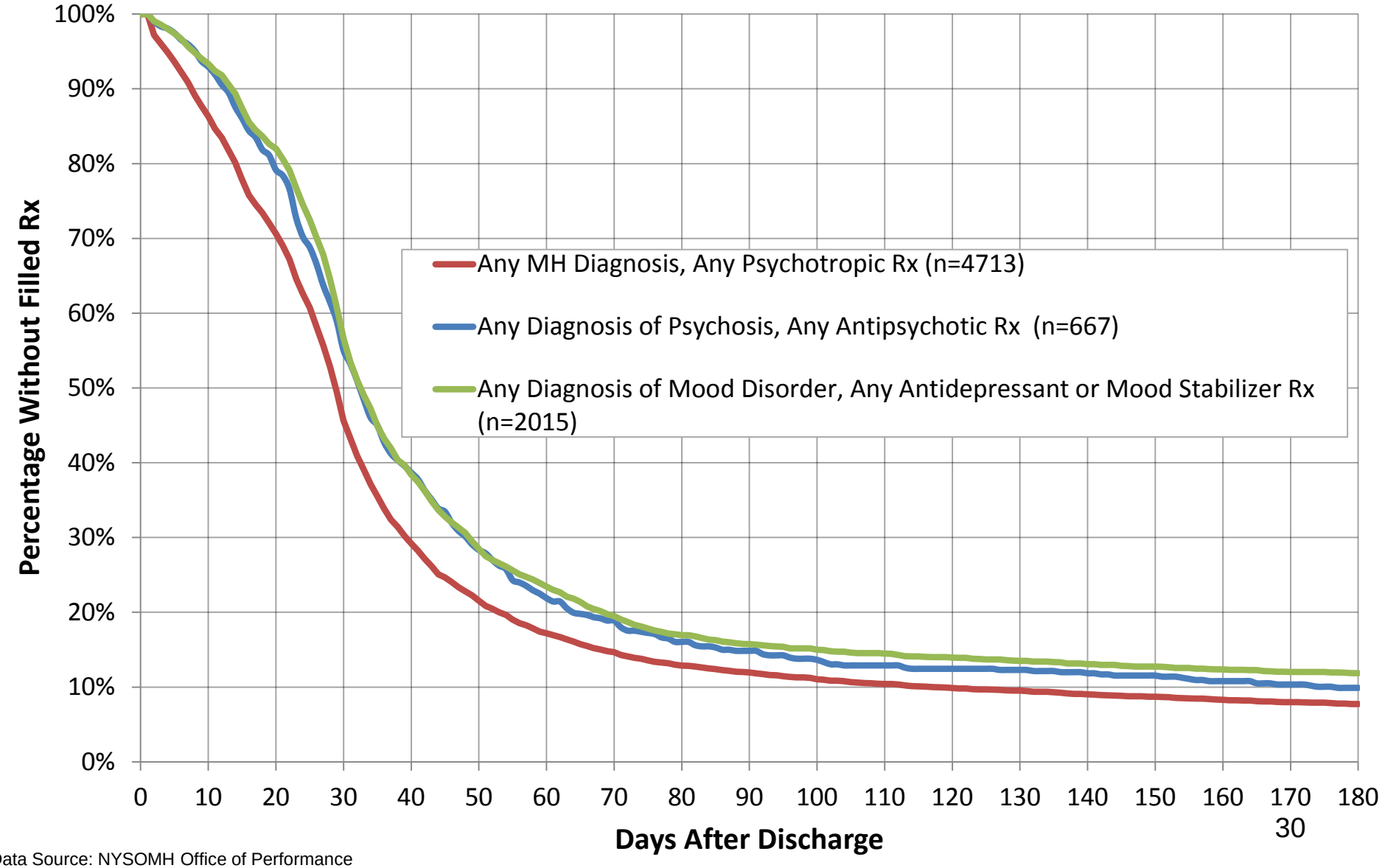
(By Diagnosis and Associated Type of Medication, Age 21 and Older)



Data Source: NYSOMH Office of Performance Measurement and Evaluation

Time from Discharge to Filling 2nd Psychotropic Prescription Where First Rx was Filled within 30 Days of Discharge (2009)

(By Diagnosis and Associated Type of Medication, Age Under 21)



Data Source: NYSOMH Office of Performance Measurement and Evaluation

Access *(cont.)*

Performance expectation:

Access to less costly, community based behavioral health services will be increased as managed care strategies are implemented, while utilization of costly inpatient and ED services will be reduced—but remain available whenever needed.

Access *(cont.)*

Metrics

1) X% of population access primary care.
2) Y% of individuals access outpatient mental health care.
3) Z% of individuals access treatment for alcohol and other drug dependence.
4) Total volume of above services increases by N%.

Metrics *(cont.)*

5) Fewer than X% of individuals utilize only inpatient or emergency room services for mental health treatment (seek to reduce the proportion with this pattern of service use).

6) Total volume of inpatient days/ED visits is reduced by Y%.

Performance expectation: Individuals' treatments are consistent with evidence-based care.

Metrics

1) Fewer than X% of adults will be taking 2 or more antipsychotics concurrently.
2) Fewer than X% of adults taking psychotropic medications will be on 4 or more such medications concurrently.
3) Fewer than Y% of children taking psychotropic medications will be on 3 or more such medications concurrently.

Outcomes

Performance expectation: *Readmissions will decrease.*

Metrics

1) Fewer than X% of individuals discharged from a behavioral health hospitalization will be readmitted to any hospital for behavioral health treatment within Z days of discharge.
2) Readmission within 30 and 90 days of discharge will decrease by X% for individuals with FFS Medicaid and by Y% for individuals at high risk of poor outcomes.

Potential Performance Standards

Phase II (risk and reward sharing)

- All of the above, plus.....

Engagement in Treatment and Continuity of Care

Performance expectation: *Each high need client will have a provider that is accountable for assuring that the client is engaged in appropriate services. Peer outreach and other engagement strategies will be used as needed.*

Metric

- Fewer than N% of individuals with SMI will have patterns of service use suggesting disengagement from appropriate care.

Engagement in Treatment and Continuity of Care *(cont.)*

Performance expectation: *Individuals in need of behavioral health services also will have their physical health needs met.*

Metrics

1) At least X% of individuals with SMI have evidence of a medical home.

Metrics *(cont.)*

2) At least Y% of high-need individuals assigned to a behavioral health home will receive at least XYZ general medical services in a 12-month period (e.g., check up with PCP, lipid panel).
3) Individuals with behavioral health comorbidities will be within N% of the general population with respect to rates of meeting general health performance standards for Health Homes.

Performance expectation: *Health homes will facilitate the provision appropriate behavioral health care to enrollees who enter the criminal justice system as long as they maintain Medicaid eligibility.*

Performance expectation: *BHOs will steer people to clinicians who provide evidence-based talk therapies (e.g., CBT, IPT, DBT), either alone or in combination with psychopharmacology.*

Appropriateness

Performance expectation: *Individuals have access to evidence-based treatments.*

Metrics

1) At least X% of individuals with SMI are served by Assertive Community Treatment Teams.
2) At least Y% of individuals receiving outpatient treatment for mental health or substance abuse treatment will receive treatment from staff trained to treat both mental health and substance use disorders.

Metrics *(cont.)*

3)At least Z% of individuals with a first psychotic episode will receive treatment by regionally based teams specializing in early psychosis who provide evidence based treatments consisting of personalized medication treatment, illness management strategies, education or employment assistance, and other supportive services for participants and their families.

Performance Expectations Measured by EMR or Chart Review

1) Collaborative care will be the standard for mental health care in primary care.
2) Primary care and mental heath care settings will implement annual screening for depression, tobacco use, and alcohol use, with evidence of following up on positive screens.
3) For people with SMI, monitoring of the person's housing status prior to and post discharge from a hospitalization for mental illness or substance use.

Performance Expectations Measured by EMR or Chart Review *(cont.)*

4) Inclusion of family when treating children's mental health problems.
5) When the discharge plan indicates the need for physical health care, the person will receive such care.
6) Face to face contact between Health Home and individuals who are homeless or otherwise unable to respond adequately to telephone based care management.

IV. What Goes Wrong and How to Make Mid-course Corrections

Structure performance expectations to recognize that no one gets everything right the first time.

- Performance measurement and feedback is central to CQI.
  - Uncovering problems is good news
  - Want to see trends in the right direction
- Need capacity to identify and measure problems, interventions, responses to interventions, and implement improvements throughout the system of care.

Look to the Current Landscape When Setting Performance Standards

Devil is in the details:

- Speaks to importance of transparent measurement methodology.
- Uniform measurement algorithms across vendors facilitate comparisons within and across vendors/ regions/ programs/ populations.

- Watch for adverse/unintended consequences and revise standards accordingly.
- Have a Phase I. *Listen. Measure. Learn.*
- Take the next steps.

On the Horizon

Enhanced attention to measuring:

- Housing, employment, recovery
- Percentage of services that are EBPs
- Provision of prevention services
- Suicide prevention activities
- Continuity of treatment for most vulnerable/ high-need populations
- Care coordination across treatment domains
- Monitoring for disparities in access/outcomes

Cautionary Tales to Guide Measurement Selection

- Full capitation invites underuse
- Phantom networks
- Where's the psychiatrist?
- Limits of telephonic care management/ disease management
- Perils of antiquated IT
- Kids are not little adults
- Vendor churn

Cautionary Tales *(cont.)*

- Buying EBPs and getting….
- The letter versus the spirit of the law
- PBM promise and perils

Measurement Approaches

Contract-specific performance standards with performance monitoring:

- Centralized provision of summaries of administrative data.
- Vendor-generated data aggregated centrally with sampling-based audits.
- Published scores
- Outlier monitoring

Transparency

- In payment rules
- In measurement rules
- In performance