State Strategies to Improve the Quality of Behavioral Health Care

Wednesday, September 7, 2016

1-2:30 p.m. ET

Webinar Logistics

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Agenda

Welcome and Introductions	**Carrie Hanlon** Project Director, National Academy for State Health Policy (NASHP)	1 p.m. ET
The Federal Perspective	**David R. Shillcutt, JD** Health Insurance Specialist, Division of Managed Care Plans, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services **Virginia (Gigi) Raney, LCSW** Health Insurance Specialist, Division of Quality and Health Outcomes, Center for Medicaid and CHIP Services, Centers for Medicare & Medicaid Services	1:05 p.m. ET
The State Experience: Rhode Island	**William McQuade, DSc, MPH** Senior Healthcare Policy Analyst Rhode Island Executive Office of Health and Human Services **Steve Kogut, PhD, MBA, RPh** Professor, University of Rhode Island College of Pharmacy	1:12 p.m. ET
The State Experience: Oregon	**Rita Moore, PhD** Policy Analyst, Office of Health Analytics, Oregon Health Authority	1:27 p.m. ET
The State Experience: Washington	**Beverly Court, PhD** Senior Research Manager, Research and Data Analysis Division, State of Washington Department of Social and Health Services	1:42 p.m. ET
Questions and Discussion	All	1:57 p.m. ET
Conclusion	NASHP	2:25 p.m. ET

The Federal Perspective

David R. Shillcutt, CMS
Virginia (Gigi) Raney, CMS

Medicaid and Behavioral Health

- Disproportionate prevalence of mental health conditions and substance use disorders in Medicaid population

TABLE 4-3. Mental Health Status and Treatment for Non-Institutionalized Adults Age 18-64 by Insurance Status, 2010-2012

	All adults age 18-64 years[3]	Percentage of adults by insurance status		
		Private	Medicaid	Uninsured
Categorical mental illness indicator[1,2]				
None	80.4	83.3*	68.6	78.6*
Mild mental illness	9.8	9.0*	13.3	10.4*
Moderate mental illness	5.2	4.5*	8.4	5.5*
Serious mental illness	4.6	3.3*	9.7	5.4*

- The 20% of Medicaid beneficiaries receiving treatment for a behavioral health diagnosis account for almost 50% of expenditures
- Among Medicaid beneficiaries with a mental illness, 61% have a co-morbid chronic physical health condition

The Quality Goal

- Quality measures strategy must be tailored to population and policy goals
  - Seek alignment, and consider value-add of additional measures
  - Account for variety of populations, including pediatric, SMI, racial/ethnic minorities, intellectual/developmental disabilities, others
  - *If you don't know where you're going, any measure can take you there*
- Behavioral health integration is a strategy, not a goal
- Effective quality measures are essential to any program quality and clinical improvement strategy
  - Performance improvement
  - Payment reform

Key Areas of Focus for BH Quality Measures

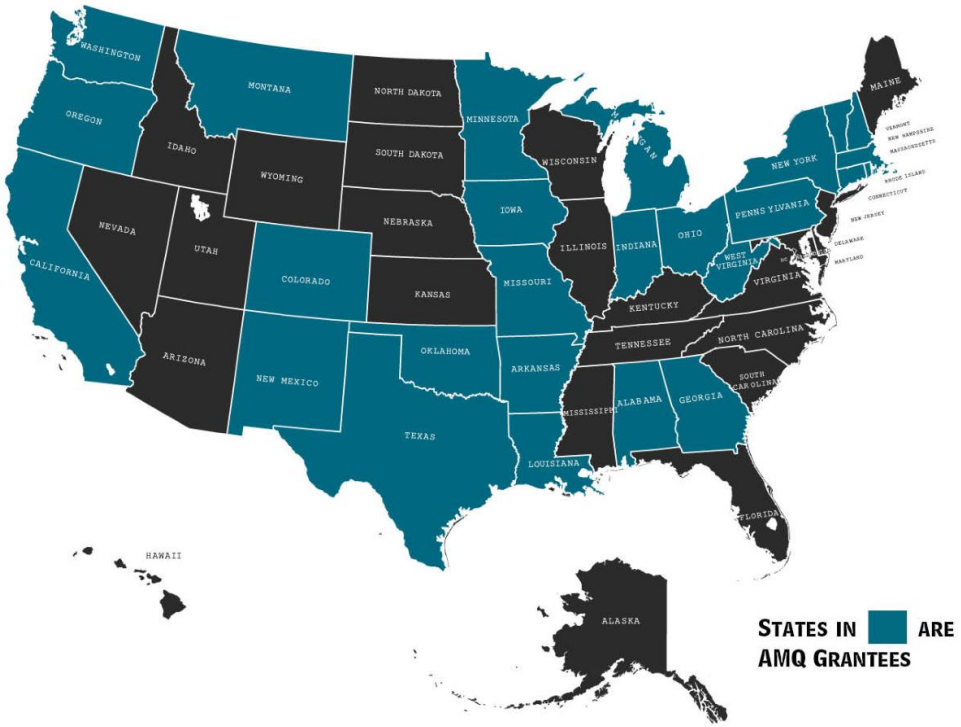
- Clinical quality of care
  - Initiation and engagement in treatment
  - Care transitions, including follow-up after hospitalization, follow-up after ED
- Access to care
  - Penetration rates
- Patient experience of care
  - Medication consultation
- Primary care settings versus specialty behavioral health settings

CMS Activities

- Medicaid Innovation Accelerator Program
  - Program areas include Substance Use Disorders and Physical and Mental Health Integration
  - Quality measurement development and TA activities
- Adult and Child Core Sets
- Technical Assistance and Analytic Support (TA/AS) Program
- Secretary's Annual Report on the Quality of Health Care for Adults Enrolled in Medicaid

Background

- December 2012, CMS began the Adult Medicaid Quality (AMQ) grant program
  - Awarded to 26 states
  - 2 year program, up to $1 million per year
  - 25 Grantees requested a no cost extension for year 3



AMQ Grant Program Goals

1. Evaluate methods for collecting, reporting and stratifying the Adult Core set measures in various care settings

2. Develop staff capacity to report, analyze, and use the data for monitoring and improving access and quality of care in Medicaid

3. Conduct at least 2 Medicaid quality improvement projects (QIPs) related to the Adult Core Set measures

Quality Improvement Projects (QIP)

BEHAVIORAL HEALTH & SUBSTANCE ABUSE QIP TOPICS

9	Medication Management/Adherence
4	Preventing Hospital Readmission
3	Depression Screening and Follow-up
3	Alcohol/Other Drug Dependence Engagement and Treatment
2	Preventive Health / Chronic Condition Management

Adult Medicaid Quality Grants on Medicaid.gov:
https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grant-details.html

Rhode Island: Antidepressant Medication Management Quality Improvement Project

Bill McQuade, DSc, MPH
Sr. Healthcare Policy Analyst
R.I. Executive Office of Health and Human Services

Stephen Kogut, PhD RPh
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R.I. Medicaid URI College of Pharmacy

National Committee for Quality Assurance
Antidepressant Medication Management (AMM)

Effective Acute Phase Treatment

- The percentage of ***newly*** treated people who remained on an antidepressant medication for at least 84 days (12 weeks)

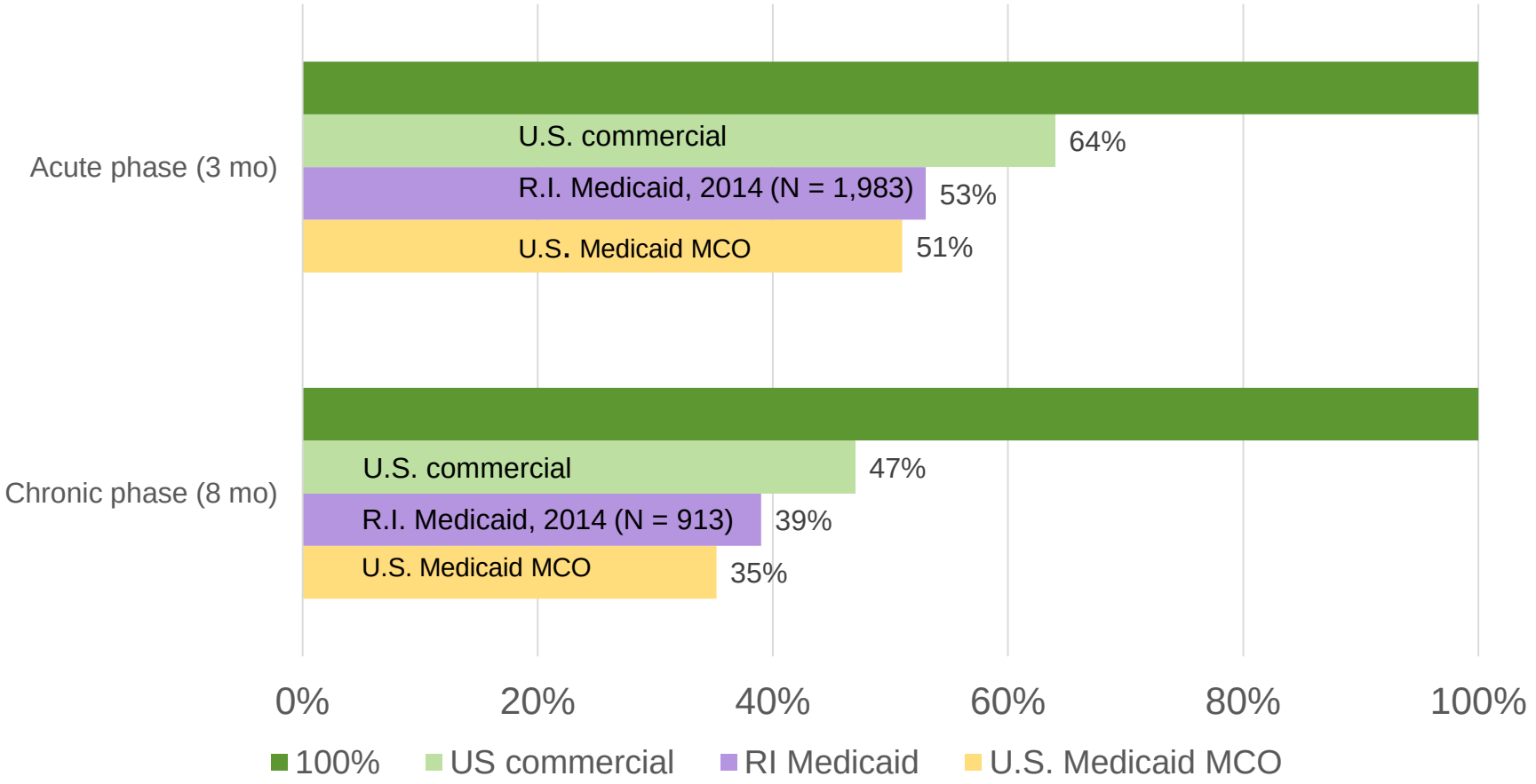
Effective Continuation Phase Treatment

- The percentage of ***newly*** treated people who remained on an antidepressant medication for at least 180 days (6 months)

Requires ICD-9 diagnosis of major depression +/- 60 days of index prescription

- 296.20-296.25, 296.30-296.35, 298.0, 300.4, 309.1, 311

Antidepressant Medication Management (AMM) The Percentage of Newly Treated People who Remained on an Antidepressant Medication (2014)



Acute-Phase Persistence with Antidepressant Medication in R.I. Medicaid in 2014 (N = 1,983)

Characteristic		Persisted with Medication		
		%	N	p-value
		53.8	1067	-
Age (years)	18-34	45.3	898	<0.001
	35+	54.7	1,085	
Gender	Male	52.6	481	0.492
	Female	54.4	1,502	
Plan type	Fee-for-service	59.7	243	<0.001
	Managed care	53.2	1,740	
Index Antidepressant	SSRI	54.2	1,285	0.804
	Other class of antidepressant	53.6	698	
Regimen type	Monotherapy	41.6	1,326	<0.001
	Poly-therapy	78.8	657	
Comorbidity*	Cardiovascular disease	47.6	63	0.305
	Respiratory disease	52.2	314	0.503
	Diabetes mellitus	61.0	195	0.037
	Anxiety	55.4	634	0.390
	Bipolar disorder	52.1	144	0.639
	Schizophrenia	46.2	39	0.323
Charlson comorbidity score	0	53.0	1,374	0.191
	1+	56.2	609	
Office visits in follow-up	0	34.5	229	<0.001
	1+	56.5	1,754	
Hospitalizations	0 during 30-day baseline	54.7	1,781	0.053
	1+ during 30-day baseline	47.5	202	
	0 during follow-up period	53.8	1,742	0.787
	1+ during follow-up period	54.8	241	
Visits for psychiatric services	0	51.1	995	0.009
	1+	56.9	988	

Antidepressant Medication Management Quality Improvement Project

FINDINGS - poorer persistence:	OPPORTUNITIES
Lacking any follow-up care	Health IT; Improve care transitions
Post-hospitalized	Discharge counselling; expectations of Rx
Younger patients; Medicaid status	Identify barriers to adherence
Lacking visits for mental health services	Primary care & behavioral health integration

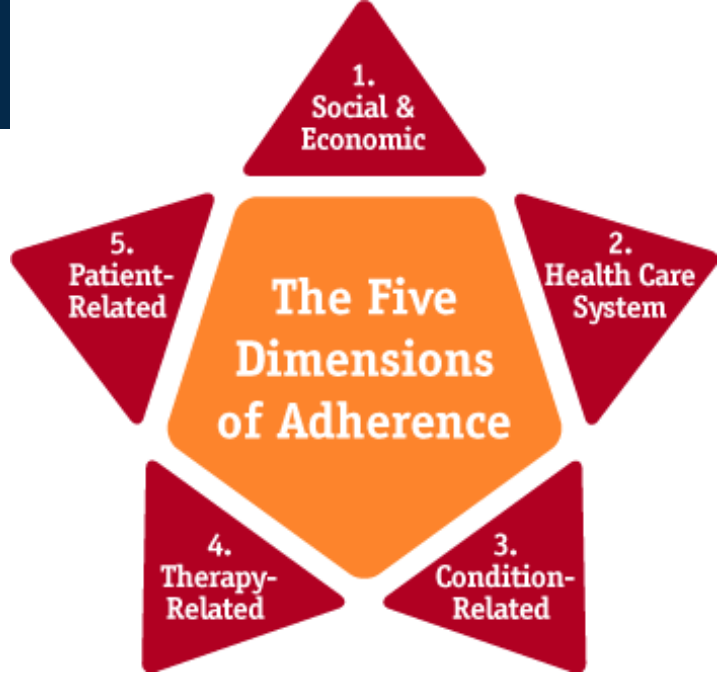
Themes for Promoting Antidepressant Medication Persistence

Patient	Adherence improves when patients are told:	• How long to expect to take the medication • How to manage minor side effects • Whom to contact if there are questions about the medication
	These groups are at greater risk for non-adherence:	• Younger patients (age under 35 years) • Patients of lower socioeconomic status • Patients who were recently hospitalized
Health-system	The intensity of follow-up care after a new diagnosis of depression affects treatment adherence	• Symptom assessment using an instrument such as the PHQ-9 repeated at each visit helps guide medication dosing and the need for regimen change
	Integrate primary care and behavioral health	• The collaborative management of depression is superior to usual care

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

THE UNIVERSITY OF RHODE ISLAND COLLEGE OF PHARMACY THINK BIG WE DO

Lessons Learned



- Adherence is multi-dimensional
- Perspectives of primary care and specialist differ
- Follow-up care is important
- Co-occurring substance use is a barrier to adherence
- Measure misclassification and bias

Promoting Adherence with Antidepressant Medication: Plan-Do-Study-Act (PDSA) Cycle 2

APPROACH

- Optimal antidepressant medication selection may promote patient adherence
- Evidence-based flowchart targeting primary care
- Validation analysis

ELEMENTS

- Assess Treatment Experience and Patient Beliefs
- Consider Coexisting Symptoms
- Avoid Contraindications and Drug Interactions
- Monitoring and Follow up

Practice Implications

- Prevalence of depression in primary care practice is 5-13% and normally much higher in Medicaid populations.
- Depression is a condition that often goes undiagnosed.
- In addition to the direct burden of disease, depression is also associated with multiple medical and psychosocial conditions which contribute to the total morbidity and mortality of the disease.

Policy Implications

- Primary care practices often lack resources for appropriate management, follow-up and referral for patients being treated for depression.

- Outreach efforts have not only improved management of depression but have also increased awareness of depression in primary care settings

- Coordinates well with Integrated Medical and Behavioral Health Care models in the State.

More Information

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Oregon: Behavioral Health Home Learning Collaborative

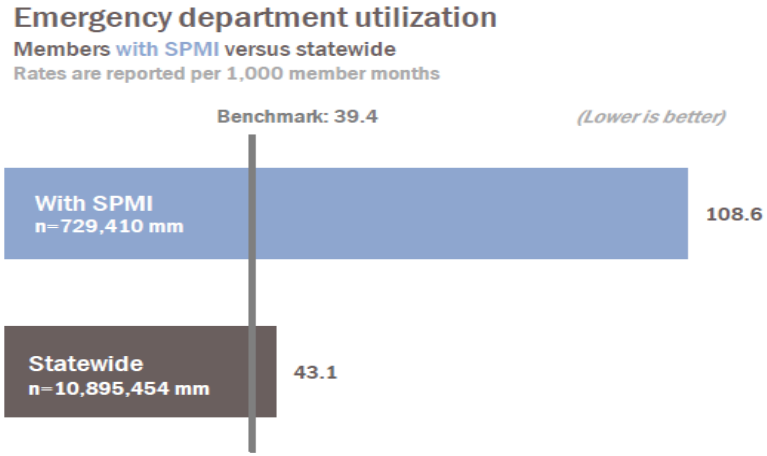
Common Challenges and Lessons Learned

Rita Moore, PhD

Office of Health Policy and Analytics, Oregon Health Authority

Behavioral Health Homes and Health System Transformation in Oregon

- Integration of physical and behavioral health is a major strategy in Oregon to achieve triple aim
- Special focus on Serious & Persistent Mental Illness (SPMI) and Substance Use Disorder (SUD) sub-populations
  - On average, SPMI populations die 25-30 years prematurely, mostly from preventable conditions (high blood pressure, high cholesterol, heart disease, and diabetes)
  - Higher rates of chronic conditions, higher costs, less access to care



- *"Behavioral health home" means a mental health disorder or substance use disorder treatment organization…that provides integrated health care to individuals whose primary diagnoses are mental health disorders or substance use disorders."* Oregon Senate Bill 832 (SB 832-C, 2015)

Behavioral Health Home Learning Collaborative

- Since May 2014, worked with 13 organizations integrating primary care into behavioral health settings, to enhance capacity in the 4 core areas of behavioral health homes (BHH), as defined by SAMHSA:
  - Screening/referral
  - Registry/tracking system
  - Care management
  - Prevention and wellness support services

- Participating agencies used all three behavioral health home integration models recognized by SAMHSA-HRSA:
  - **In-House**
  - **Co-Located Partnerships**
  - **Facilitated Referrals**

- By end of 2016, about 4,000 individuals expected to receive integrated care across 11 sites (up from 2500 individuals in 9 sites in 2015)

Site Models and Services

County	Integration Model			Services Provided Onsite		Federally Qualified Health Center (FQHC) affiliation	Consumers with chronic conditions
	In-House	Co-Located Partnership	Facilitated Referral	Mental Health	Addictions		
Benton	Not implemented			√		√	NA
Douglas		√ (MH)	√ (Addictions)	√		√	90%
Hood River			√	√	√		NA
Jackson		√ (MH)	√ (Addictions)	√		√	60%
Josephine	√			√			NA
Lane		√ (MH)	√ (Addictions)	√		√	NA
Lane		√		√	√		95%
Lane	√			√	√		90%
Marion	√			√	√		100%
Multnomah		√		√	√	√	28%
Multnomah		√		√	√		90%
Umatilla	Not Implemented			√	√		NA
Washington		√		√	√		52%

Common Challenges to Building Care Teams

- Culture & Workflow
- Communication/Record Sharing
- Knowledge Gap
- Staff Recruitment and Retention
- Current Payment Models Often Do Not Support BHHs
- Data on Outcomes, Cost-Savings Difficult to Collect

Bottom Line

Regardless of the model, creating a BHH requires time, organizational change, and staff flexibility from both physical health and behavioral health providers

Lessons Learned

- Multi-disciplinary, team-based care is the essence of a BHH; can be achieved under all 3 models (in-house, co-located, or referral)
  - Co-location helpful, but not sufficient or required
  - Regardless of model, BHHs should be held to same standards for delivery of primary care as other medical homes
- What seems to work:
  - Top-to-bottom, visible organizational commitment to new model
  - Medical services available all day, every day; drop-in availability; longer visits
  - Panel size sufficient to cover costs of delivering services
  - New workflows on both Behavioral Health (BH) and Physical Health (PH) sides: a "Third Way"
  - Frequent, intentional, cross-disciplinary communication
  - Shared records; common EHR is gold standard
  - "Right fit" staff and cross-training
  - Leveraging provider relationships with clients/patients
  - Dedicated care coordination position, especially nurse care managers
  - Case management and robust ancillary services: "housing is health"
  - Practice Coaching creates space, structure, and focus for sustained integration work

Preliminary Trends

- BHHs especially useful for individuals with SUD
  - Integration facilitates information sharing between BH and PH providers while complying with privacy regulations (42 CFR).
  - Facilitates Medication Assisted Treatment for opiate use disorder (Suboxone, Buprenorphine)
  - Relationships with providers across BH and PH promotes patient engagement in both medical and alcohol and drug (A&D) treatment
  - Shared care facilitates earlier identification of relapse and relapse risk and immediate intervention

- Tracking Outcomes
  - Steep learning curve for BH organizations; big investment in IT and training needed
  - Preliminary trends from qualitative and quantitative evaluation:
    - Health:
      - SMI/SUD populations sicker and “undoctored;” need stabilization before improvement evident
      - Transient populations skew measurement: no health histories, unstable enrollment
      - Given patient demographics and issues, are we tracking best measures?
    - Costs:
      - Cost savings unclear: anecdotal evidence of short-term spike during stabilization, then later decrease
      - Cost/benefit displacement: immediate cost reductions may be in other systems (public safety, corrections, child welfare)

More Information

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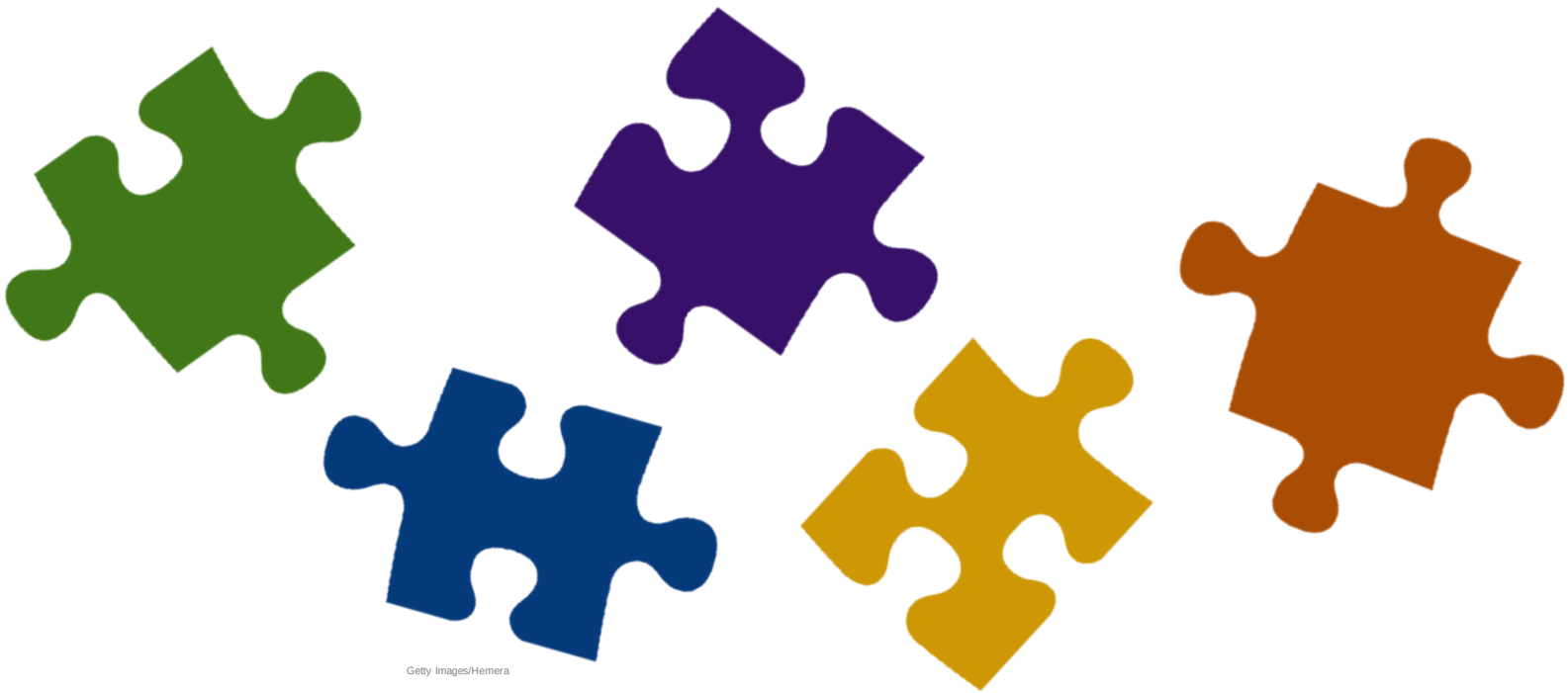
Washington State

Partnership to Reduce Psychiatric Rehospitalization

Beverly Court, PhD

September 7, 2016



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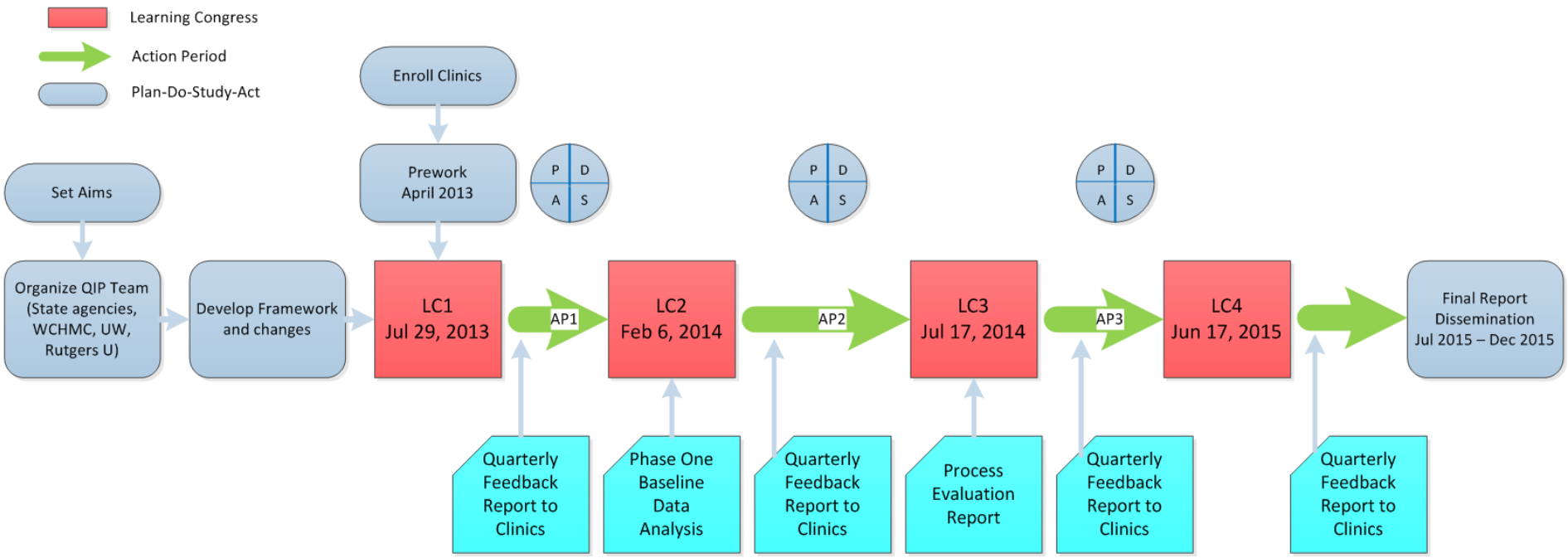
Team

- **Washington Council for Behavioral Health**
  - Lead organizer
- **Four community mental health agencies and their community partners**
  - In counties with highest 30 day Psychiatric Rehospitalization rate
- **University of Washington Health Policy Center and Department of Psychiatry**
  - Design educational component (4 in-person learning conferences, 13 webinars)
- **Washington State Research and Data Analysis**
  - Provider feedback reports on readmissions
- **Rutgers University**
  - Baseline analysis and pilot evaluation

Structure



AQM Psychiatric Rehospitalization QIP Supports:

Email • Visits • Phone Conferences • Team Reports • Assessments

Monthly QIP Worksheets • Quarterly Feedback Reports Process Evaluation

Sample Finding

- **Readmission rate dropped**
- **Predominately driven by one individual during the Pre-PDSA period**

Measurement Period	Readmission Rate with Top Utilizer	Readmission Rate without Top Utilizer
Pre-PDSA	20.83%	17.39%
Post-PDSA	14.50%	14.50%

- **Top five hospitalized individuals all have a co-occurring disorder: substance use**
- **Lack of 24 hour supervised housing with tolerance for high-risk behaviors (substance use, self harm)**
- **Difficult to intervene in ITA process**

Lessons Learned

From Pilots:

- Local Team Building
- Reconcile / Harmonize Data Collection and Reporting
- Divert patients facing involuntary commitment to crisis diversion team
- Assign chemical dependency professionals to Emergency Departments
- Peer counselors for transitions

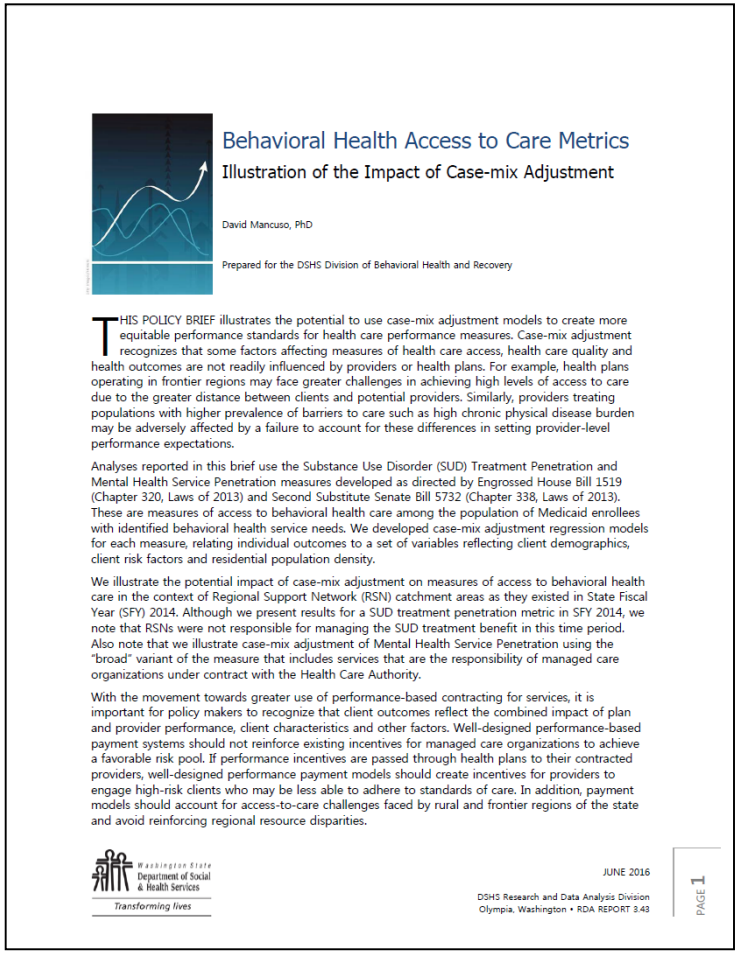
Policy Recommendations:

- Data transparency
- Use of rehabilitation case management
- Care coordination for those with unstable housing
- Long-Acting Injectables for those who are nonadherent

"Policy Brief: Reducing Hospital Readmissions for Psychiatric Illness," Washington Council for Behavioral Health.

Policy Impact

- **System Integration – April 2016**
  - Integration of mental health and substance use under capitated managed care in 37 of 39 counties
  - Integration of medical, mental health and substance use under managed care
- **Statewide Purchasing Measures**
  - Psychiatric 30 day Rehospitalization
  - Behavioral Health Access to Care
    - Substance Use Disorder Treatment Need
    - Mental Health Service Penetration
      - Importance of case-mix adjustment



Behavioral Health Access to Care Metrics

Illustration of the Impact of Case-mix Adjustment

David Mancuso, PhD

Prepared for the DSHS Division of Behavioral Health and Recovery

THIS POLICY BRIEF illustrates the potential to use case-mix adjustment models to create more equitable performance standards for health care performance measures. Case-mix adjustment recognizes that some factors affecting measures of health care access, health care quality and health outcomes are not readily influenced by providers or health plans. For example, health plans operating in frontier regions may face greater challenges in achieving high levels of access to care due to the greater distance between clients and potential providers. Similarly, providers treating populations with higher prevalence of barriers to care such as high chronic physical disease burden may be adversely affected by a failure to account for these differences in setting provider-level performance expectations.

Analyses reported in this brief use the Substance Use Disorder (SUD) Treatment Penetration and Mental Health Service Penetration measures developed as directed by Engrossed House Bill 1519 (Chapter 320, Laws of 2013) and Second Substitute Senate Bill 5732 (Chapter 338, Laws of 2013). These are measures of access to behavioral health care among the population of Medicaid enrollees with identified behavioral health service needs. We developed case-mix adjustment regression models for each measure, relating individual outcomes to a set of variables reflecting client demographics, client risk factors and residential population density.

We illustrate the potential impact of case-mix adjustment on measures of access to behavioral health care in the context of Regional Support Network (RSN) catchment areas as they existed in State Fiscal Year (SFY) 2014. Although we present results for a SUD treatment penetration metric in SFY 2014, we note that RSNs were not responsible for managing the SUD treatment benefit in this time period. Also note that we illustrate case-mix adjustment of Mental Health Service Penetration using the "broad" variant of the measure that includes services that are the responsibility of managed care organizations under contract with the Health Care Authority.

With the movement towards greater use of performance-based contracting for services, it is important for policy makers to recognize that client outcomes reflect the combined impact of plan and provider performance, client characteristics and other factors. Well-designed performance-based payment systems should not reinforce existing incentives for managed care organizations to achieve a favorable risk pool. If performance incentives are passed through health plans to their contracted providers, well-designed performance payment models should create incentives for providers to engage high-risk clients who may be less able to adhere to standards of care. In addition, payment models should account for access-to-care challenges faced by rural and frontier regions of the state and avoid reinforcing regional resource disparities.

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PAGE 1

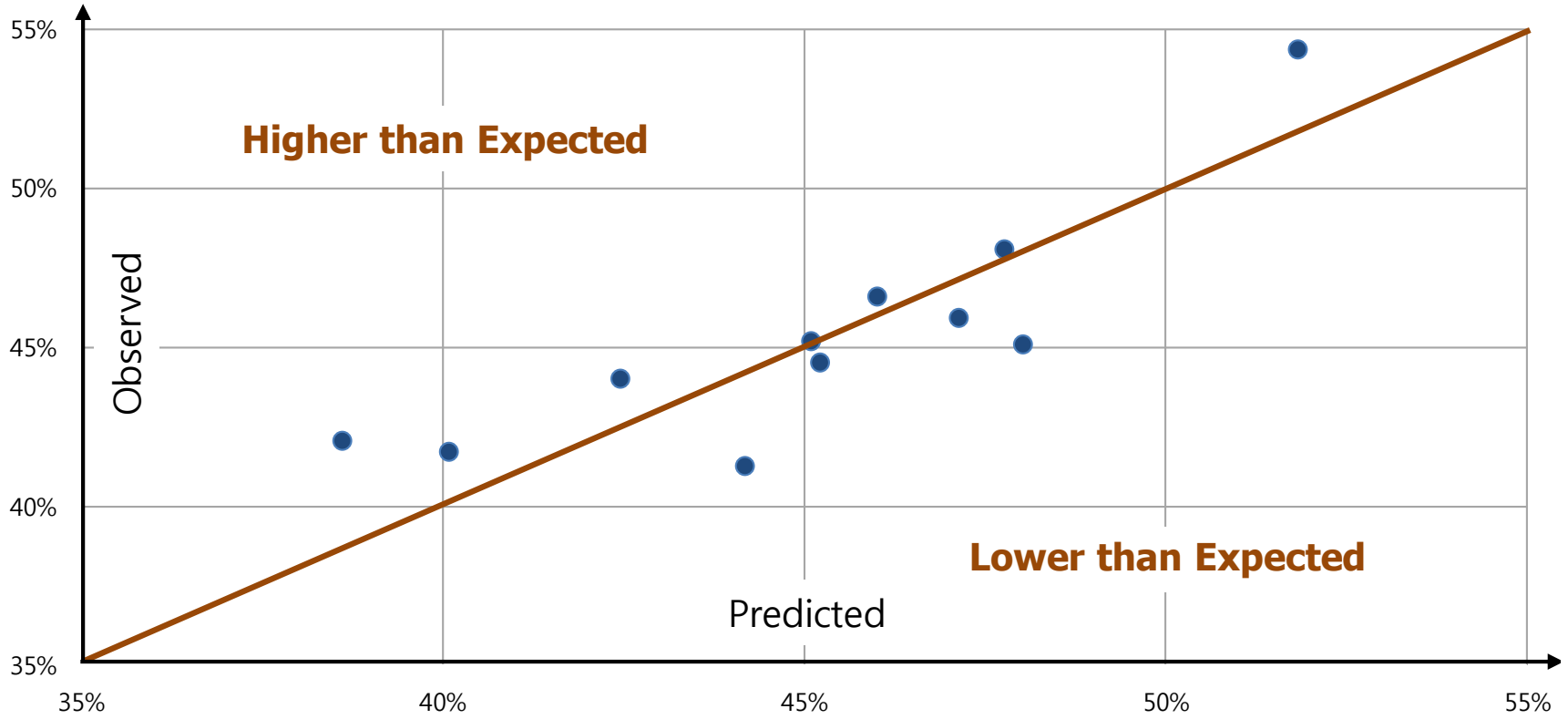
https://www.dshs.wa.gov/sesa/rda/research-reports/behavioral-health-access-care-metrics

Mental Health Treatment Penetration

FIGURE 2.

Mental Health Treatment Penetration, Broadly Defined

Among Adults 18 and Over with Alcohol/Drug Treatment Need, by RSN Catchment Area • State Fiscal Year 2014



 SOURCE: Washington State Department of Social and Health Services, Research and Data Analysis Division.

More Information

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Questions and Discussion

- Please submit questions and comments in the chat box on the right side of your screen.

Thank you

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