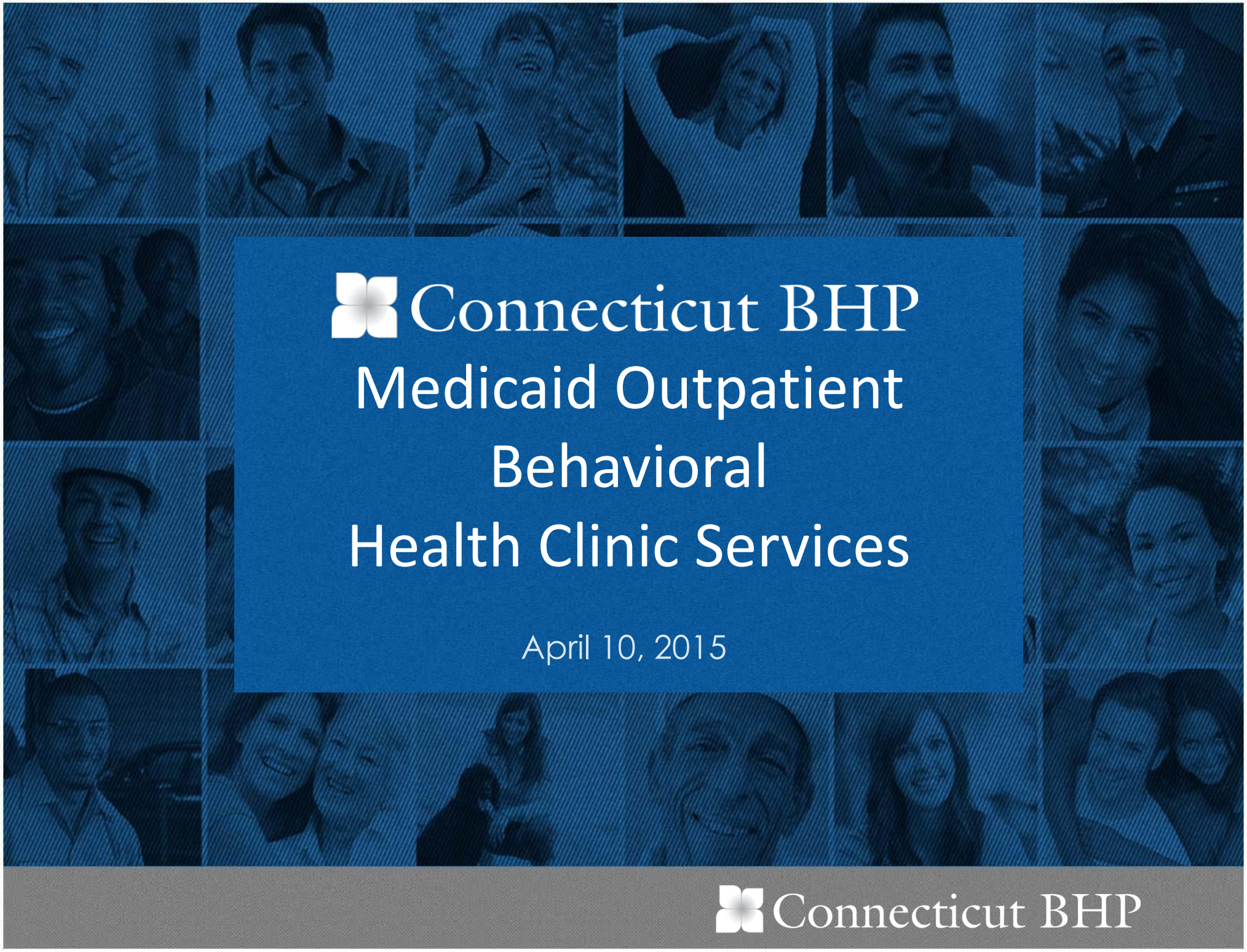

Connecticut BHP
Medicaid Outpatient Behavioral Health Clinic Services
April 10, 2015
Connecticut BHP

A report of the Connecticut Behavioral Health Partnership (CTBHP) regarding methods seen nationally for improving the quality of care, outcomes, participant experience, payment methods , and cost effectiveness of clinic based outpatient mental health and substance abuse care for children and adults.

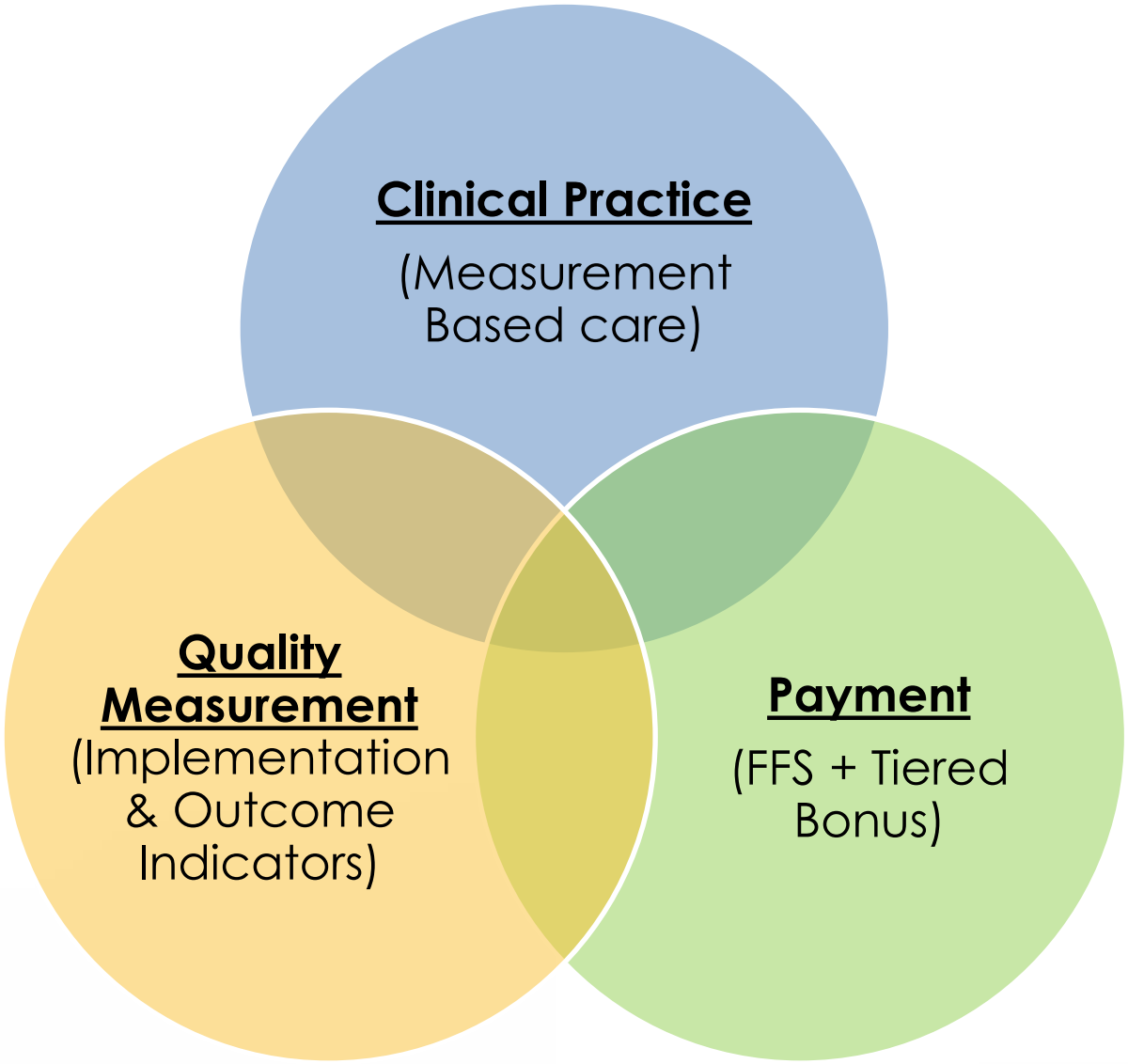
Need for Stakeholder Input

- This report is an analysis of the current state of outpatient care
- It presents options, concepts, and recommendations but will require the input of multiple stakeholders to develop a plan of action
- Key decisions will need to be made regarding each of the three domains addressed in the report
  - Clinical Practice Improvement
  - Quality Measurement
  - Payment Methodology

Overview

- Purpose
- National Landscape re: Outpatient Care
- Connecticut Landscape
- Evidence Based Practice and Implementation Science
- Clinical Best Practices
  - Measurement Based Care
  - Implementation Methods
  - Common Elements
- Quality Measures
- Payment Reform
- Integration of Best Practice, Quality Measurement, & Payment Reform

Simplified Model of Outpatient System Components




purpose.

Statement of Purpose

- Explore and describe methods of improving:
  - The quality of care
  - Outcomes
  - Participant experience
  - Payment methods
  - Cost effectiveness

  of outpatient behavioral health care
- Explore and describe general strategies, methods, and approaches
- Provide a framework for discussion regarding design and implementation of a Value Based Payment System for Outpatient Behavioral Health Clinics

Why Outpatient Clinics?

- Outpatient Clinics serve more individuals in the behavioral health service system than any other level of care

(Pires, et al., 2013)

Why Outpatient Clinics?

- Outpatient Clinics are usually the first point of entry into the service system

Why Outpatient Clinics?

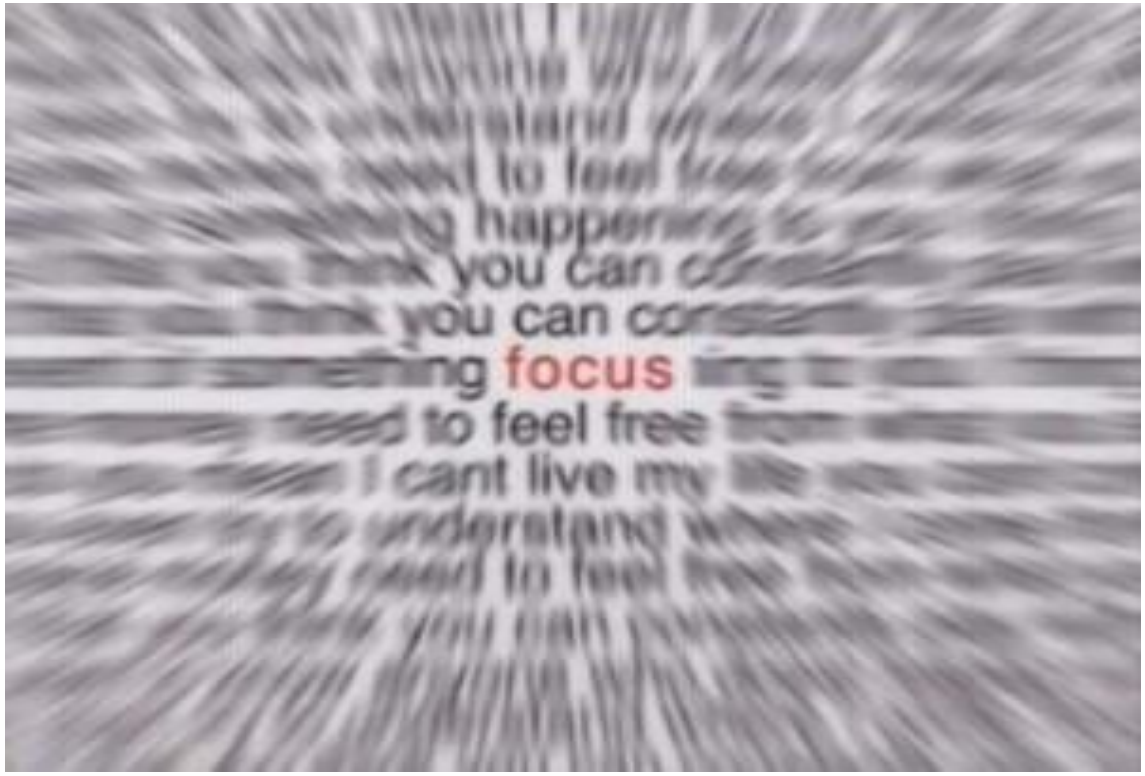
- Effective intervention at the outpatient level of care can alter health trajectories, supporting health, avoiding deterioration and reducing high end utilization

Why Outpatient Clinics?

- Nationally, there is a gap between typical outcomes achieved in outpatient care and what can be accomplished with evidence based interventions

Why Outpatient Clinics?

- A focused, active effort to further improve quality and outcomes is required



National Landscape

National Landscape

- Outpatient psychotherapy is the dominant method/setting for the delivery of behavioral health care

National Landscape

CONTRADICTORY FINDINGS on OP CARE

- Individuals who receive outpatient psychotherapy are better off than 8 out of 10 individuals with a mental health disorder who do not receive care (1)

- "Usual Care" delivered in clinic settings is seldom evidence-based (2)
- "multiple studies have documented serious limitations of usual care" (3)
- usual care is (children) "at best uneven, and at worst, harmful."(4)
- only 20% of over 6000 adult clients receiving "usual care" were treated successfully (5)
- of youths receiving usual care, 44% improved or recovered, 32% showed no reliable change, and 24% deteriorated. (6)

National Landscape

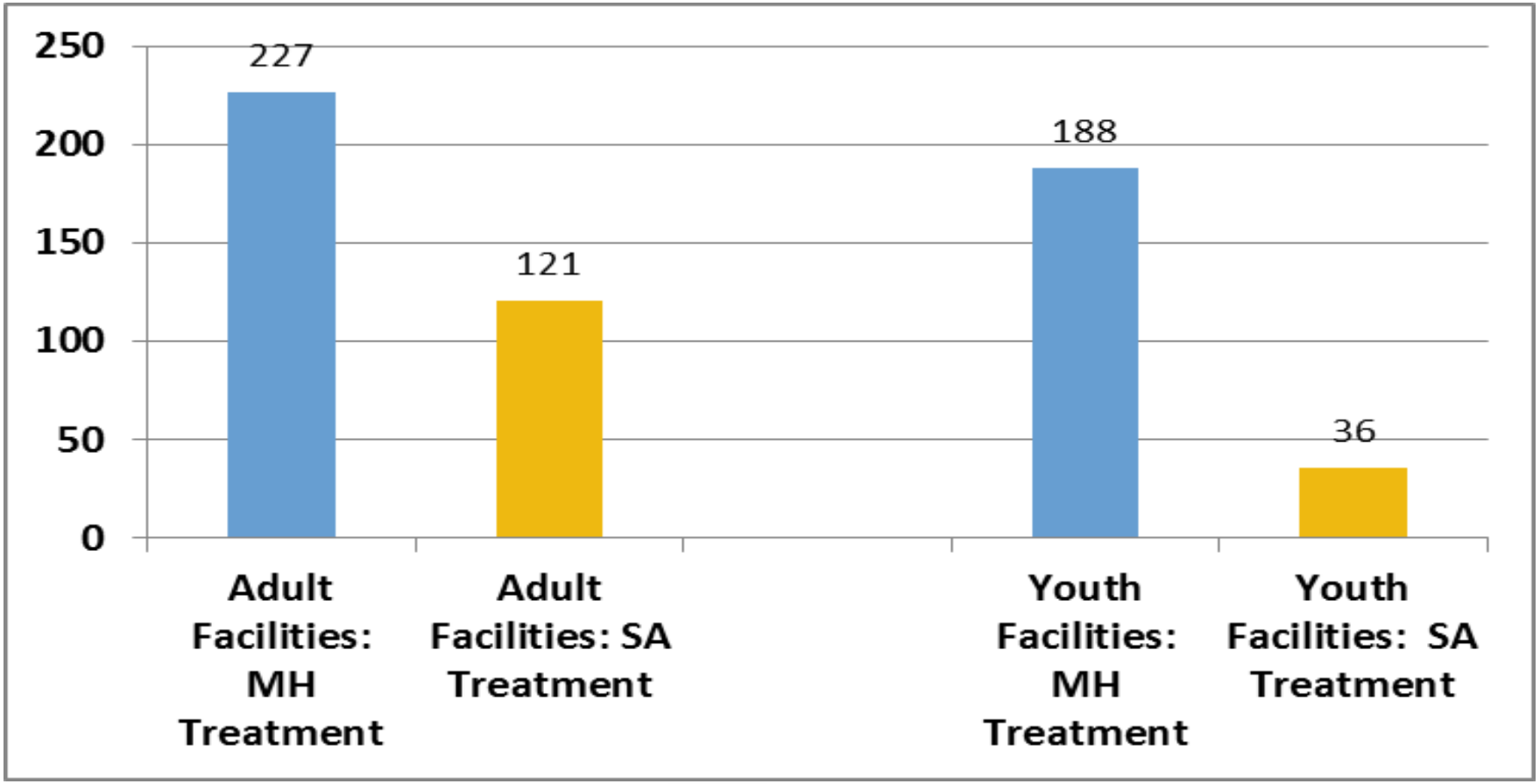
- **Engagement and dosage have been cited as significant issues in the delivery of outpatient care**

- **a single session is the modal number of treatment sessions attended**

- individuals or families living in poverty or experiencing high levels of parent and family stress are less likely to attend

Connecticut Landscape

OUTPATIENT CLINIC SITES (CTBHP Network Report – 10-2-2014)



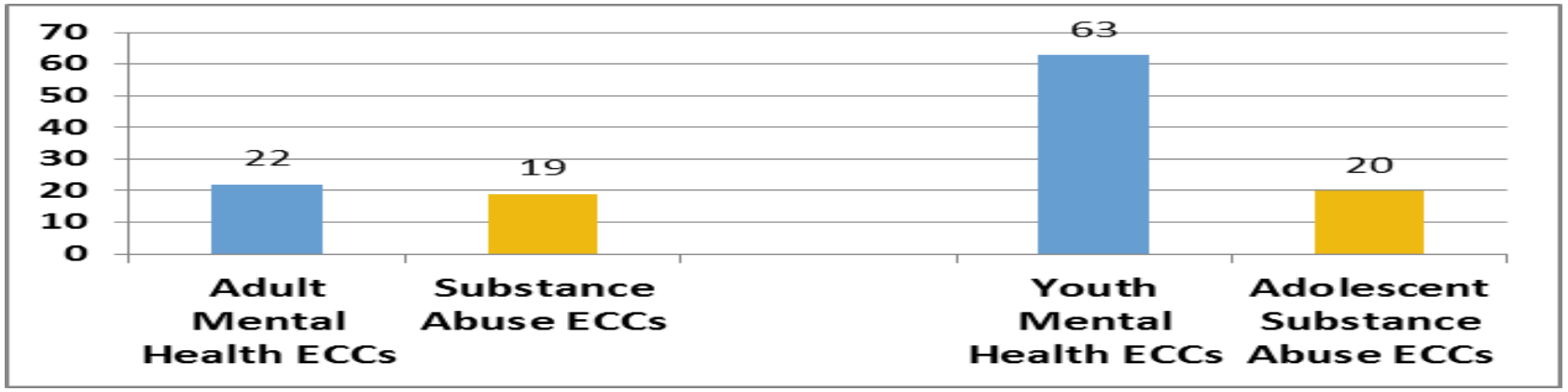
FQHCs

BH Clinics

School Based Clinics

Hospital Outpatient Clinics

Outpatient Services: Enhanced Care Clinic (ECCs) (CTBHP Network Report 10-2-2014)



ECCs are reimbursed at a higher rate and held to higher standards

- Timely Access to emergent (2 hours), urgent (2 days) and routine (2 weeks) appointments
- Coordination of Care with Medical Providers
- Substance Use Evaluation and Treatment/Referral
- Mystery Shopper and Survey oversight
- Transportation
- Timely access to a prescriber
- Referral to Self-Help/Mutual Support

Penetration Rate of Outpatient Services in Medicaid (As of 10/1/13)

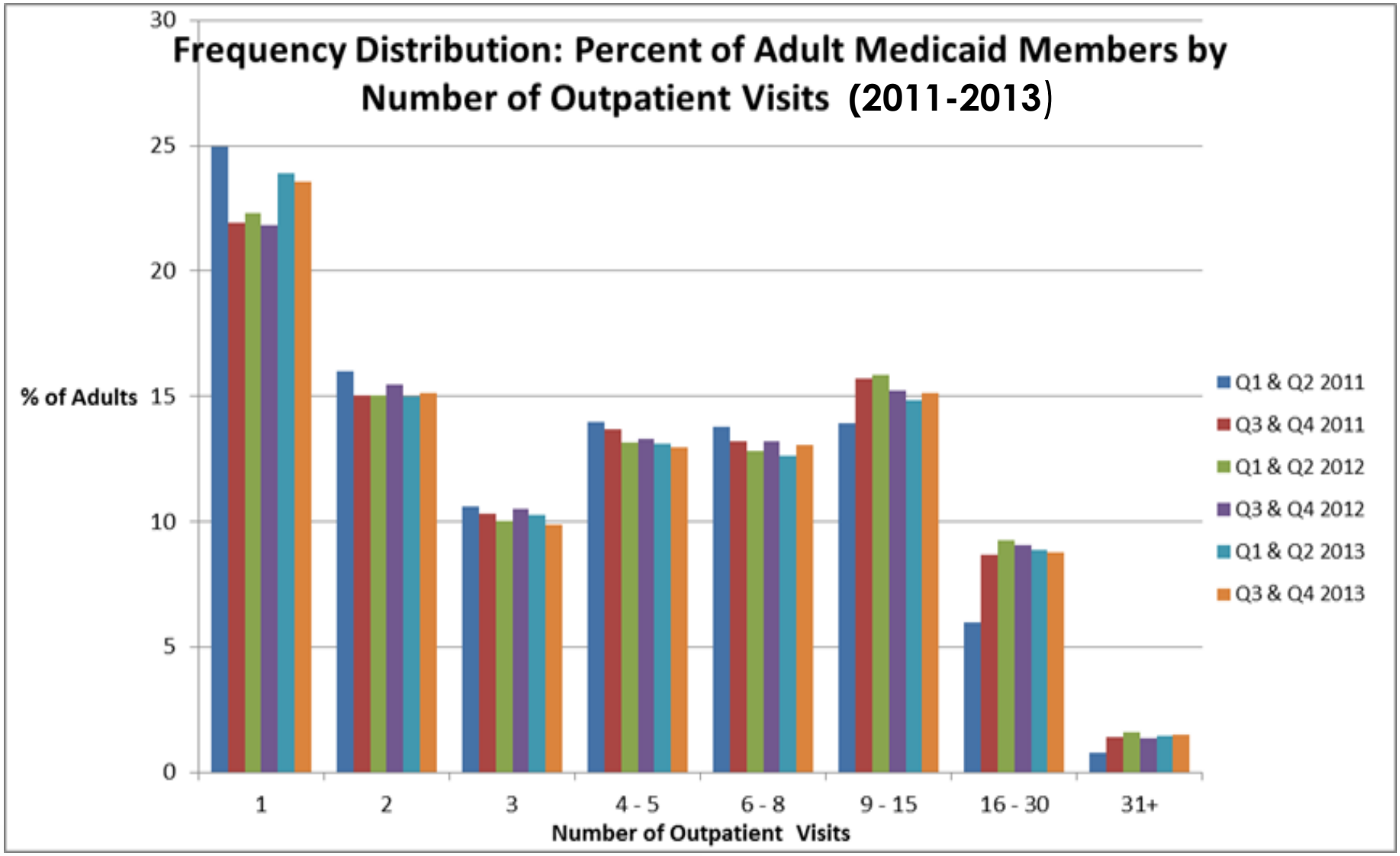
Age Group	All Medicaid Members	Percent of Members	Medicaid Members Authorized for Outpatient Services	Percent Authorized for Outpatient Services
Total	593,468	100%	104,939	17.7%
Adult (18+)	303,529	51.1%	75,659	25%
Youth (0-17)	289,939	48.9%	29,280	10%

Adult & Youth Primary Diagnoses

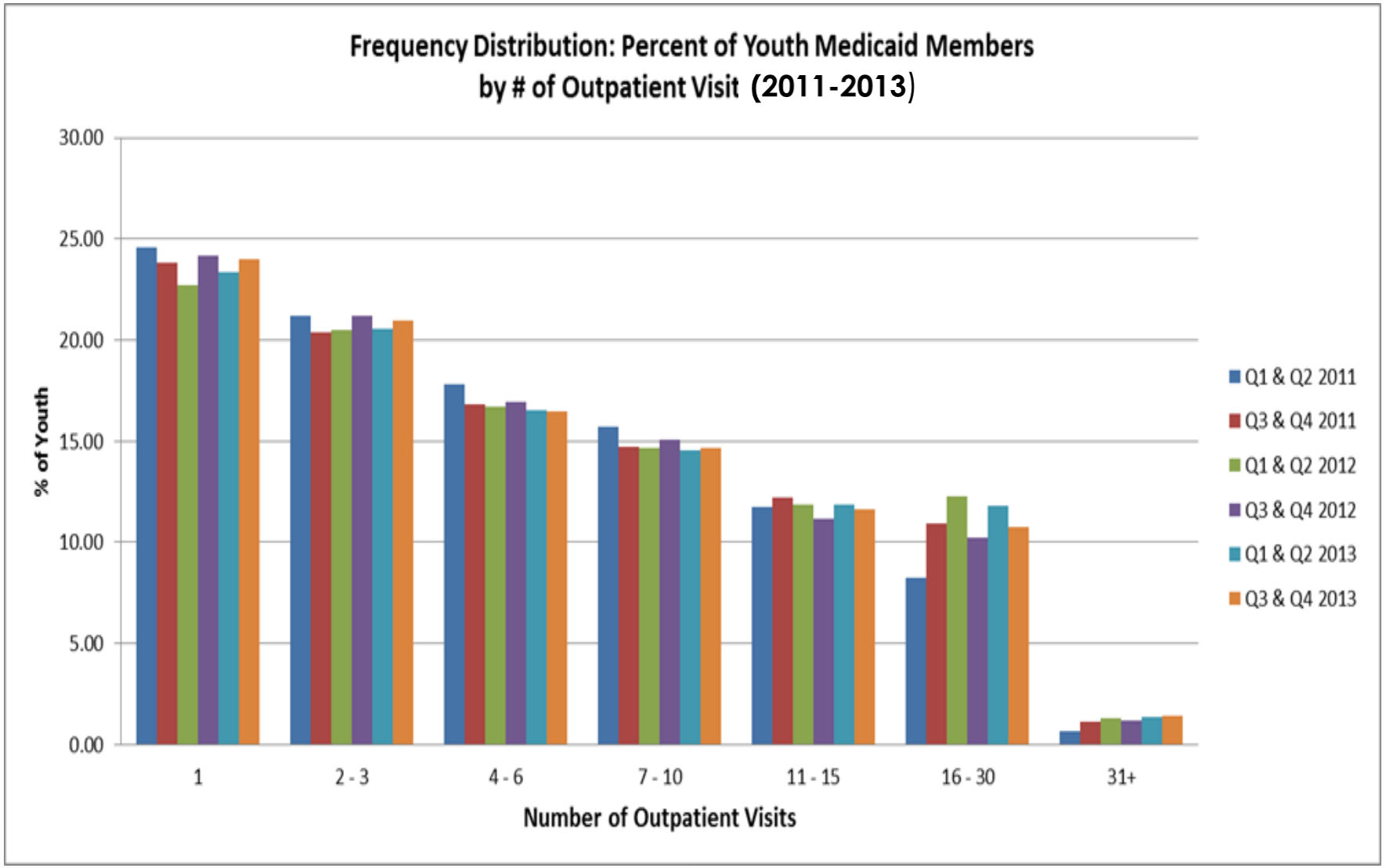
ADULTS Primary Diagnostic Category	Number of Adults with Primary Diagnosis	Percent of Adults with Primary Diagnosis
MH	59,926	79.2%
SA	15,668	20.7%
Primary Diagnosis is V Code or outside of ICD-9 codes of 291-316.99	65	0.1%

YOUTH Primary Diagnostic Category	Number of Youth with Primary Diagnosis	Percent of Youth with Primary Diagnosis
MH	28,798	98.4%
SA	334	1.1%
Primary Diagnosis is V Code or outside of ICD-9 codes of 291-316.99	148	0.5%

Frequency Distribution of OP Visits - Adults



Frequency Distribution of Outpatient Visits - Youth

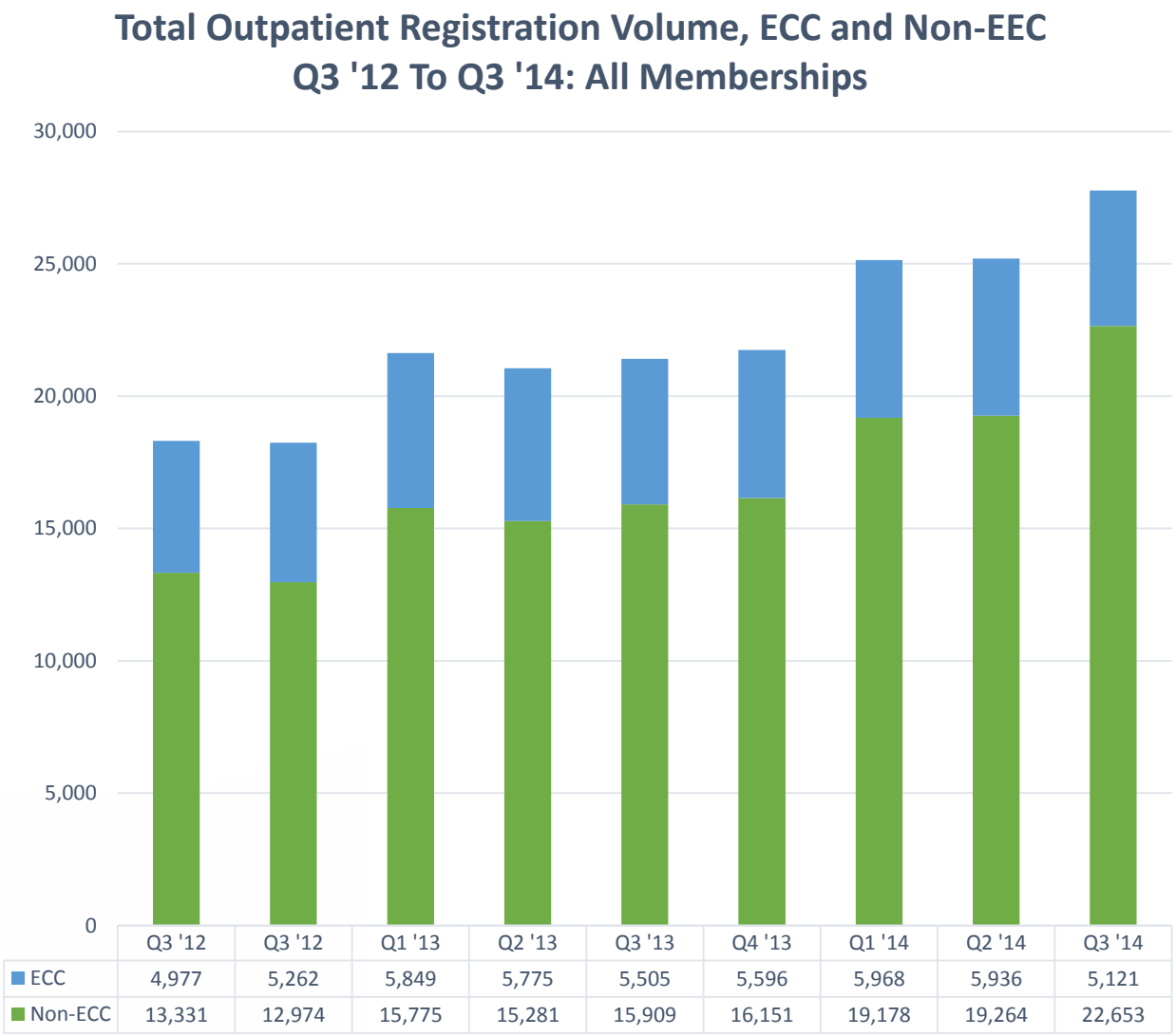


Medicaid Outpatient Behavioral Health Expenditures 2011 & 2012 (Youth & Adult)

Year	Age	Service	# Members	Cost
2011	Youth	Clinic Outpatient	19,035	$ 18,191,620
2011	Youth	Independent Clinician	7,560	$ 5,634,193
2011	Adult	Hospital Outpatient	13,608	$ 5,065,810
2011	Adult	Clinic Outpatient	64,648	$13,371,665
2011	Adult	Independent Clinician	19,230	$ 8,371,665
2012	Youth	Clinic Outpatient	19,823	$ 18,582,599
2012	Youth	Independent Clinician	7,987	$ 5,940,390
2012	Adult	Hospital Outpatient	18,708	$ 7,616,058
2012	Adult	Clinic Outpatient	82,529	$18,719,410
2012	Adult	Independent Clinician	22,115	$ 9,532,584

ECC and Non-ECC Registration Volume

- ECC's account for 24% of total outpatient registrations
- The percentage of outpatient registrations accounted for by Non-ECC clinics has been rising
- ECCs out perform Non-ECCs on access but the gap has been closing



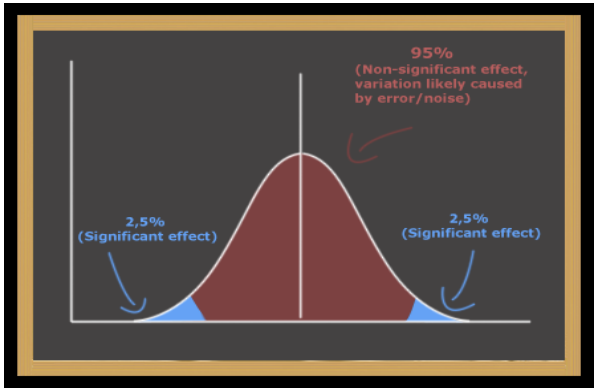
	Q3 '12	Q3 '12	Q1 '13	Q2 '13	Q3 '13	Q4 '13	Q1 '14	Q2 '14	Q3 '14
ECC	4,977	5,262	5,849	5,775	5,505	5,596	5,968	5,936	5,121
Non-ECC	13,331	12,974	15,775	15,281	15,909	16,151	19,178	19,264	22,653

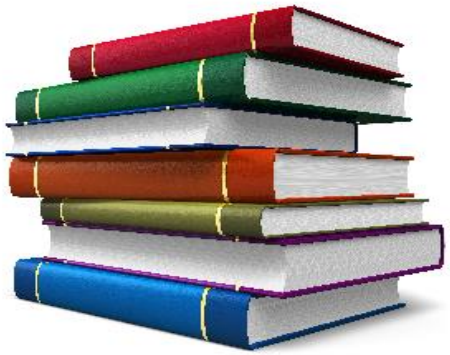
Evidence-Based Practices

- Over the last 10-15 years, a primary strategy to improve the quality of outpatient clinic services has been the implementation of Evidence Based Practices

Core Features of Evidence Based Practice

- Evidence of Effectiveness





- Sufficient Explication of the Model of Care

- Dissemination Readiness and Replicability

Lack OF EBPs In Outpatient Practice Nationally

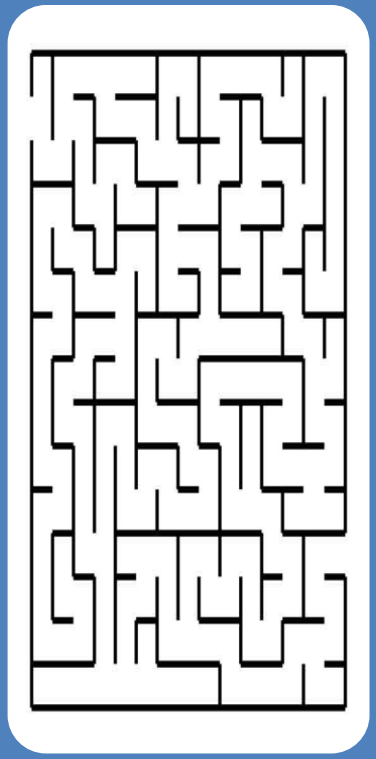
1% or less of current practice in the (children's) public sector is supported by an emerging or existing evidence base. (7)

"the dissemination and implementation of manualized, treatments (MESTs) remains strikingly limited in practice settings." (8)

"available scientific knowledge is too often underutilized." (9)

Institute of Medicine – The Gap between medical research and practice is so wide that it is regarded as a "chasm" (10)

Barriers to EBP Implementation



The process of implementing EBPs can be complex and challenging

- **Requires training, consultation, and monitoring**
- **Impacts caseloads, supervisory structures, and documentation requirements**

Barriers to EBP Implementation

Costs can be higher without increased compensation

- **Funding is typically the number one policy concern of public sector providers**
- **Few public or private systems provide higher rates or other financial incentives, for the provision of evidence based practices**

Barriers to EBP Implementation

Typically OP Clinics serve a heterogeneous population while most EBPS are targeted to a specific disorder

- **Effectively providing EBPs to the majority of those served would require the implementation of an array of separate EBPs.**
- **Requires a complex infrastructure**

EBPs and MBC

Penetration of EBPs in outpatient care has been slow and EBPs have not grown to scale

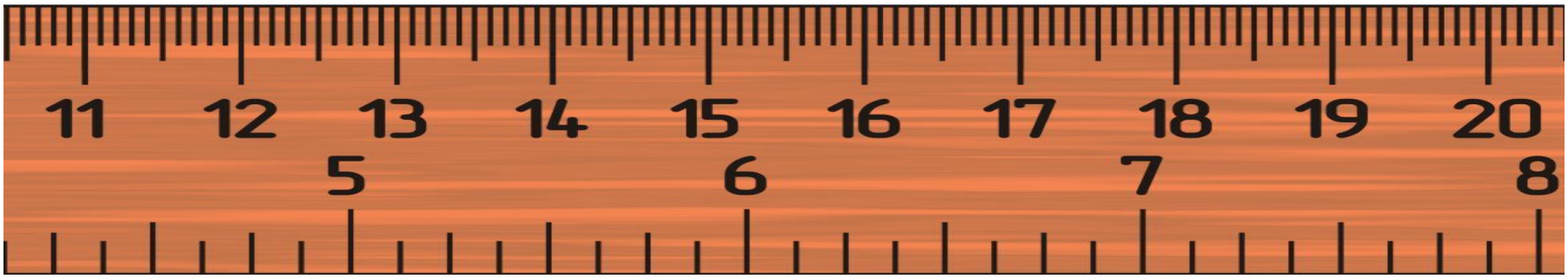
We can not rely on traditional EBP implementation as the only method of improving quality of outpatient care

Measurement Based Care (MBC) can be considered a viable alternative

Clinical Best Practices

MEASURMENT BASED CARE (MBC)

- **Measurement Based Care (MBC)** – an approach to improving outcomes and client experience by collecting standardized assessment information continuously throughout the course of treatment and regularly feeding back that information to clinicians as a clinical decision-support tool, and to clients as feedback on progress and as motivation for change.



MBC Terms

Measurement Based Care (MBC)

Measurement Feedback Systems

Continuous Outcomes Assessment

Patient Reported Outcome Measures (PROMs)

Contextualized Feedback

Evidence Base for MBC

- Lyon, et al - Based on a literature review of standardized assessment and a study with a cohort of 498 clinicians across 53 agencies;
  - Concluded "**the use of standardized assessment tools for evaluation and progress monitoring is regarded as an evidence based clinical competency in the provision of psychotherapy.**" (11)

Evidence Base for MBC

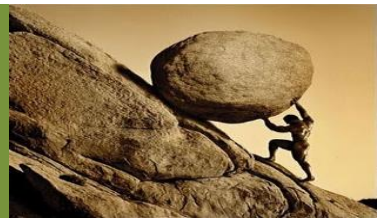
Evidence-Based Practices

- MBC has been incorporated into several EBPs including Reinforcement Based Therapy (RBT), & Modular Approach to Therapy with Children (MATCH)

The Value of Feedback

Measures and Markers are important components of Medical decision making

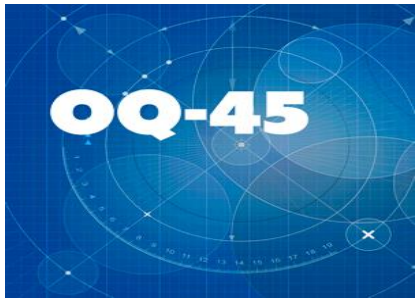
Feedback improves motivation



Feedback enhances engagement

Feedback improves clinical care

Four MBC Models W/Empirical Support



- Partners in Change Outcome's Management System – (PCOMS)
- OQ-45 Outcomes Management System
- Contextualized Feedback System
- Modular Approach to Therapy with Children (MATCH)

Key Features of MBC Best Practice

1. Brief Measures
2. User Friendly
3. Low Cost or Free
4. Provides Immediate Feedback in a useful format
5. Measures Symptoms/Functioning & Well-being
6. Includes Multiple Informants
7. Used with child and adult populations
8. Used with MH and SA populations
9. Can be used in group treatment
10. Is supported by evidence
11. User Friendly and Efficient IT System

Comparison Chart of MBC Systems

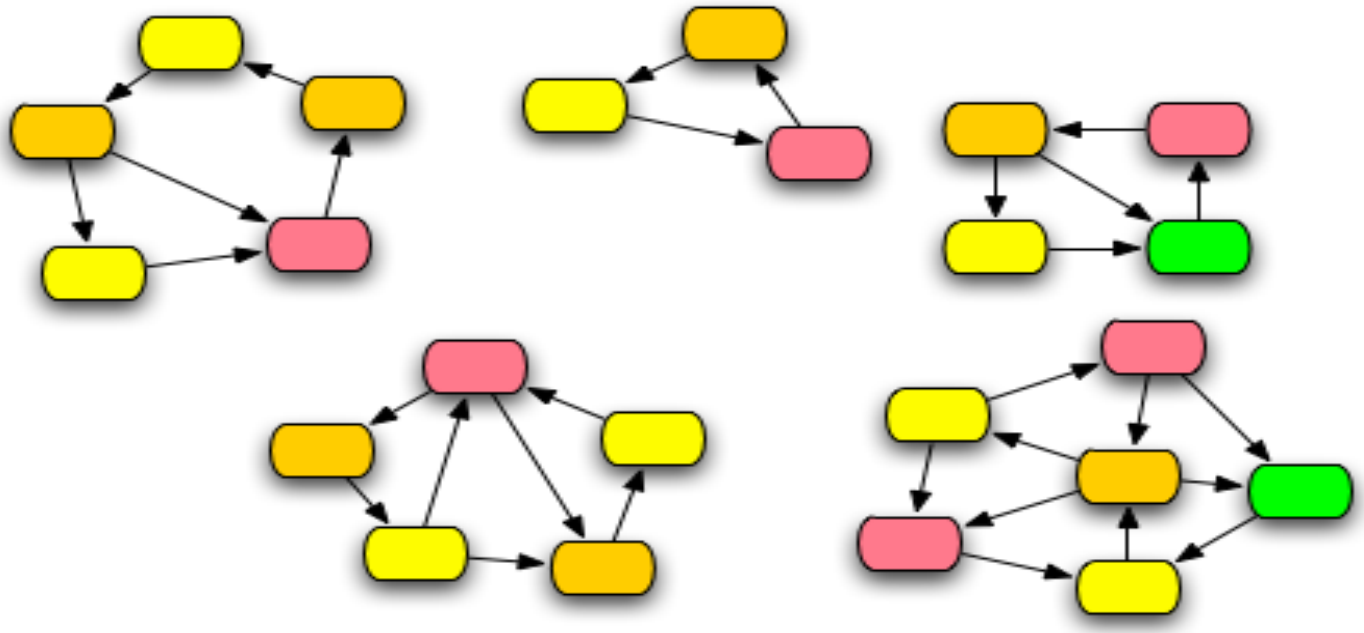
COMPARISON OF MEASUREMENT BASED CARE SYSTEMS											
MBC SYSTEM	ADULT	CHILD	+ SA	SYMPT. & FUNCT.	EB	GROUP	MANY REPORTS	IT SYSTEM INTE-GRATION	LOW COST	COMMON ELEMENTS	Total
PCOMS	4	3	3	0	3	4	0	1	2	2	22/40
OQ-45	4	3	4	4	3	3	2	1	1	2	27/40
CFS	0	4	2	4	3	0	4	1	2	2	22/40
MATCH	0	4	1	4	2	0	4	1	1	4	21/40
CUSTOM	3	3	3	3	0	3	3	3	3	2	26/40

0 = does not meet standard or N/A, 1= minimally meets standard, 2 =partially meets standard, 3=substantially meets standard, 4=fully meets standard

MBC – Supports Required

- IT Framework
- Manuals
- Training
- Consultation
- Fidelity Monitoring
- Performance Feedback
- Incentives/Sanctions
- Systems/regulatory Supports (e.g. higher education, licensing, accrediting bodies, etc.)

Common Elements



Common Elements

- A common elements approach is complementary to measurement based care
- The feedback and clinical decision support provided by MBC can help to direct clinical interventions built on the common elements of discrete EBPs
- Recognizing the limitations of discrete EBPs some researchers, clinical providers, and jurisdictions are advocating a Common Elements Approach to practice improvement

Common Elements

- **Common Elements** – the discrete, psychotherapeutic practices/skills that are common across multiple evidence based treatments. These factors include practices such as psycho-education, relaxation exercises, exposure, use of rewards to promote behavior change, positive reframing, parent training, genogram development, reframing of family conflict, etc.

Common Elements Transdiagnostic Approach (CETA)

- A Common Elements Transdiagnostic Approach (CETA) trains clinicians to flexibly apply common elements techniques based on symptoms/problems vs. diagnosis.

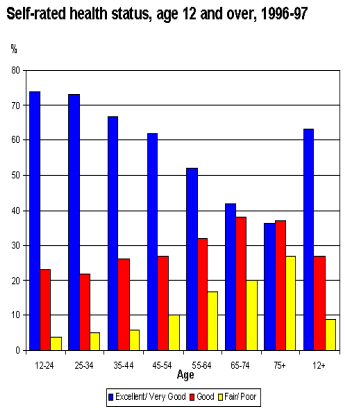
QUALITY MEASURES

Quality Measures

In addition to promoting best practices such as MBC and Common Elements approaches, state, county and private systems are introducing various quality measures to assist in practice improvement.

Types of Health Care Quality Measures

Process Measures



Source: Statistics Canada, National Population Health Survey, 1996-1997, *Statistical Report on the Health of Canadians*, catalogue no. 82-570-XIE.

Outcome Measures

Structural Measures

Process Measures

- Face Validity
- Results from feedback are clearly actionable
- Do not require risk stratification
- More directly under providers control
- Fewer issues with measurement
- Not the "ultimate" outcome being sought
- Need to be reliably related to outcomes
- Less subject to "gaming"
- May shift efforts/attention towards the specific processes being measured and away from other valuable activities

Outcome Measures

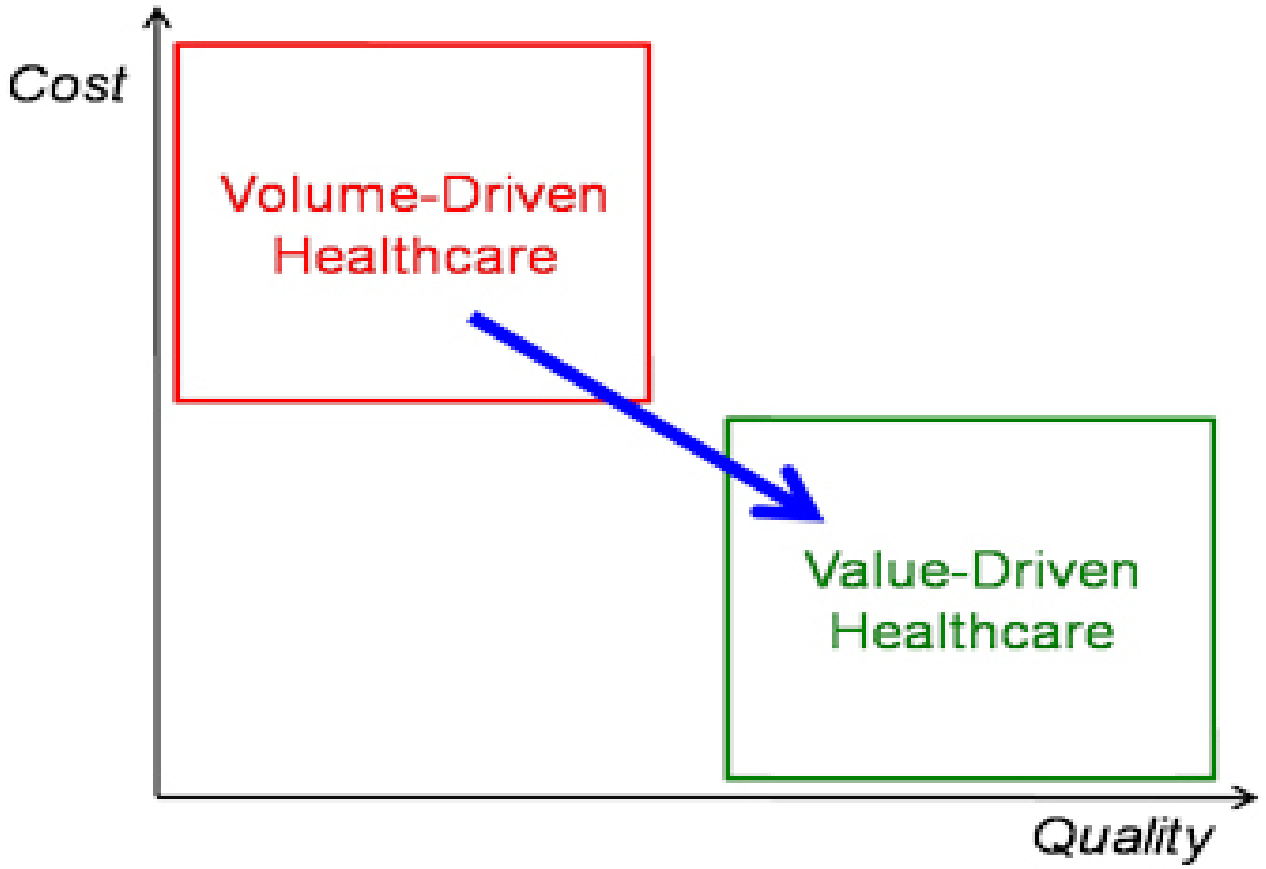
- The ultimate result we are seeking – an indicator of improved health (Improved mood, reduced mortality rates, etc.)
- Strong face validity – are people better off?
- May require case-mix adjustment
- Shifts effort/attention to what is being measured with possible neglect of other process/outcome
- Means of achieving may not be known
- Adjustments for sample attrition may be necessary depending on the measure
- Not always directly under providers control

Measurement Best Practice

- Reliable
- Valid
- Face Validity
- Sensitive
- Brief
- Cost-effective
- User Friendly

- Broad
- Non-duplicative
- Acceptable - reasonable rationale
- Efficient collection and aggregation.
- Clinically Useful – integral to better practice

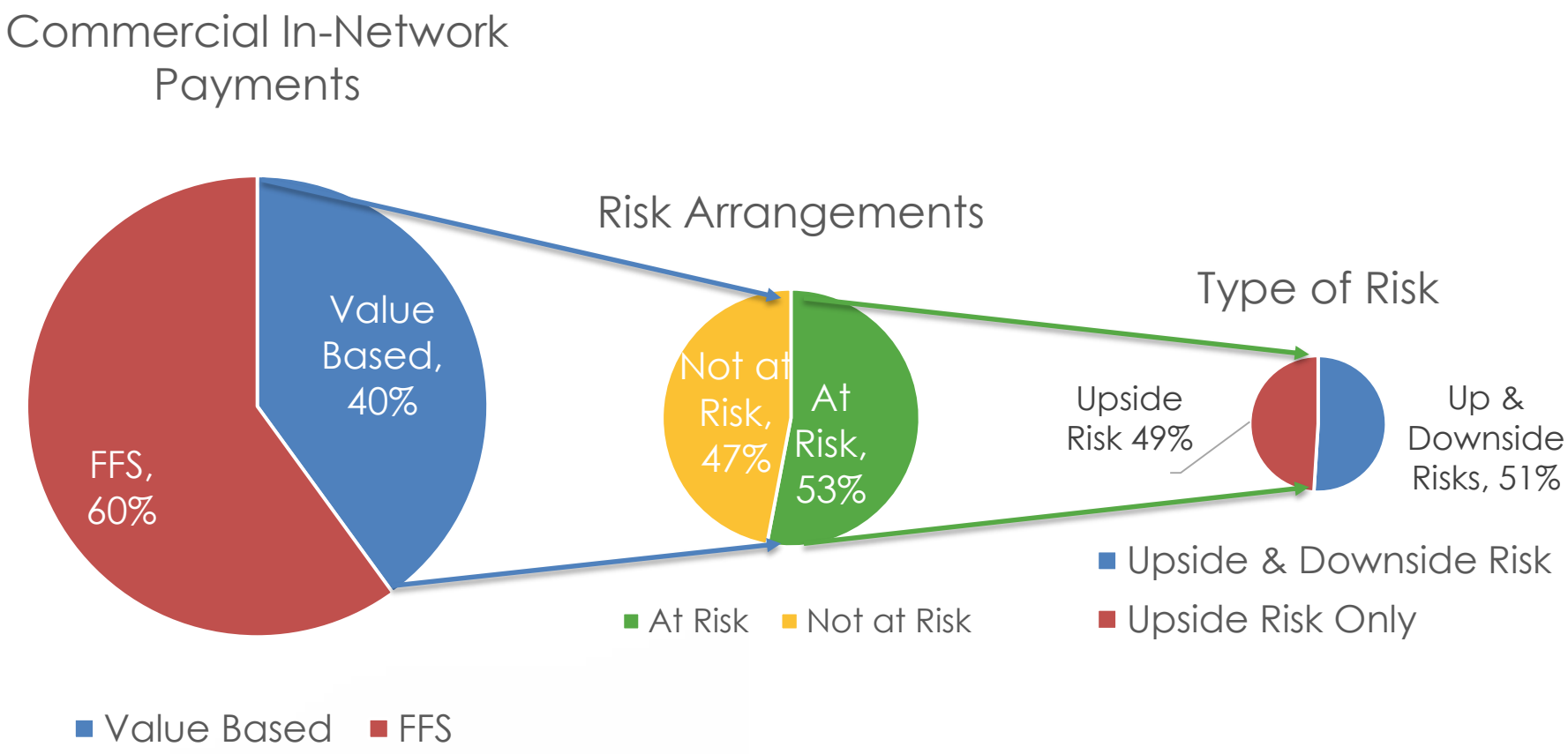
Value Based Payment



Fee-for-Service vs. Value Based Payment

- pure fee-for-service payment arrangements include little to no financial incentive for improving quality or outcomes
- under value-based payment arrangements, providers are paid for the value they produce through enhanced practice or improved outcomes

Types of Value Based Payment – Commercial Sector



"Recommended Best Practice" in Value Based Payment (VBP)

Applications of Behavioral Economics

- Size of Reward – Most VBPs are1% or less of compensation
- Series of Smaller Payments vs. One Lump Sum
- Tiered Thresholds vs. a Single Threshold
- Incentives delivered closer in time to desired behavior
- Downside risk more impactful but has other negative consequences
- Simple vs. Complex
- Gifts/perks more effective than money
- Money is not the only motivator – pride, competition, professional values, etc.

Payment Structures

- Fee-for-Service
- PMPM for Care Coordination
- Episode of Care/Case Rate
- Shared Savings
- Advance Payments for Practice Transformation
- Tiered Bonus Incentives
- Full Capitation

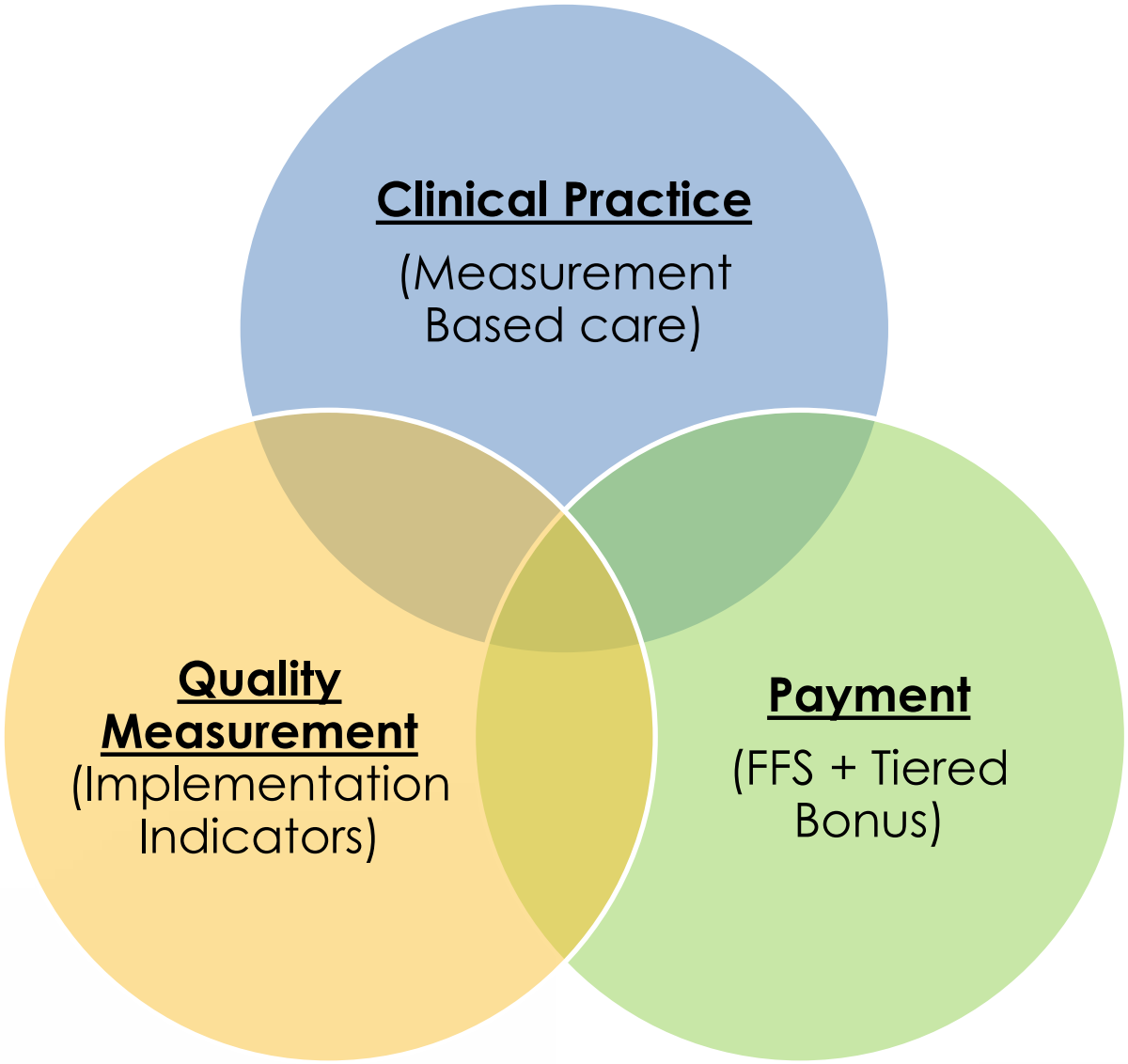
Public System State Payment Reform Examples

- **Oklahoma** - Tiered Payment System – MH
- **Oregon** – PMPM with Quality Bonus – Health
- **Arkansas** – Risk Sharing Episode of Care Payments for 9 Health and MH Conditions
- **Iowa** – Medical Home with FFS plus PMPM for coordination with PMPM bonus based on a tiered payment
- **Philadelphia** – Base rate plus annual performance bonus for meeting individualized quality metrics
- **MaineCare** – FFS to primary care with annual bonus. Focus on primary care.

Approaches to Payment for Consideration

- Consider modifying, incorporating, or revamping the current ECC program
- Explore Feasibility of a tiered bonus incentive system with upside risk only
- Consider incorporating best practices derived from behavioral economics as much as possible
- Initial focus on process measures of MBC; consider phasing in outcomes expectations in latter years
- Consider pros and cons of restructuring under the rehabilitation option to offer more flexibility in care delivery and place of service

Simplified Model of Outpatient System Components



Example of a Comprehensive Model

Clinical Practice

- Routine Collection of Measures
- Include Wellbeing, Symptoms & Functioning
- Embed Collection in VO Authorization System in lieu of other Auth. Data
- Provide a real-time data dashboard
- Provide Training, Coaching, and Quality Mgt.

Quality Measures

Process Focus

- Completion of Training
- Participation in Web-based LC
- Data Submission
- Use of Measures in Care
- Incorporation of Measures in Care Planning
- Phase in Outcomes over time

Payment Method

- Continue FFS
- Consider Rehab Option
- Review/Revise current ECC Structure
- Establish thresholds for participation
- Develop tiers
- Assign payment levels by tier
- Incorporate best practice from Behavioral Economics
- Reassess

Questions & Discussion

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