

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.

## Simplified Model of Outpatient System Components

#### **Clinical Practice**

(Measurement Based care)

**Quality Measurement** 

(Implementation & Outcome Indicators) **Payment** 

(FFS + Tiered Bonus)

#### Overview

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

## 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?



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

## **National Landscape**



#### **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

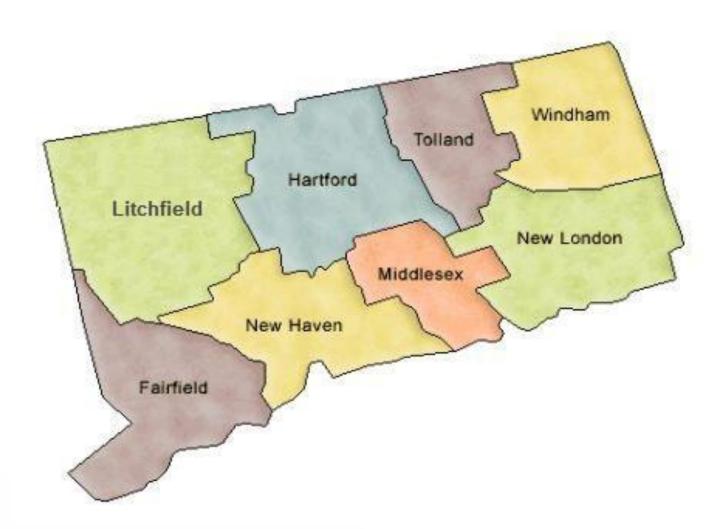


 a single session is the modal number of treatment sessions attended

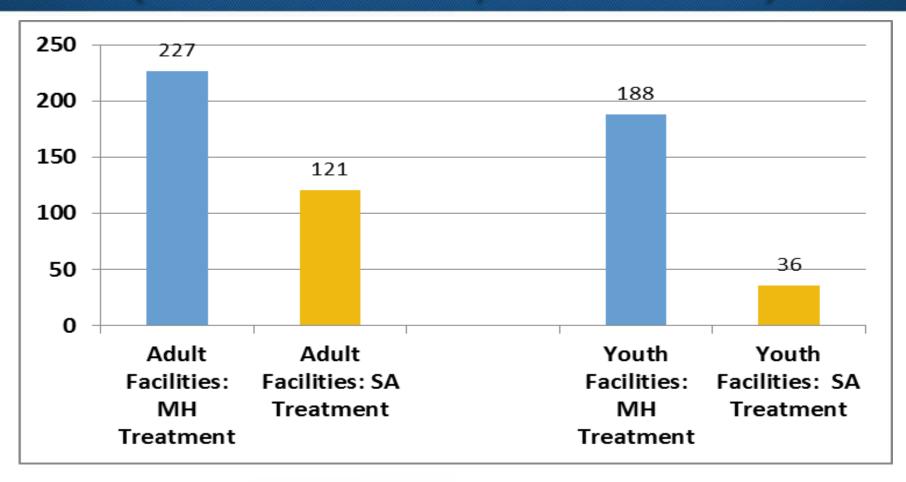


 individuals or families living in poverty or experiencing high levels of parent and family stress are less likely to attend outpatient therapy

## Connecticut Landscape



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

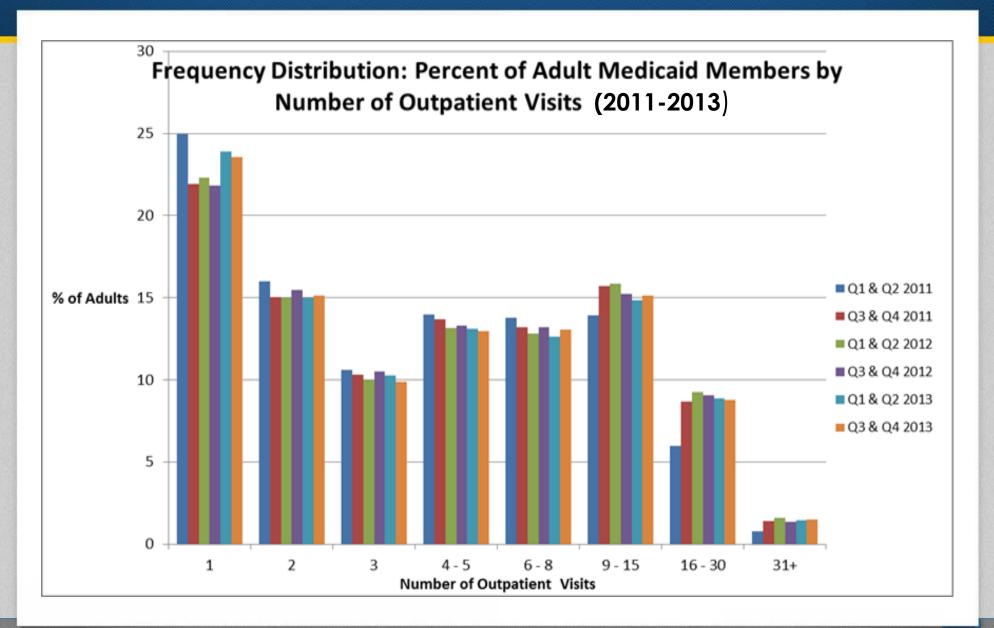


FQHCs BH Clinics School Based Clinics
Hospital Outpatient Clinics

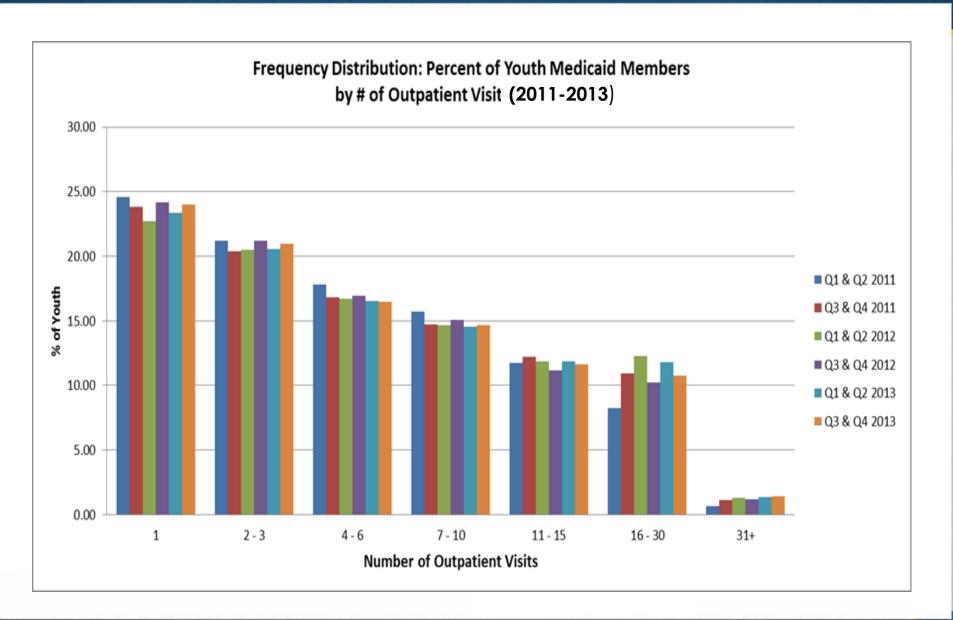
## Penetration Rate of Outpatient Services in Medicaid (As of 10/1/13)

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%

## Frequency Distribution of OP Visits - Adults



## Frequency Distribution of Outpatient Visits - Youth



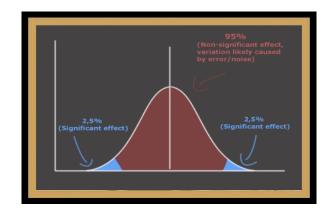


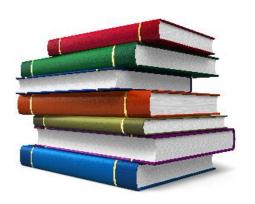
# Evidence-Based Practices

 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**



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

#### **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

#### 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

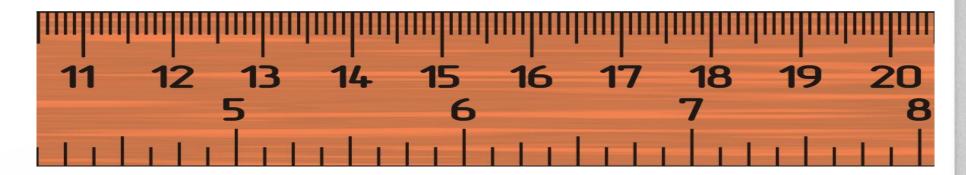
#### **Clinical Best Practices**





## 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.



#### The Value of Feedback

Measures and
Markers are
important
components of
Medical decision
making



Feedback improves motivation



Feedback enhances engagement



Feedback improves clinical care



#### **MBC Terms**

## Measurement Based Care (MBC)

Measurement Feedback Systems

Patient
Reported
Outcome
Measures
(PROMs)

Continuous Outcomes Assessment

Contextualized Feedback

## Four MBC Models W/Empirical Support









- Partners in Change
   Outcome's
   Management System –
   (PCOMS)
- OQ-45 Outcomes
   Management System
- ContextualizedFeedback 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

## 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.)





## **QUALITY MEASURES**





## **Quality Measures**

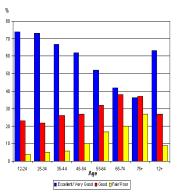
In addition to promoting best practices such as MBC, state, county and private systems are introducing various quality measures to assist in practice improvement.

## Types of Health Care Quality Measures

#### **Process Measures**



Self-rated health status, age 12 and over, 1996-97



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**

#### **PROS**

- Face Validity
- Results from feedback are clearly actionable
- Do not require case mix adjustment
- More directly under providers control
- Fewer issues with measurement
- Need to be reliably related to outcomes

#### CONS

- Not the "ultimate" outcome being sought
- Less subject to "gaming"
- May shift efforts/attention towards the specific processes being measured and away from other valuable activities

#### **Outcome Measures**

#### **PROS**

- The ultimate result we are seeking – an indicator of improved health (Improved mood, reduced mortality rates, etc.)
- Strong face validity are people better off?
- Most closely associated with costs of care

#### CONS

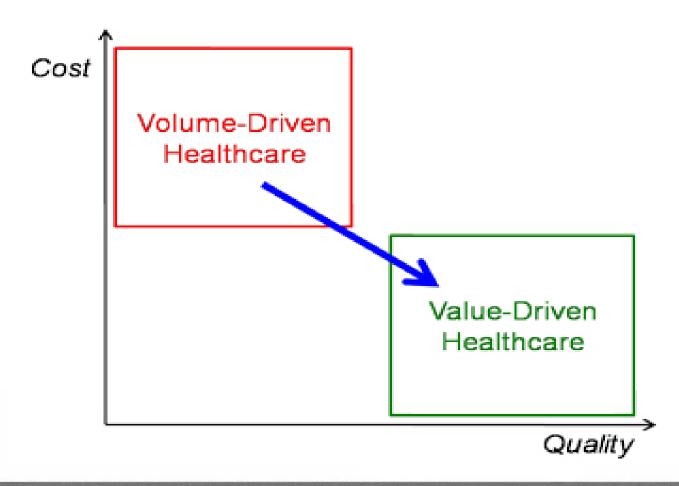
- May require case-mix adjustment
- Shifts effort/attention to what is being measured with possible neglect of other process/outcome
- Means of achieving may not be known
- Adjustments for sample attrition may be necessary depending on the measure
- Not always directly under providers control

#### **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

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

#### **Applications of Behavioral Economics**

- Size of Reward Most
   Downside risk more VBPs are 1% 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

- 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

#### **Clinical Practice**

(Measurement Based care)

Quality
Measurement
(Implementation
Indicators)

#### **Payment**

(FFS + Tiered Bonus)

## **Questions & Discussion**





#### References

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