IAP Medicaid Innovation Accelerator Program

Medicaid Innovation Accelerator Program Physical and Mental Health Integration

Measures that Matter: State Measurement Strategies that Drive Integration

National Dissemination Webinar

October 30, 2017, 3:00pm-4:30pm ET

Logistics for the Webinar

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Agenda

- Welcome and Introductions
- Medicaid Innovation Accelerator Program's (IAP) Physical and Mental Health (PMH) Integration initiative
- Emerging Themes and Strategies
- Measures that Drive Integration
- Quality Measurement in Colorado
- Questions and Discussion

Facilitator

- **Kitty Purington**, Senior Program Director, National Academy for State Health Policy

Presenters

- **Karen LLanos**, Director, Medicaid Innovation Accelerator Program
- **Dr. Harold Pincus**, MD, Professor and Vice Chair, Department of Psychiatry, Columbia University, Director of Quality and Outcomes Research, New York-Presbyterian Hospital
- **Leilani Russell**, Data Coordinator/Analyst, Colorado State Innovation Model (SIM) Office

Medicaid Innovation Accelerator Program's (IAP) Physical and Mental Health (PMH) Integration Initiative

Karen Llanos

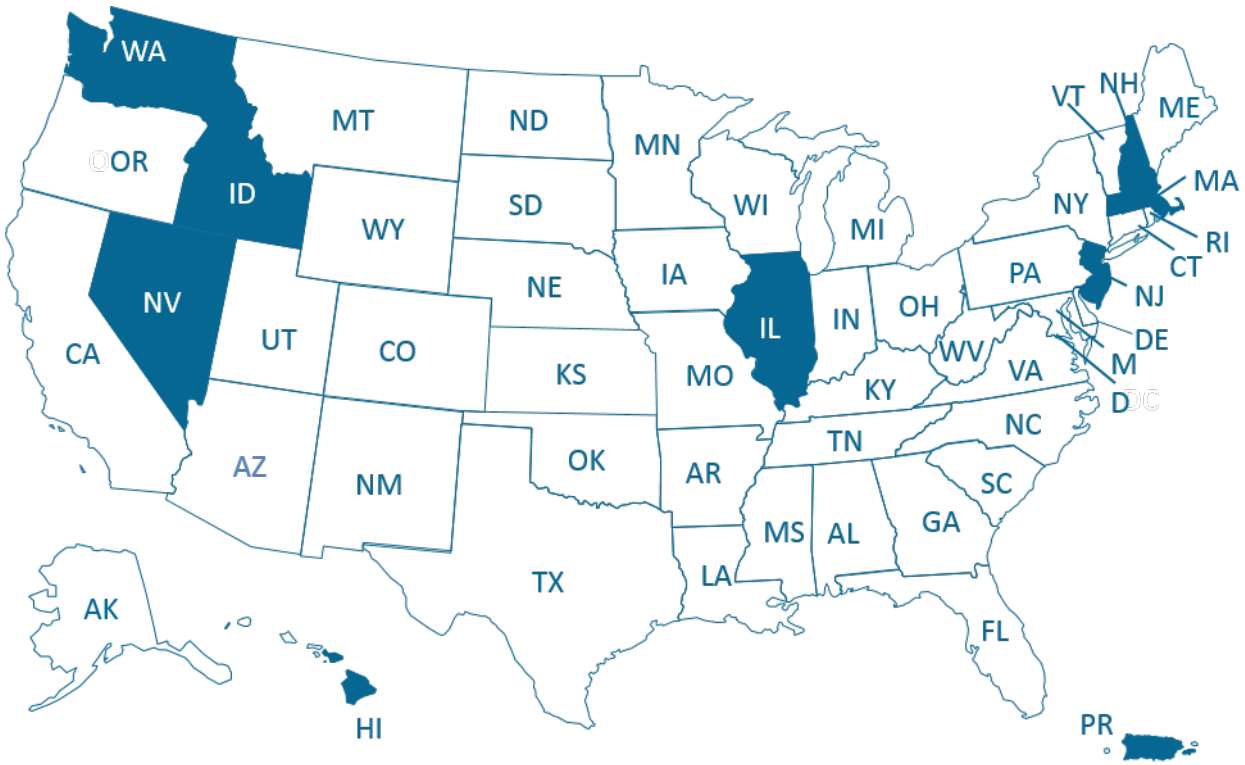
Director, Medicaid Innovation Accelerator Program

Background

- IAP worked with nine states over twelve months to enhance or expand diverse integration approaches by providing technical support on issues such as:
  - Administrative alignment
  - Payment and delivery system reform
  - Quality measurement
- This webinar is the second in a series of four national dissemination webinars for the IAP Physical and Mental Health Integration program area

Teams Participating in the IAP PMH Program Area

- Idaho
- Illinois
- Hawaii
- Massachusetts
- New Hampshire
- New Jersey
- Nevada
- Puerto Rico
- Washington



IAP Medicaid Innovation Accelerator Program

Poll Question

What is your biggest challenge in designing and implementing strategies that measure integrated care?

- Identifying measures that support state's goals
- Understanding what to measure regarding integration: care coordination, practice transformation, etc.
- Accessing the necessary data
- Incorporating integrated care measures into alternative payment methodologies
- Other (type in chat box)

Measuring PMH Integration: Themes and Strategies

Kitty Purington, JD

Senior Program Director, National Academy for State Health Policy

Themes and Strategies

- Define state goals and vision:
  - Engage stakeholders
  - Review models and definitions
  - Leverage best practices
- Create a measurement strategy
  - Align with existing state measurement activities
  - Inventory measures in use
  - Prioritize
  - Determine feasibility
- Use a combination of structure, process, and outcome measures to understand how PMH integration efforts are changing and improving care

Measures that Drive Integration

Dr. Harold Pincus
Professor and Vice Chair,
Department of Psychiatry
Co-Director, Irving Institute for Clinical and Translational Research,
Columbia University

Director of Quality and Outcomes Research
NewYork-Presbyterian Hospital

Behavioral Health/General Health Integration: Top Issues

1. Understanding the Interface of physical and behavioral health
2. "Measurement-Based Care" as a core clinical concept
3. Key Organizational Principles in a "continuum-based framework"
4. Creating a balanced portfolio across types of measures
5. Key strategies at policy levels
6. Challenges to measurement
7. "Shared Accountability" as a core concept
8. Creating a measurement agenda
   - Commonwealth Fund Project

A Reality Check

- How do YOU choose a doctor for yourself, your children, your parents?
- How do YOU choose a mental health provider for your children or suggest one for a friend or a family member?
- How do YOU determine whether your children are receiving high quality medical care?
- High quality mental health care?
- What DATA do you examine to answer these questions? What data do you WISH you had?

Clinical Examples at the Interface

- 35 year old male with schizophrenia, diabetes, and tobacco dependence
  - Can expect up to 25 year shortened life span, increased medical costs
- 25 year old HIV+ female IV drug user with post traumatic stress syndrome
  - Frequent emergency department visits, non adherence to meds, increased medical costs
- 60 year old female with diabetes, congestive heart failure and depression
  - Frequent (re-) hospitalizations, poor self management and adherence, early candidate for long term care

Assessing Both Sides of the Interface

- Patients primarily in contact with the general medical sector with co-morbid behavioral health conditions, e.g., depression, substance use disorders (SUD)
  - Not identified, or treated as acute problems with little follow-up
- Patients with severe and persistent behavioral health conditions (e.g., schizophrenia, bipolar disorder) and treated in behavioral health specialty settings
  - Poor self-care, medications worsen general medical conditions
  - Limited provider capacity and incentives
- Medical and behavioral health providers operate in silos

Measurement-Based Care

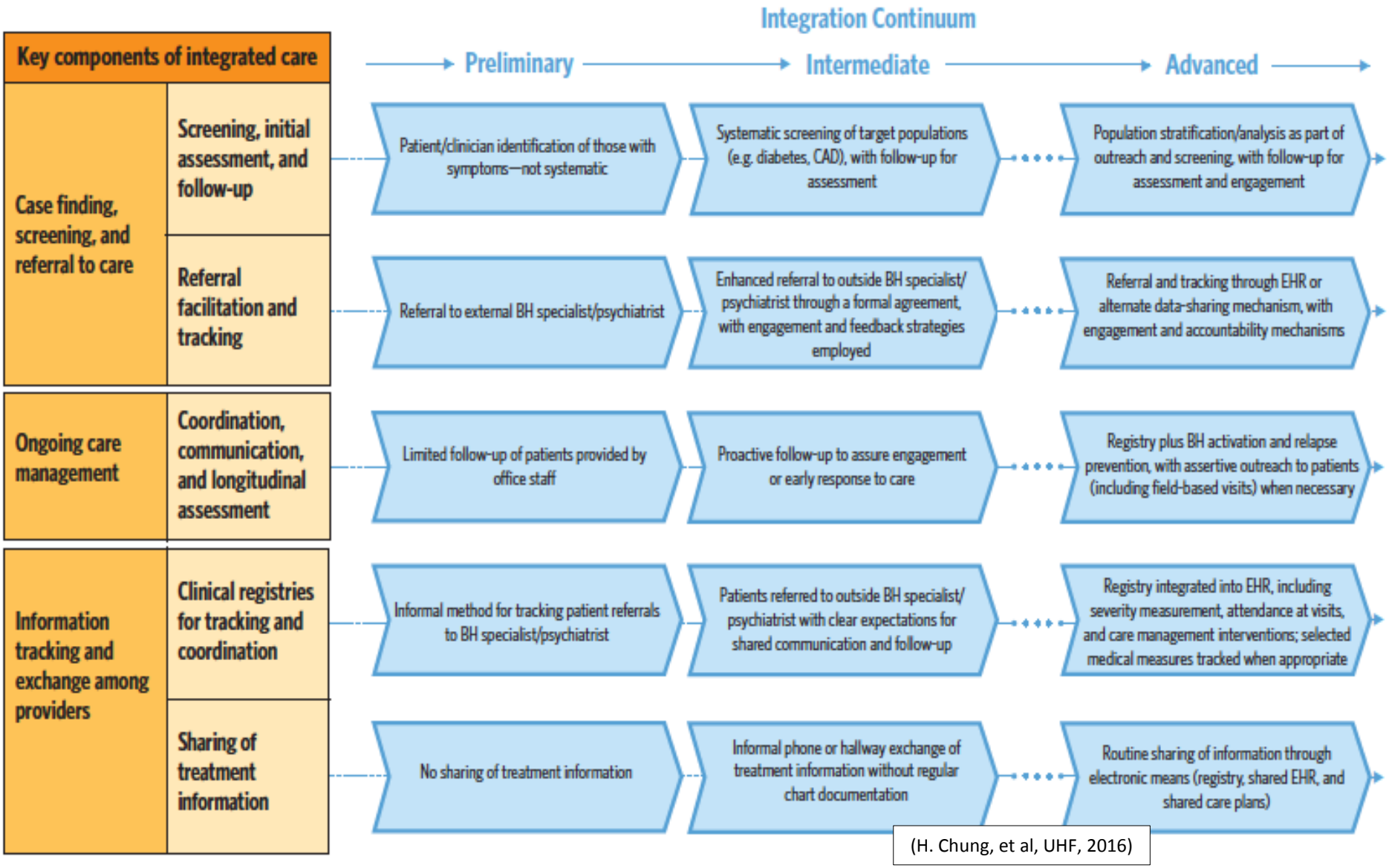
- Systematically apply appropriate clinical measures
  - e.g. Hemoglobin A1c, PHQ-9, Vanderbilt Assessment Scales
  - Create a measurement toolkit
- Assure consistent, longitudinal assessment
  - "Ruthless" follow-up/care management
- Use action-oriented menu of evidence-based options
  - Treatment intensification/"stepped care"
- Establish practice-based infrastructure
  - Build information technology/registry capacity
- Enhance Connectivity among Systems
  - Mental health/primary care/SUD/social services/education
- Incentivize structures that produce outcomes

10 Key Organizational Practices

1. Formalized partnerships (co-location?)*
2. Population management /predictive modeling*
3. Effective communication*
4. Care management with relentless follow-up*
5. Clinical registries for tracking and coordination*
6. Decision support for measurement-based/stepped care*
7. Access to evidence-based psychosocial services
8. Self-management as part of a recovery framework*
9. Link with community services/resources*
10. Data-driven quality measurement and improvement*

* = Health Information Technology (HIT)-sensitive practice

Key Principles: Continuum-Based Framework



(H. Chung, et al, UHF, 2016)

Creating a Balanced Portfolio Across Types of Measures

- Structure:
  - Are adequate personnel, training, facilities, Quality Improvement (QI) infrastructure, information technology resources, policies, etc. available for providing care?
  - Structures that support use and reporting of outcomes
  - The Joint Commission, Patient-Centered Medical Homes, Certified Community Behavioral Health Clinics (Protecting Access to Medicare Act, Section 223)
  - "Continuum Model"

Creating a Balanced Portfolio

- Process:
  - Are evidence-based processes of care delivered?
  - Behavioral health AND general medical care
  - Screening/follow-up, preventive care, acute care, maintenance care
  - Underuse, overuse, appropriateness, fidelity
    - Monitoring of depression symptoms and monitoring of hemoglobin A1c

Creating a Balanced Portfolio

- Outcome:
  - Does care improve clinical outcomes?
  - Clinical/symptoms, function/health-related quality of life
  - Behavioral health AND general medical outcomes
  - E.g. PHQ-9 for depression and blood pressure for hypertension

Creating a Balanced Portfolio

- Patient Experience:
  - What do users and other stakeholders think about the system's structure, the care they have received, and their outcomes?
  - Access, communication, engagement, etc.

Creating a Balanced Portfolio

- Resource Use:
  - What/how much resources are expended for providing care?
  - Are resources being used in an efficient way?
  - Readmissions (both behavioral health and general medical), total costs of care

Key Strategies at Policy Levels

- Realign financial and non-financial incentives
  - At patient, provider, practice, plan, purchaser, policy levels
- Incentivize structures that produce outcomes
- Establish national quality integrated care measures
  - Structure, Process, Outcomes – Commonwealth Fund Study
- Alter contractual/organizational arrangements between/among Providers and Payers
- Develop health information technology infrastructure/policies supporting effective communication and measurement
- Build bridges to "non-health" services
  - Transportation, Housing, SUD, Dental, Criminal Justice, Social Security
- Establish "Shared Accountability"

Shared Accountability Breaking Down Silos

- Relatively simple concept
- Applies to all participants caring for a patient;
- For example, the primary care physician is jointly responsible for assuring quality for both physical and behavioral health (BH) care
- BH provider is responsible for assuring quality for both BH and physical health care;
- The same applies to Med/Surg Health Plan and BH carve out
- Instantiated in training, practice, contracts, performance incentives, and ultimately, culture

Challenges to Measurement

- Adequacy/specificity of evidence base!
- Agreement/development/health information technology integration of clinical measures for “Measurement-Based Care”
- Codifying psychosocial interventions in administrative data (psychotherapy/“90806” v. Cognitive Behavioral Therapy v. Cognitive Behavioral Therapy with fidelity)
- Adequacy of data sources - documentation or reality
- Determining benchmarks/risk adjustment

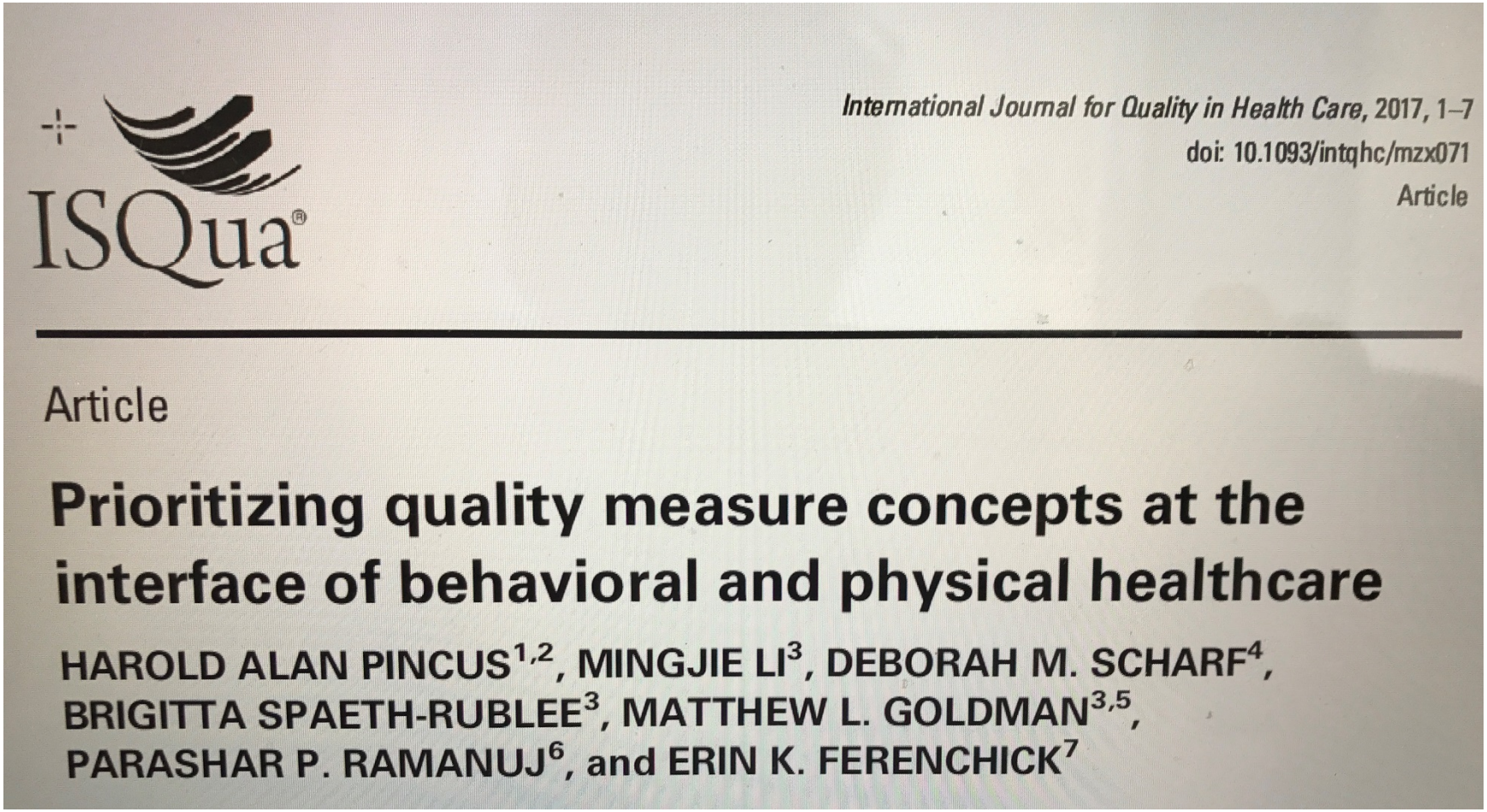
Challenges to Measurement

- Linking structure-process-outcome measures (e.g. Action to Control Cardiovascular Risk in Diabetes outcomes)
- Who is stewarding/funding measure development?
- Behavioral health providers far behind in implementation of health information technology (exclusion from the Health Information Technology for Economic and Clinical Health Act)
- Heterogeneity of providers/training/certification

Creating a Measurement Agenda: Commonwealth Fund Project

- Reviews of potential
  - Process
  - Structure
  - Access
  - Outcome/patient perceptions
  - Costs/efficiency
- Expert/Delphi panel process
- Serious Mental Illness (SMI) as a “Disparities Category”
- Engaging the QMIC (“Quality Measurement Industrial Complex”)

Commonwealth Fund Delphi Panel



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Article

Article

Prioritizing quality measure concepts at the interface of behavioral and physical healthcare

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Domain Framework: Measurement Development for Integrated Care

- Overall Strategic Framework: Structure, Process and Outcomes
  - Domain 1: Stratification/disparities for preventive/chronic disease care in populations with serious mental illness
- Section A: General medical care for individuals with behavioral health conditions
  - Domain 2: General medical screening or diagnostic assessment and prevention
  - Domain 3: Outcomes and patient perception of care
  - Domain 4: Continuity and coordination of care
  - Domain 5: Access to general medical care

Domain Framework: Measurement Development for Integrated Care

- Section B: Behavioral health care in general medical settings
  - Domain 6: Mental health screening or assessment
  - Domain 7: Behavioral health evidence-based treatment
  - Domain 8: Behavioral health patient-centered care
  - Domain 9: Continuity and coordination of care
  - Domain 10: Access to behavioral health care
- Section C: Concepts applying to both general medical and behavioral health settings
  - Domain 11: Continuity and coordination of care
  - Domain 12: Social service access
  - Domain 13: Cost and efficiency

Serious Mental Illness as a "Disparities Category"

- High level of general medical co-morbidity
- Lack of access to primary/preventive care
- Poor quality of care
- Reduced life span
- Potentially easily implemented measurement strategy
- Report existing endorsed measures for this population segment, for example:
  - Receipt of preventive health interventions, screening, immunizations
  - Process and outcomes measures for common general medical comorbidities such as smoking, diabetes, hypertension, cardiovascular
- Include in national disparity reports

Quality Measurement SMI Segmentation

National Quality Forum (NQF) Endorsed Measures

Measure Number	NQF Endorsed Measures
1927	Cardiovascular screening for Schizophrenia or Bipolar patients on antipsych meds
1932	Diabetes screening for Schizophrenia or Bipolar patients on antipsych meds
1933	Cardiovascular monitoring for people with cardiovascular disease and schizophrenia
1934	Diabetes mellitus monitoring for people with diabetes mellitus and schizophrenia
2601	Body Mass Index screening and follow-up for SMI population
2602	Blood Pressure control for SMI population with hypertension
2603	Hemoglobin A1c testing for SMI population with diabetes mellitus
2604	Nephropathy screening for SMI population with diabetes mellitus
2606	Blood pressure control for SMI population with diabetes mellitus
2607	Hemoglobin A1c control for SMI population with diabetes mellitus
2608	Hemoglobin A1c control for SMI population with diabetes mellitus
2609	Eye exam for SMI population with diabetes mellitus
2600	Screen (and follow-up) for tobacco use in SMI or alcohol or other drug use population
2599	Screening (and counseling) for alcohol use in SMI population

Questions?

Measuring PMH Integration: Colorado

Leilani Russell
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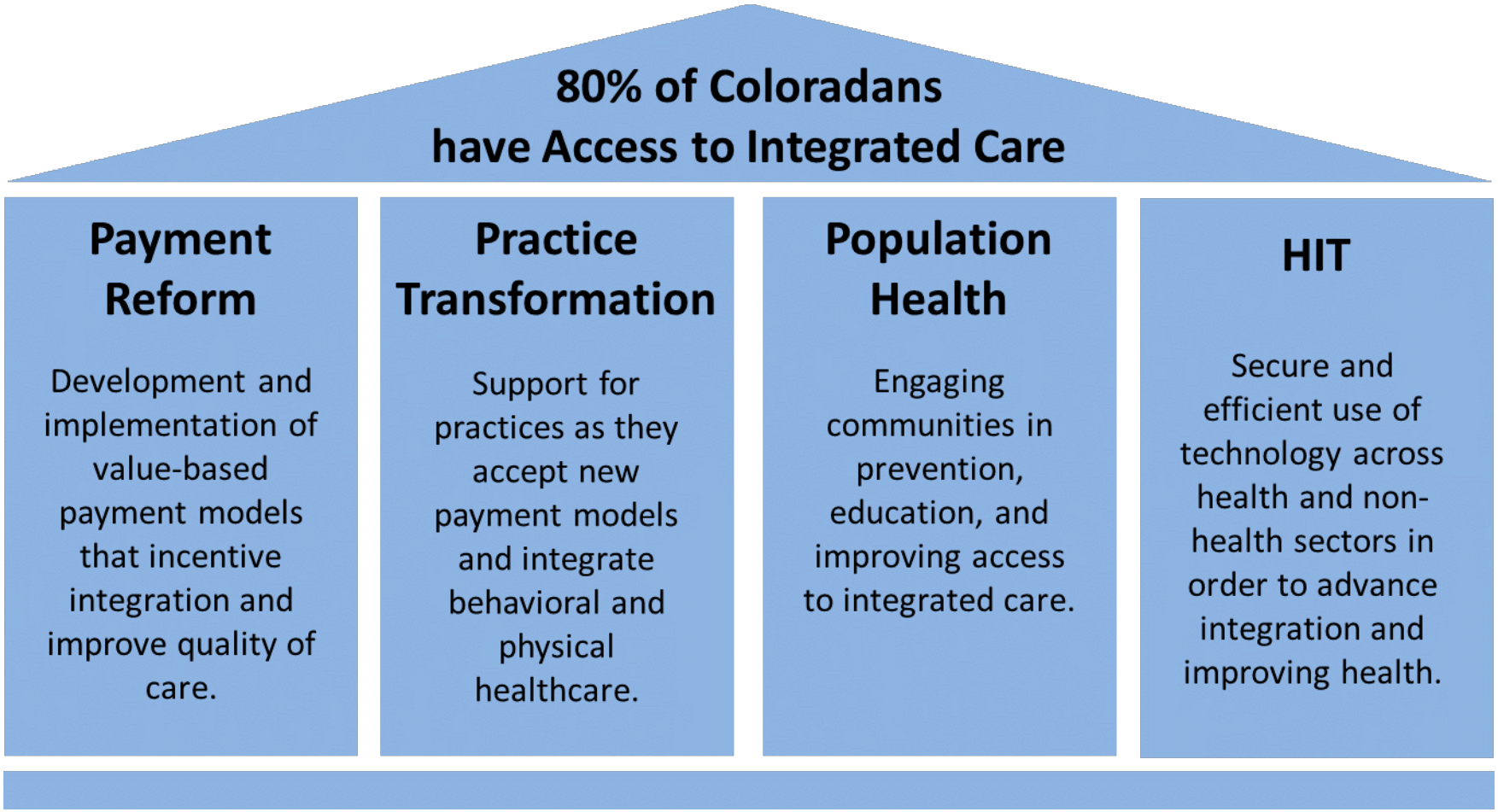
Colorado State Innovation Model (SIM) Office

SIM celebrates one year of practice implementation and plans for future success.

Colorado State Innovation Model (SIM) Approach



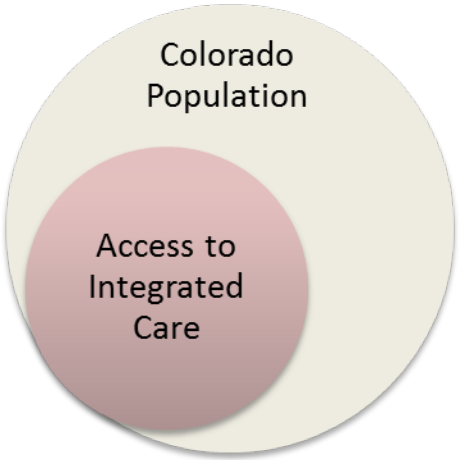
Measuring Success

Goal

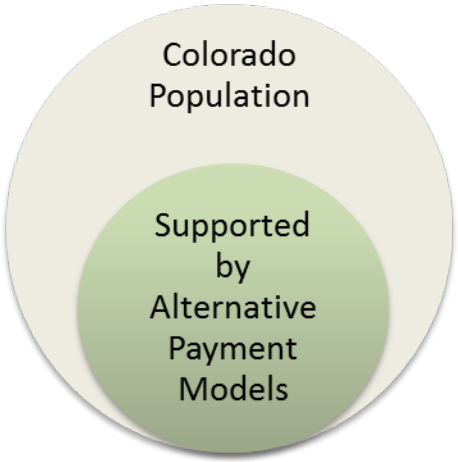
CO SIM Overarching Goal:

Improve the health of Coloradans by providing access to integrated physical and behavioral healthcare services in coordinated systems with value-based payment structures for 80% of Colorado residents by 2019.

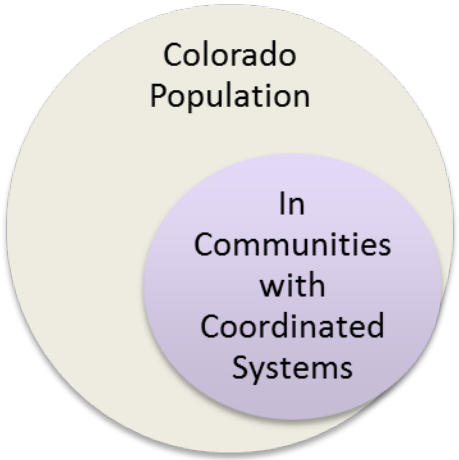
Access to Integrated Healthcare



Healthcare Supported by Alternative Payment Models



Healthcare in Communities with Coordinated Systems



Measuring Impact

Clinical Quality Measures	Population Health	Cost & Utilization	Model participation (process)	Access to care	Additional Evaluation Measures
•Depression Screening	•Anxiety disorders among adults	•Total Cost of Care	•Payment reform (practices/beneficiaries in APMs)	•Prevention Quality Chronic Composite	•Access to *integrated* care (IPAT, milestones, CHAS)
•Diabetes: Hemoglobin A1c	•Adults being treated for mental health	•Out of Pocket Expenditures for Consumers	•Practice transformation (practices, providers, beneficiaries in cohort)	•Prevention Quality Acute Composite	•Client experience of care
•Hypertension	•Prenatal care counseling about maternal depression	•Admissions	•Population health (LPHAs, RHCs, provider education)	•Pediatric Quality Overall Composite	•Payer/provider ROI
•Obesity: Adult & Adolescent	•Adults who are currently depressed	•Psychiatric Admissions	•HIT (broadband, CQM reporting)	•Prevention Quality Overall Composite	•Community System Coordination Index
•Developmental Screening	•Suicide death rate	•Readmissions			•Collaboration, stakeholder engagement
•Maternal Depression	•Developmental screening for children	•Psychiatric Readmissions			•Workforce and policy efforts
•Substance Use Disorder: Alcohol and Other Drug Dependence, Tobacco	•Binge Drinking	•Emergency Department (ED) Rate			•SPLIT assessment data (performance improvement plans, data quality, field notes)
•Asthma	•Current smoking among adults	•Psychiatric ED Rate			•Key informant interviews (challenges, successes, lessons learned)
•Fall Safety	•Heavy Alcohol Consumption	•Follow-up after Hospitalization for Mental Illness			
	•Non-medical opioid use	•Actuarial calculations			

Measuring Prioritization

- Center for Medicare & Medicaid Innovation reporting requirements
  - Model participation (process measures)
  - Model performance (outcomes measures)
  - Payer participation (APM/payment measures)
- Seven SIM stakeholder workgroups
  - Practice Transformation
  - Healthcare Information Technology
  - Population Health
  - Evaluation
  - Consumer Engagement
  - Policy
  - Workforce Development

Measuring Prioritization

- Alignment with existing initiatives
  - Comprehensive Primary Care Plus, Quality Payment Program/Merit Based Incentive Payment System
  - Medicaid primary care alternative payment model
- Multi-payer Collaborative
  - Alignment with national Health Care Payment and Learning Action Network data collection efforts
  - Priorities for value-based payment models
- Leverage existing data and infrastructure where possible
  - Reduce reporting burden for practices and other partners

Data Sources & Systems

Shared Practice Learning and Improvement Tool (SPLIT) Assessments

Assessment Name	Purpose	Who Fills it Out	Responsible for Reporting	Timing	Expected Time to Complete (Minutes)
Medical Home Practice Monitor	Practice self-assessment of level of implementation of core aspects of advanced primary care.	Practice Team led by PF	Practice Champion or PF	Baseline & Annually	60
IPAT (*Integrated Practice Assessment Tool*)	Assesses current behavioral health integration (BHI) methods along levels of coordination, co-location, and integration.	Practice Champion	Practice Champion or PF	Baseline & Annually	10
Clinician and Staff Experience Survey	Individual provider and staff survey that assesses two subscales - Clinician and Staff Experience, and Burnout.	All members of Practice	Each practice member	Baseline & Annually	15
SIM Milestone Activity Inventory	Assesses practice's current implementation of SIM milestone activities, helps identify gaps and prioritizes practice's next steps.	Practice Team led by PF	Practice Champion or PF	Baseline & Every 6 Months	60
Data Quality Assessment	Assesses practice's current state of data quality including accuracy of data element capture, validity of CQM reports and desired next steps for HIT.	Practice HIT Champion led by CHITA	CHITA	Baseline & Annually	60
Practice Improvement Plan	SMART goals related to practice transformation as it relates to milestone activities (can be done at same time as SIM Milestone Activity Inventory).	Practice Team led by PF	PF	Baseline & Every 6 Months	15
Clinical Quality Measures	Track patient and process outcomes achieved by practices.	Practice Champion	Practice Champion or CHITA	Every calendar quarter	Variable

Clinical Quality Measures: Adults

Measure Condition	SIM Metric Title	Citation	CPC+	QPP	TCPI	HCPF APM
Primary CQMs						
Depression	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	NQF 0418 CMS 2v6	Depression Remission at 12 Months	✓	✓	✓
Diabetes: Hemoglobin A1c	Diabetes: Hemoglobin A1c Poor Control	NQF 0059 CMS 122v5	✓	✓	✓	✓
Hypertension	Controlling High Blood Pressure	NQF 0018 CMS 165v5	✓	✓	✓	✓
Obesity: Adult	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up Plan	NQF 0421 CMS 69v5	No obesity measure (not required for SIM if in CPC+)	✓	✓	✓
Substance Use Disorder: Alcohol and Other Drug Dependence	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	NQF 0004 CMS 137v5	✓	✓		✓
Substance Use Disorder: Tobacco	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	NQF 0028 CMS 138v5	✓	✓	✓	✓
Secondary CQM						
Asthma	Medication Management for People with Asthma *(replaced to align with QPP)*	NQF 1799 CMS n/a		✓		✓
Fall Safety	Falls: Screening for Future Fall Risk	NQF 0101 CMS 139v5	✓	✓		
Maternal Depression	Maternal Depression Screening	NQF 1401 CMS 82v4		✓	✓	✓
Substance Use Disorder: Alcohol	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	NQF 2152 CMS n/a	Alcohol & Other Drug Dependence measure *(above)*	✓		✓
Measures reported via APCD claims data automatically						
Breast Cancer	Breast Cancer Screening	NQF 2372 CMS 125v5	✓ *(clinical)*	✓ *(clinical)*		✓
Colorectal Cancer	Colorectal Cancer Screening	NQF 0034 CMS 130v5	✓ *(clinical)*	✓ *(clinical)*	✓	✓

Clinical Quality Measures: Pediatrics

Measure Condition	Metric Title	Citation	QPP	TCPI	APM
Primary CQMs					
Depression	Preventive Care and Screening: Screening for Clinical Depression and Follow-up Plan	NQF 0418 CMS 2v6	✓	✓	✓
Development Screening	Developmental Screening in the First Three Years of Life *(developed by Mathematica)*	NQF 1448 CMS – under development	No developmental screening measure	✓	blank
Maternal Depression	Maternal Depression Screening	NQF 1401 CMS 82v4	✓	✓	blank
Obesity: Adolescent	Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NQF 0024 CMS 155v5	✓	✓	✓
Secondary CQM					
Asthma	Medication Management for People with Asthma *(replaced to align with QPP)*	NQF 1799 CMS n/a	✓		✓

[CQM Reporting Requirements Summary]

[Updated CQM Guidebook]

Measurement: Access to Care

- All Payer Claims Database (APCD) data using standardized Agency for Healthcare Research and Quality Access to Care metrics
- Shared Practice Learning and Improvement Tool data: Integrated Practice Assessment Tool (IPAT), Medical Home Practice Monitor, Milestone Activity Inventory
- Number of patients served by providers scoring a specific integration threshold level on the IPAT, Milestone Inventory, and access estimates from APCD data analysis
- Colorado Health Access Survey

Challenges

- No one data source or measure for estimating access to integrated care
- Piecing together a puzzle from various data points:
  - Access to care (not necessarily integrated care)
  - Behavioral health outcomes
  - Primary care outcomes
  - Clinical data
  - Claims data
  - Statewide data
  - SIM cohort practice specific data
  - Assessment data on milestones (interim process achievements)

Return on Investment

- SIM is expected to save or avoid $126.6 million in healthcare costs and have a 1.95 return-on-investment (ROI) by the end of the program.
- Cost, cost savings/avoidance, return on investment projections (proposal, baseline, annually)
- SIM cost and utilization measures (quarterly)
  - Aggregate cohort
  - Individual reports for each participating practice
- Actuarial cost and utilization measures (semi-annually)
  - Aggregate cohort
  - Individual reports for each participating practice
- Cost savings/avoidance and return on investment analyses (annually)

Questions?

Key Takeaways

- A robust quality measurement strategy for PMH integration can include a diversity of measure types, such as:
  - Structure, process, outcome, cost, access
- There are emerging frameworks for structuring and measuring integrated care that states can use in developing their measurement strategy
- States can build infrastructure for data collection using diverse sources, including:
  - Existing data, EHRs, practice assessments and reporting, etc.

Upcoming IAP PMH Integration Webinars

Coming Winter 2018!

- Building Provider Capacity National Learning Webinar
- Administrative Alignment National Learning Webinar

Thank you for joining!

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