Measurement & Public Reporting of Behavioral Health Integration: Current State & Moving Forward

QC BH Committee

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April 2012
Objectives

• Review goals, timeline of BHI Metrics initiative
• Review current challenges of identifying, reporting BHI metrics
• Provide overview of potential public reporting metrics
  – Current status
  – Near-term
  – Long-term
QC BH Integration Metrics Initiative

Original Project Goals:

• Develop/adopt measures of physical and behavioral health integration that are aligned with efforts in other states and possible national measures

• Implement a sustainable statewide data collection system

• Implement a sustainable public reporting system for behavioral health integration measures
Original Project Timeline (3 years)

2010 – Design for Sustainability
• Develop/adopt measures
• Recruit participating sites
• Field test measures with a sample of sites
• Develop data infrastructure plan

2011 – Implement
• Finalize metrics and data infrastructure
• Collect and report blinded data to sites
• Develop public reporting parameters, policies, educ. tools
Original Project Timeline (3 years)

2012 – Finalize for Sustainability

- Begin unblinded data distribution
- Finalize metrics, reporting processes and ownership
- Work with national groups on comparative reporting
- Go live with public reporting
- Hand off systems to post-grant reporting “owner”
**Original Proposed BHI Measures**

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Primary Care Sites - Adult</th>
<th>Primary Care Sites - Ped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of Integration</td>
<td>BH Integration into 1° Care</td>
<td>BH Integration into 1° Care</td>
</tr>
<tr>
<td></td>
<td>Site Self Assessment</td>
<td>Site Self Assessment</td>
</tr>
<tr>
<td>Integration Measures</td>
<td>Depression Screening</td>
<td>Pedi Sx Checklist</td>
</tr>
<tr>
<td></td>
<td>Depression Care</td>
<td>Depression Screening</td>
</tr>
<tr>
<td></td>
<td>Alcohol Screening</td>
<td></td>
</tr>
<tr>
<td>Patient Experience of</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Care</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Staff Experience</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
In the Meantime...
A Changing Health Care Environment

• Evolving performance measurement & public reporting
• Importance of engaging consumers in identifying, using quality data
• Changing payment models
  – P4P
  – PCMH
  – Risk models, ACOs
Purchasers (MHMC) Vision for a Transformed Healthcare System

Healthy, productive, connected people & families

...receiving healthcare from highly functioning “accountable care organizations”

... supported by a robust & well-supported primary care base
## Transforming Current Health Care Systems: A Glide Path to Change

<table>
<thead>
<tr>
<th>Engaged Communities / ACOs</th>
<th>Improved Care Transitions</th>
<th>Community Care Teams</th>
<th>Patient Centered Medical Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Purchaser led payment reform</td>
<td>- Focused care transition strategy, standard key changes</td>
<td>- ‘Hot Spotting’ high needs patients</td>
<td>- Team-based approach to care</td>
</tr>
<tr>
<td>- Training and data for Medicaid Value Based Purchasing</td>
<td>- Enhanced discharge planning process</td>
<td>- care coordination</td>
<td>- Practice-integrated care management</td>
</tr>
<tr>
<td>- Community-based consumer engagement</td>
<td>- Community-based care transition coaches</td>
<td>- Social and community support</td>
<td>- Data for population health management</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Integrated behavioral health</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Shared decision making</td>
</tr>
</tbody>
</table>

- Community-based consumer engagement
Changing Delivery System & Payment

- **Advanced Primary Care/PCMH**
  (New workforce: Practice RN Care Managers)

- **Community Care Teams for High-Cost/High-Risk Patients**
  (New workforce: CCT staff)

- **Enhanced Care Transitions**
  (New workforce: Hospital + Community-based Care Transition Coaches)

- **Bundled Payments, or**
- **Shared Savings, or**
- **Partial Capitation, or**
- **Global Capitation**

Healthcare Delivery System Change + Payment Reform = System Transformation
BHI Metrics Public Reporting

• **Current status:**
  – MHMC “Get Better Maine” (PTE) public reporting
  – Maine PCMH Pilot

• **Near-term**
  – MHMC Get Better Maine – “Advanced Primary Care” /Medical Home reporting

• **Long-term**
  – ACO pilots & public reporting / accountability
Quality Measurement & Public Reporting: MHMC “Get Better Maine” (PTE)

• Reporting quality on Maine hospitals & PCP practices since 2002
• Over 50% Maine PCP practices voluntarily participate
  • Office systems
  • Clinical outcomes: diabetes, CVD, depression
• Employers using for tiering, steering
• Have strongly endorsed including BHI measures
MHMC: [www.getbettermaine.org](http://www.getbettermaine.org)
## Compare Practice Ratings

### See how your selected Practices compare for Quality ratings:
- **Good**
- **Better**
- **Best**

*Practices can only receive a "Best" rating in the Safe category*

> Where do these ratings come from?

Adult Care ratings for your selected practices

(Last updated on Fri, 08/19/2011 - 10:41)

<table>
<thead>
<tr>
<th>Practice</th>
<th>Ratings</th>
<th>Safe</th>
<th>Patient Satisfaction</th>
<th>Other Areas of Consumer Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baker Family Health</td>
<td>Better</td>
<td>Did Not Report</td>
<td>Coming Soon</td>
<td>Accepting New Patients</td>
</tr>
<tr>
<td>33 Bath Rd, Brunswick, ME 04011 (207) 721-9323</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Bowdoin Medical Group - Brunswick</td>
<td>Good</td>
<td>Good</td>
<td>Coming Soon</td>
<td>Yes</td>
</tr>
<tr>
<td>74 Boniboue Dr, Brunswick, ME 04011 (207) 798-4050</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Martin's Point Medical Group - Brunswick</td>
<td>Better</td>
<td>Good</td>
<td>Coming Soon</td>
<td>Yes</td>
</tr>
<tr>
<td>6 Farley Rd, Brunswick, ME 04011 (207) 725-8070</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Lisbon Family Practice</td>
<td>Did Not Report</td>
<td>Did Not Report</td>
<td>Coming Soon</td>
<td>Yes</td>
</tr>
<tr>
<td>2 Beebe St, Lisbon, ME 04250 (207) 353-6721</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
</tbody>
</table>

### Effective

Provides the care that experts recommend

- **Diabetes Care**
  - Download a diabetes checklist for your doctor
  - Ratings explained
  - Better
  - Good
  - Better
  - Good

- **Heart Disease Care**
  - Download a heart disease checklist for your doctor
  - Ratings explained
  - Good
  - Good
  - Better
  - Did Not Report

### Safe

Has systems to prevent medical errors

- Systems to track test results, send reminders, avoid medication errors
  - Ratings explained
  - Better
  - Better
  - Best
  - Best

### Patient Satisfaction

What patients say about this practice

- How Patients Have Rated Their Experiences
  - Coming Soon
  - Coming Soon
  - Coming Soon
  - Coming Soon

### Other Areas of Consumer Interest

Taking new patients, office hours, health benefit discounts, and other useful information

- Accepting New Patients
  - Yes
  - Yes
  - Yes
  - Yes
Get Better Maine – Current Primary Care Practice Reporting

• Clinical quality - processes & outcomes of care (NCQA or BTE recognition)
  – Diabetes – e.g. HbA1C, BP, LDL, eye exams
  – CVD – e.g. BP, LDL, tobacco
  – Depression – e.g. screening, response to treatment

• Office systems of care
  – e.g. Use of EMR, registries, nurse care management

• Coming soon: Patient experience of care
  (CG-CAHPS - MQF plans for statewide surveying)
Maine’s Medical Home Movement

~ 540 Maine Primary Care Practices

92 NCQA PCMH Recognized Practices

~100 MaineCare HH Practices??

26 Maine PCMH Pilot Practices

20 Pilot Phase 2 Practices (TBD)

14 FQHCs CMS APC Demo

Payers:
- Medicare
- Medicaid
- Commercial plans (Anthem, Aetna, HPHC)
- Self-funded employers

Payer: Medicaid

Payer: Medicare
Maine PCMH Pilot Practice “Core Expectations”

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT
Promoting BH Integration in Pilot

• Pilot “Core Expectation” for BH integration:
  • Practices to conduct baseline assessment of BH integration (SSA)
  • Practices commit to taking steps to make specific improvements in BH integration – e.g.
    • Implement routine PHQ-9 screening
    • Co-locate BH services in practice
    • Improve communication w/ BH providers
PCMH Pilot Community Health Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, helping patients overcome barriers to care, improve outcomes
- Includes expectation to provide and/or coordinate BH & SA needs
- Key element of PCMH cost-reduction strategy, targeting high-cost patients to reduce avoidable costs (ED use, admits)
Maine PCMH Pilot Community Care Teams

Community Resources

High-need Individual

PCMH Practice

Behavioral Health & SA

Care Mgt

Medication Mgt

Coaching

Outpatient Services

Hospital Services

Specialists

Physical Therapy

Communication

Family

Workplace

Environment

Schools

Transportation

Food Systems

Shopping

Income

Heat

Faith Community

Literacy

Housing

Medication Mgt

Coaching

Maine Quality Counts

Better Health Care Better Health
Medicaid Health Homes: ACA Section 2703

- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid “State Plan Amendment”
- Health Homes may serve individuals with:
  - Two or more chronic conditions
  - One chronic condition and who are at risk for another
  - Serious mental illness
    - Adults with serious & persistent mental illness (SPMI)
    - Children with severe emotional disturbance (SED)
- Dual eligible beneficiaries cannot be excluded from Health Home services
MaineCare Health Homes Proposal

**Stage A:**
- Health Home = Medical Home primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
  - Two or more chronic conditions
  - One chronic condition and at risk for another

**Stage B:**
- Health Homes = Community Mental Health Center (CMHC) CCT + Medical Home primary care practice
- Payment weighted toward CMHC CCT
- Eligible Members:
  - Adults with Serious and Persistent Mental Illness
  - Children with Serious Emotional Disturbance
MaineCare Health Homes Proposal

**Stage A:** Serve Individuals with Chronic Conditions

- Health Homes Beneficiary
- PCMH Practice
- Care Mgt
- Medication Mgt
- Coaching
- Behavioral Health & SA (Community Care Team)
MaineCare Health Homes Proposal

**Stage B:** Serve Individuals with SPMI and/or SED
BHI Metrics Consumer Input

• Focused, facilitated group discussion with consumers held June 2011
• Consumers expressed low awareness of integration efforts between physical & behavioral health providers
• Expressed interest in reporting measures of overall health, functional status
BHI Metrics Public Reporting

• Current status:
  – MHMC “Get Better Maine” (PTE) public reporting
  – Maine PCMH Pilot

• Near-term
  – MHMC Get Better Maine - “Advanced Primary Care” / Medical Home reporting

• Long-term
  – ACO pilots & public reporting / accountability
MHMC/PTE Medical Home Recognition

• MHMC/PTE aiming to develop “Advanced Primary Care”/PCMH/Health Home” recognition that ties together various medical/health home initiatives
• Aims to create recognition that relates closely to reward programs of different national health plans, CMS, and Medicaid
• Seeks to be consistent with and/or leads where national efforts are going
• Aims to tie together various organizations in Maine working on this
### MHMC “Advanced Primary Care” / Medical Home Recognition

<table>
<thead>
<tr>
<th>Possible APC Ratings</th>
<th>NCQA PCMH Office Survey</th>
<th>Outcomes BTE</th>
<th>Patient Experience (CG-CAHPS)</th>
<th>BH Integration</th>
<th>Access (CG-CAHPS)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Good</strong></td>
<td>PCMH Level 1 or BTE</td>
<td>2 Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td><strong>Better</strong></td>
<td>Better</td>
<td>2 Better</td>
<td>Better</td>
<td>Better</td>
<td>Better</td>
<td>Better</td>
</tr>
<tr>
<td><strong>Best</strong></td>
<td>Best</td>
<td>2 Best</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
<td>Best</td>
</tr>
</tbody>
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![Quality Counts Logo](image)
MHMC “Advanced Primary Care”/Medical Home Recognition

• Pt experience, access to care:
  – Current: practice efforts to systematically measure pt exp
  – Coming soon: MQF statewide CG-CAHPS survey, with public reporting of results from all participating practices

• BH Integration: practice self-report using web-based data collection tool:
  – “Level of integration” (Level II or higher)
  – Depression screening for high-risk pts (diabetes & CVD) using PHQ-2/9 (50%+)
Behavioral Health Integration into Primary Care

Measuring Behavioral Health into Primary Care: Practices will be recognized for early steps in behavioral health integration and screening of a majority of their patients with diabetes and/or heart disease for depression.

Reporting will begin with:

--The primary care practice's level of integration (requiring a Level II or higher) (for more information, please see the Levels of Integration Matrix on Maine Quality Counts' website: BHI Levels of Integration Matrix), and

--The administration of annual depression screening (using the PHQ-2 or PHQ-9 or equivalent) with 50% or more of the practice's high risk population (defined as all patients in the practice with diabetes and/or heart disease per NCQA Physician or Bridges to Excellence (BTE) definitions. Please see: Advanced Primary Care Diabetes and CVD Definitions. For more information on NCQA, please see: NCQA Recognition Programs).

3. I understand that based on my responses entered below, I may be asked to participate in a validation of the data. This practice agrees to participate in a validation of the data, on request.

   Name:
   
   Title:

1) Self-assessment of Level of Behavioral Health Integration

Criteria: Scores Level II or higher on Behavioral Health Integration into primary care, based on the survey below (For more information on the Levels of Integration, please see the Maine Quality Counts website: BHI Levels of Integration Matrix)

Please answer the following questions about your practice:

4. Does your practice have a mental health clinician located onsite (in this case defined as within the physical walls of the practice)?
How GBM Quality Ratings Are Being Used

• Employers – e.g. State of Maine Employees
  – Tiered hospitals, PCPs as “preferred” if achieve higher levels of quality performance
  – Offer financial incentives to employees for using “preferred” hospitals & providers (waive copays)
  – Recently expanded elements for tiering to include costs

• Payers – some (small) P4P, now moving towards “Value Based Purchasing” initiatives
BHI Metrics Public Reporting

• Current status:
  – MHMC “Get Better Maine” (PTE) public reporting
  – Maine PCMH Pilot

• Near-term
  – MHMC Get Better Maine - Advanced Primary Care / Medical Home reporting

• Long-term
  – ACO pilots & public reporting / accountability
Long-Term: ACO Reporting & Accountability

• ACO outcomes: frequent focus on “Triple Aim” of outcomes
  – Total health care costs, population health, patient experience

• Potential measures:
  – Patient experience – e.g. CG-CAHPS access, BH questions
  – BH / SA screening, treatment quality measures
  – Functional status
ACO Measures

• CMS – Pioneer ACO – 33 clinical quality measures
  – Pt exp (CG-CAHPS): access, dr communication, health status
  – Depression screening

• NCQA – ACO Recognition
  – Patient experience (CG-CAHPS)
  – Clinical measures – e.g. depression med management,
    initiation of alcohol/SA treatment, f/u after MH hosp

• Local ACO pilots
  – Individual purchaser/ provider pilots (e.g. MEGeneral-SEHC)
  – MaineCare – Accountable Communities RFP – TBD
Functional Status Assessment: The Ultimate Measure of Integration?

e.g. Patient Reported Outcomes Measurement System (PROMIS)
PROMIS Tool – Measuring Global Fxn

<table>
<thead>
<tr>
<th>Item</th>
<th>Excellent</th>
<th>Very Good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>In general, would you say your health is...</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>In general, would you say your quality of life is...</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>In general, how would you rate your physical health?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>In general, how would you rate your mental health, including your mood and your ability to think?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>In general, how would you rate your satisfaction with your social activities and relationships?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
Next Steps

- **Current**: Encourage primary care practices to pursue PCMH status & seek MHMC/GBM Adv’d Primary Care/ Medical Home recognition

- **Near-term**: Use all available paths to promote BH integration as key to PCMH model
  - Maine PCMH Pilot, MaineCare HH, NCQA PCMH

- **Long-term**: Work to encourage inclusion of measures that reflect BH integration into ACO models
A Healthier Maine

Did you know people in Maine get the right care only about half the time, yet we pay more for health care than almost any other state in the country? This is not “the way it should be.” The good news is that we are working hard to improve health...  [Read more]

Upcoming QC Events

- Sep 12 2pm: Membership & Marketing Planning Call
- Sep 15 2pm: Monthly All Team PUP Collaborative Conference Call
- Sep 16 10am: AF-40 National Alliance Maine REL Training

QC News

- QC Board Committee on Behavioral Health featured a guest speaker at Sept meeting
- Health IT Roundtable Ask the Experts Webinar on 9.8 at 12N
- QC 2011 Aroostook County: Strategies for Improving Care Integration 9.14

Other News & Events

- Maine Health Workforce Forum 2011 Summit - 10-18
- MPIN Learning Session Webinar on 9.20 - Managing Medications for High Risk Patients
- Important Information from CMS for eligible Hospital and Critical Access Hospital Providers
- Important Information from CMS for eligible Medicare Providers

Sign up for E-News

Learn about new programs in Maine designed to promote high quality healthcare, improve access to healthcare, and contain healthcare costs.
Contact Info / Questions

- BHI Metrics initiative: Lisa Tuttle MPH
  - Ltuttle@mainequalitycounts.org

- Lisa Letourneau MD, MPH
  - LLetourneau@mainequalitycounts.org

- BHI Metrics Initiative
  - www.mainequalitycounts.org
  (See “Programs” → BHI Metrics)

- MHMC Get Better Maine reporting
  - Ted Rooney: trooney@healthandwork.com