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)
Outpatient Clinics are usually the first point of entry into the service system
Nationally, there is a gap between typical outcomes achieved in outpatient care and what can be accomplished with evidence based interventions.
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)
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.
OUTPATIENT CLINIC SITES
(CTBHP Network Report – 10-2-2014)

<table>
<thead>
<tr>
<th>Type</th>
<th>Adult Facilities: MH Treatment</th>
<th>Adult Facilities: SA Treatment</th>
<th>Youth Facilities: MH Treatment</th>
<th>Youth Facilities: SA Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHCs</td>
<td>227</td>
<td>121</td>
<td>188</td>
<td>36</td>
</tr>
<tr>
<td>BH Clinics</td>
<td></td>
<td></td>
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<tr>
<td>School Based Clinics</td>
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<tr>
<td>Hospital Outpatient Clinics</td>
<td></td>
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</tbody>
</table>
### Penetration Rate of Outpatient Services in Medicaid (As of 10/1/13)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>All Medicaid Members</th>
<th>Percent of Members</th>
<th>Medicaid Members Authorized for Outpatient Services</th>
<th>Percent Authorized for Outpatient Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>593,468</td>
<td>100%</td>
<td>104,939</td>
<td>17.7%</td>
</tr>
<tr>
<td>Adult (18+)</td>
<td>303,529</td>
<td>51.1%</td>
<td>75,659</td>
<td>25%</td>
</tr>
<tr>
<td>Youth (0-17)</td>
<td>289,939</td>
<td>48.9%</td>
<td>29,280</td>
<td>10%</td>
</tr>
</tbody>
</table>
Frequency Distribution: Percent of Adult Medicaid Members by Number of Outpatient Visits (2011-2013)
Frequency Distribution: Percent of Youth Medicaid Members by # of Outpatient Visit (2011-2013)
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
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
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.
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
**Measurement Based Care (MBC)**

- **Measurement Feedback Systems**
- **Continuous Outcomes Assessment**
- **Patient Reported Outcome Measures (PROMs)**
- **Contextualized Feedback**
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
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
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**

- **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

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

Cost

Volume-Driven Healthcare

Value-Driven Healthcare

Quality
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

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Size of Reward – Most VBPs are 1% or less of compensation</td>
<td>Downside risk more impactful but has other negative consequences</td>
</tr>
<tr>
<td>Series of Smaller Payments vs. One Lump Sum</td>
<td>Simple vs. Complex</td>
</tr>
<tr>
<td>Tiered Thresholds vs. a Single Threshold</td>
<td>Gifts/perks more effective than money</td>
</tr>
<tr>
<td>Incentives delivered closer in time to desired behavior</td>
<td>Money is not the only motivator – pride, competition, professional values, etc.</td>
</tr>
</tbody>
</table>
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
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Questions & Discussion