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Maximize success with performance and quality measures

Don’t let your organization get left behind

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Stakeholders at all levels of the human services industry are focusing on performance and outcome measures as tools for improving quality of care and reducing healthcare costs, regardless of their care delivery model.

Executive summary

With the shift from volume to value ramping up across the healthcare industry, there has been an increased focus on healthcare quality, particularly among the organizations serving consumers with chronic conditions and complex support needs. Stakeholders at all levels of the human services industry are focusing on performance and outcome measures as tools for improving quality of care and reducing healthcare costs, regardless of their care delivery model.[1] These measures are increasingly tied to reimbursement.[2]

Due to standardized measures and data collection practice, physical health has long seen positive clinical outcomes, improvements in quality of care, increases in consumer satisfaction and cost savings for both the consumer and the provider organization. Behavioral health, unfortunately, has missed out on these benefits, with many agencies only in recent years beginning to implement and collect data on quality measurements. One challenge that has mitigated the adoption of quality measures in behavioral health is symptoms and conditions don’t offer the same concrete, binary measures and outcomes as physical health. Therefore, many of the current behavioral healthcare quality measurements have been process-based or have only a cursory connection to behavioral health. To truly operate as a consumer-centric entity, behavioral health care organizations need quality measures that support a focus on consumer outcomes, satisfaction and engagement.

Organizations serving consumers with chronic conditions and complex support needs should be advocating for standardized data collection for behavioral health services. To be sustainable in this complex, value-based care market, provider organizations will need to build a new business model—this includes creating new partnerships, developing innovative service lines, and creating a sound technology infrastructure. The agencies governing behavioral health need to be pushed to develop standardized outcome measures and data collection that focuses less on process-based measures and more on measures that truly track clinical outcomes and recovery. This standardization would help improve consumer behavioral health outcomes and save both the consumer and provider organization time and money related to health costs and conditions.

1 Kilbourne, et al. (2018, Feb 17). *Measuring and improving the quality of mental health care: a global perspective.* World Psychiatry. 17(1); 30-38. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/

2 New England Journal of Medicine Catalyst Newsletter. (2018 Mar.) *What is Pay for Performance in Healthcare?* Retrieved from https://catalyst.nejm.org/pay-for-performance-in-healthcare/

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Leveraging technology is essential to gain value and build a sustainable strategy. Without the right tools, it will be increasingly difficult for organizations to quantitatively demonstrate their value to payers and other stakeholders. Building a comprehensive technology infrastructure is critical in both improving performance and reducing costs. A comprehensive electronic health record (EHR) is the key to creating a system that collects the right data and enables a variety of teams to be strategic in identifying the behavioral health needs of their consumer population. Organizations must ensure their EHR has the capability to collect, calculate and report on the various quality measures required under both current and future performance-based contracts.

Don't let your organization get left behind—make sure you are equipped with the right technology to support quality measurements to not only compete, but thrive in the new value-based care environment.

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The rise of performance measures

Only one-third of consumers with mental health issues receive adequate mental healthcare, and less than half of those with Medicare/Medicaid receive adequate follow up after hospitalization.[3] Individuals with depression only receive effective care 57.7% of the time, and individuals with alcohol dependence receive effective care only 10.5% of the time—the lowest of any condition.[4] The National Committee of Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures show only half of individuals with mental health and substance use needs receive recommended care.[5] Lower quality care and outcomes in behavioral health lead to poor health outcomes and higher healthcare costs, making the need for quality measurements to improve consumer outcomes even greater.

Yet quality measurement in behavioral health care tends to be more complicated than physical health care, mostly because in physical health, many of the quality and performance measures are concrete and binary. For example, if a consumer has diabetes, a provider can measure whether their hemoglobin A1c went up or down. This is a quantifiable measure that can demonstrate a positive or negative outcome. Unfortunately, these concrete measurements are not readily available in behavioral health. For example, for a consumer with schizophrenia, there is no singular way to measure progress in recovery and there is no industry-wide agreement on what that progress and recovery should look like.

This puts behavioral health care at a disadvantage compared to physical health care, which has been using well-established performance measures for years.[6] Most performance measures have been generally relegated to "process measures," or checking to confirm that certain events have occurred—i.e., was a consumer screened for depression, or was a consumer with schizophrenia taking antipsychotic medications screened for diabetes. This poses a great need for the entire behavioral health industry—the need for standardization of data collection and quality measures.

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3 Kilbourne, et al. (2018, Feb 17). *Measuring and improving the quality of mental health care: a global perspective.* World Psychiatry. 17(1); 30-38. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/

4 New England Journal of Medicine Catalyst Newsletter. (2018 Mar.) *What is Pay for Performance in Healthcare?* Retrieved from https://catalyst.nejm.org/pay-for-performance-in-healthcare/

5 Pincus, H.A., et al. (2016, Jun). *Quality Measures For Mental Health And Substance use: Gaps, Opportunities, And Challenges.* Health Affairs. 35(6). Retrieved from https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0027

6 New England Journal of Medicine Catalyst Newsletter. (2018 Mar.) *What is Pay for Performance in Healthcare?* Retrieved from https://catalyst.nejm.org/pay-for-performance-in-healthcare/

Standardized data collection and measures would allow provider organizations to provide higher quality care to consumers, which in turn would result in overall improved health outcomes and cost savings for the consumer. With these cost savings and health improvements, behavioral health organizations improve their sustainability despite changing models of care.

In recent years, there has been a greater emphasis on improving the quality of behavioral healthcare, while also focusing on reducing costs. Quality has been a priority on the legislative front for the past 10 years. The Patient Protection and Affordable Care Act (PPACA), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, and the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 all have some aspect tied to quality of care—whether it's provisions to improve outcomes or linking payments to quality of care, these reforms provide increased resources and requirements to assess the quality of care consumers receive.[7] Since the passage of these reforms, quality measures have been effectively used in various care delivery models to improve quality of care and consumer outcomes. This effectiveness is evident in self-reported data, such as the Centers for Medicare and Medicaid Services (CMS) Star ratings, as well as through reviews of claims data, research studies and provider reports. Some quality of care process measures, such as appropriate pharmacotherapy, continuity of care and psychotherapy use, have even been associated with reduced mortality and symptom severity.[8]

Improving quality outcomes doesn't necessarily mean you need to change your organization or how you run your program. Sometimes, quality outcomes can be improved through small changes to processes or by sharing different aspects of consumer data within your organization. Regardless of which strategies organizations use to improve behavioral health outcomes, one thing is key: Provider organizations must be able to substantiate the value of their services. The real question is how?

Provider case study

Intermountain Medical Group has been able to improve the value of care for individuals they serve by providing coordinated behavioral health care. By sharing data and empowering their physical and behavioral health care teams to collaborate, the organization has seen improvements in consumer outcomes and a **$115 lower overall annual cost per member**.[9]

7 American Psychiatric Association. (2018.) *MIPS Quality Performance Category: 2018 Performance/2020 Payment.* Retrieved from https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/2018-quality-performance-category

8 Kilbourne, et al. (2018, Feb 17). *Measuring and improving the quality of mental health care: a global perspective.* World Psychiatry. 17(1); 30-38. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5775149/

9 OPEN MINDS. (2019, Feb.). *Where Are We On The Road To Value?: The 2019 OPEN MINDS Performance Management Executive Survey.* Retrieved from https://www.openminds.com/market-intelligence/resources/where-are-we-on-the-road-to-value-the-2019-open-minds-performance-management-executive-survey/

The need to substantiate the value of your services

The current formula in behavioral health involves collecting data, measuring performance and creating clinical interventions. While this formula has worked in the past, it's in dire need of evolution if provider organizations want to compete and thrive in the new value-based environment. Robust reporting should be incorporated into day-to-day activities and workflows to prove the value of services. Implementing a standardized tool to capture data allows behavioral health organizations to collect longitudinal data that can tie quantitative value—both clinical and financial—to efforts to improve care. This data can then be used in performance dashboards to identify appropriate evidence-based practices for populations and even provide alerts notifying gaps in care. Imagine having real time data that proactively notifies the care team at the point of care when there are clinical gaps so those inefficiencies could be addressed sooner, potentially saving clinician time and organizational dollars, while also improving consumer outcomes.

The ability to collect and share data is important not only to internal performance management—many new payment methods are linking reimbursement with demonstrated performance improvement. These payment arrangements use scores from quality and performance measures to reward or penalize provider organizations. Organizations under these payment arrangements are at financial risk for their overall performance but can receive bonus payments based on improvements. In 2014, 40% of all commercial in-network payments were value-oriented.[10] Since that time, there has been a push for more value-based payment arrangements appearing in a variety of formats.

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which rewards clinical professionals for value rather than volume, streamlines several quality programs under the Merit-Based Incentive Payments System (MIPS) and provides bonus payments for participating in alternative payment models (APMs). Through this program, provider organizations may choose from a menu of quality metrics to achieve increased reimbursement. In order to receive a bonus payment or reward, organizations must be able to effectively and quantitatively demonstrate their performance improvements in four categories: resource use, clinical practice improvement activities, meaningful use of EHR technology, and quality. They will also receive positive, negative or neutral changes to their Medicare Part B payment.[11]

Examples of MIPS quality measures for psychiatrists[12]

- Adult Major Depressive Disorder (MDD): Suicide risk assessment
- Preventive care and screening: Screening for clinical depression and follow-up plan
- Initiation and engagement of alcohol and other drug dependence treatment
- Falls screening: Screening for future fall risk
- Dementia cognitive assessment
- Bipolar disorder and major depression: Appraisal for alcohol or chemical substance use

10 Delbanco, S. (2014, Sep). *Following The ACA: The Payment Reform Landscape: Value-Oriented National Scorecard on Payment Reform.* Health Affairs. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20140930.041710/full/

11 Centers for Medicare and Medicaid Services. *The Medicare Access & CHIP Reauthorization Act of 2015: Path To Value.* Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-LAN-PPT.pdf

12 American Psychiatric Association. (2018.) *MIPS Quality Performance Category: 2018 Performance/2020 Payment.* Retrieved from https://www.psychiatry.org/psychiatrists/practice/practice-management/coding-reimbursement-medicare-and-medicaid/payment-reform/toolkit/2018-quality-performance-category

Medicare has also implemented other value-based financing systems that are designed to improve hospital performance, including the Hospital Readmission Reduction Program, the Hospital Value-Based Purchasing (VBP) Program and the Hospital-Acquired Condition Reduction Program. Each of these programs promote better clinical outcomes and improved consumer experience by putting the hospitals at risk for possible payment reductions.[13] The Centers for Medicare and Medicaid Services (CMS) has also designed other, similar Medicare programs to address performance through alternative payment models at other types of provider organizations, including the Skilled-Nursing Facility Value-Based Program and the Health Home Value-Based Program.[14]

In the commercial space, 90% of payers and 81% of hospitals have implemented some mix of value-based reimbursement and fee-for-service. For example, Blue Cross Blue Shield has endorsed value-based reimbursements by changing payment incentives to encourage reduced admissions, readmissions, emergency room visits and high-cost interventions, proactively enabling access to preventative care and the management of chronic conditions. These changes improved overall quality of care and efficiency, resulting in a $500 million savings in 2012.[15]

In fact, the use of value-based reimbursement among specialty provider organizations (mental health, addictions, children's services, autism, I/DD, etc.) is on the rise.

In a 2019 survey conducted by OPEN MINDS, 69% of respondents were participating in value-based reimbursement (VBR). Fifty-eight percent of respondents were achieving revenue from these arrangements with primary care and Federally Qualified Health Center (FQHC) respondents experiencing the highest revenues of specialties; 74%.[16]

While many of these outcomes and performance-based programs are rooted in hospital systems, they are creating an environment built on performance expectations and setting the stage for a healthcare system built around outcomes measurement.

As VBR continues to gain traction in the behavioral health market, there are some existing care delivery models that provide insights and practices that can be expanded to meet the rising payer and health plan demand for better demonstration of value.

A few of the care delivery models best positioned for future expansion include accountable care organizations (ACOs), integrated delivery networks (IDNs), certified community behavioral health clinics (CCBHCs), prescription drug monitoring programs (PDMPs), Medicaid managed long-term services and supports (MLTSS) programs, and health home initiatives.

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13 Medicare.gov. *Linking quality to payment.* Retrieved from https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html

14 Centers for Medicare and Medicaid Services. (2018, Jul). *What are the value-based programs?* Retrieved from https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Value-Based-Programs.html

15 Brown, B., MBA. *Why You Need to Understand Value-Based Reimbursement and How to Survive It.* Retrieved from https://www.healthcatalyst.com/understand-value-based-reimbursement

16 OPEN MINDS. (2019, Feb.). *Where Are We On The Road To Value?: The 2019 OPEN MINDS Performance Management Executive Survey.* Retrieved from https://www.openminds.com/market-intelligence/resources/where-are-we-on-the-road-to-value-the-2019-open-minds-performance-management-executive-survey/

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs were established under Section 223 of the Protecting Access to Medicare Act (PAMA) and are required to provide services to all individuals on a sliding scale regardless of their ability to pay. These state-certified organizations operate under a Prospective Payment System (PPS) to receive enhanced Medicaid funding for reimbursable behavioral health services.[17] Organizations participating in the CCBHC demonstrations have six critical domains for organizational readiness and numerous required quality measures to report on. CCBHCs must coordinate care across the full spectrum of healthcare services—physical, behavioral and social services—and form required partnerships with other specialty organizations to be successful.[18] This demonstration program offers a vital opportunity to create a nationally recognized mental health community-based provider system focused on improving the care and well-being for the consumers we serve.[19]

These measures all aim to ensure provider organizations are providing high-quality, evidence-based care. This shifts treatment goals from being reactive in nature to encouraging more preventative care to alleviate negative symptoms and reduce healthcare costs to the consumer and to provider organizations themselves.[20] Provider organizations not in the eight states currently participating in CCBHC demonstrations should still be aware of the measures being tracked and ensure they are prepared by getting the tools necessary to begin complex analytics and reporting on quality measures. This preparation will enable provider organizations to allow adequate time for preparation and implementation, while also utilizing new tools that will provide added benefits to consumers. These tools would allow for predictive analytics and population segmentation to increase quality and outcome improvements.

Tips and tricks[21]

- Ensure you have the right workflows in place (both throughout the organization and in your EHR) to encourage follow-ups, appointment alerts and referrals.
- Find ONC-certified health information technology to support increased integration of physical and behavioral health services.
- Determine the reporting and analytics capabilities within your current or future systems to track the availability of services and aggregate clinical data.
- Be sure you have an EHR that supports evidence-based practices and behavioral health-specific workflows and data.

Required measures for quality bonus payment:

- Follow-up after hospitalization for mental illness (adult age groups)
- Follow-up after hospitalization for mental illness (child/adolescents)
- Adherence to antipsychotics for individuals with schizophrenia
- Initiation and engagement of alcohol and other drug dependence treatment
- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Child and adolescent MDD: Suicide risk assessment

Additional eligible measures:

- Follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) medication
- Screening for clinical depression and follow-up plan
- Antidepressant medication management
- Plan all-cause readmission rate
- Depression remission at twelve months-adults

17 Otsuka America Pharmaceutical, Inc., Lundbeck, LLC, & OPEN MINDS. (2018, Apr). *Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System.* Retrieved from https://www.psychu.org/trends-behavioral-health-reference-guide-u-s-behavioral-health-financing-delivery-system/.

18 Threnhauser, S.C., MPA. (2016, Dec). *CCBHCs Are Moving Forward – What This Means If Your State Isn't Moving Forward.* Retrieved from https://www.openminds.com/market-intelligence/executive-briefings/ccbhcs-moving-forward-means-even-organization-not-eight-states/

19 Otsuka America Pharmaceutical, Inc., Lundbeck, LLC, & OPEN MINDS. (2018, Apr). *Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System.* Retrieved from https://www.psychu.org/trends-behavioral-health-reference-guide-u-s-behavioral-health-financing-delivery-system/.

20 Marshall, N. (2015, Sept. 15). *CCBHCs in Pennsylvania: Rehabilitation and Community Providers Association.* Retrieved from http://www.paproviders.org/wp-content/uploads/2015/09/NCCBH_CCBHC_PP_Marshall.pdf

21 Netsmart. *CCBHC FAQ.* Retrieved from https://www.ntst.com/CCBHC/FAQ.aspx

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Accountable Care Organizations (ACOs)

Originally a Medicaid model of care, accountable care organizations (ACOs) have been taking root across all payer systems over the last decade. This model was initially created for Medicare under the Patient Protection and Affordable Care Act (PPACA), but state Medicaid programs and commercial health plans have also adopted similar models. Under this model, a group of organizations form an agreement to supply care coordination and deliver services for specific populations.

ACO performance is gauged based on financial and quality benchmarks.[22] The ACO model incentivizes groups of provider organizations to deliver high-quality care, while lowering care cost by offering the organization a portion of the savings generated.[23] ACOs provide the industry with a successful service delivery model that focuses on improving care coordination to ultimately increase care quality and reduce costs.

This model allows provider organizations to bring the focus back to the consumer while remaining sustainable. When consumers receive quality care, it increases overall health and wellness, decreases the need for costly healthcare services, and increases consumer satisfaction. This counts as a win for the consumer and the provider organization.

ACOs are currently required to report on quality measures in four domains, all focusing on improving consumer health and experience. Provider organizations are given reporting templates to follow to ensure every ACO is providing the same reports across the nation. This type of standardization allows for benchmarking across the industry, furthering the emphasis on improving consumer health through coordinated care.

Tips and tricks

- Ensure your EHR has robust reporting capabilities to compile and export the necessary reports for your contracts.
- Set up visual dashboards and create workflows that increase utilization to keep data and information top of mind among care teams.
- Determine if your EHR is equipped with predictive analytics and can identify gaps in care for your behavioral health clinicians and enable clinicians to utilize this information for preventative measures.
- Develop a shared platform across all users in your care coordination team to allow provider organizations to identify behavioral health concerns and address the whole person so consumers receive the best possible care.

ACO quality scoring domains and measures[24]

- **Patient/caregiver experience:** Eight individual survey module measures
- **Care coordination/patient safety:** 10 measures, one of which being the EHR measure
- **Preventive health:** Eight measures focused on screenings and other preventative care practices
- **Clinical care for at-risk population:** Four measures, three of which are individual measures while one is a two-component diabetes composite measure

22 Otsuka America Pharmaceutical, Inc., Lundbeck, LLC, & OPEN MINDS. (2018, Apr). *Trends In Behavioral Health: A Reference Guide On The U.S. Behavioral Health Financing & Delivery System.* Retrieved from https://www.psychu.org/trends-behavioral-health-reference-guide-u-s-behavioral-health-financing-delivery-system/.

23 OPEN MINDS. 2018. *The 2018 OPEN MINDS Medicare ACO Update: A Four-Year Trends Report.* Retrieved from https://s11042.pcdn.co/wp-content/uploads/indres/OpenMinds_Report_MedicareACOs_020918_alm.pdf

24 Centers for Medicare and Medicaid Services. (2018, Jan.). *Medicare Shared Savings Program: Accountable Care Organization (ACO) 2018 Quality Measures: Narrative Specifications Document.* Retrieved from https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-reporting-year-narrative-specifications.pdf

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Integrated Delivery Networks (IDNs)

Integrated delivery networks (IDNs) are one of the most common hospital collaborations. An IDN is a formal system of provider organizations and health systems that aims to improve consumer care while reducing costs and preventable readmissions.[25] These systems, however, set themselves apart by offering a comprehensive array of complementary services, including preventative and acute care services. By being in control of every aspect of care delivery, from offering their own health plans to managing and operating care sites, IDNs are uniquely positioned to assess the care needs of their local populations and address social determinants of health.

This opens the door for IDNs to focus on the behavioral and physical health issues most prevalent in the populations they serve by offering and providing needed services and reducing unnecessary services.[26] This model offers the industry a unique collaborative approach to assessing the care needs of populations to improve the quality of services provided.

IDNs provide a way to address the shortage in behavioral health professionals and address major health concerns and issues in local communities, such as the opioid epidemic and drug overdose-related deaths. By taking an integrated approach to care delivery for populations, this model increases care coordination to ensure each consumer has easy access to behavioral and physical healthcare services. By focusing on and addressing individual consumer needs and the health concerns of local populations, consumers are increasingly likely to receive high-quality care to ensure they get and remain healthy. This means lower health-related costs for the consumer, as well as greater cost savings and increased sustainability for the provider organization.

IDN outcomes measure categories[28]

- Assessment and screening (e.g. Follow-up for positive screenings for potential substance use disorder and/or depression)
- HEDIS-based effectiveness of care measures (e.g. Antidepressant medication management—continuation phase)
- Community mental health center timeliness measures (e.g. first psychiatrist visit timeliness)
- Patient experience of care (e.g. Adult experience of care survey)
- Emergency department (ED) use and follow-up (e.g. Frequent (4+ per year) ED use in the behavioral health population)
- Inpatient hospital use and follow-up (e.g. Follow-up after hospitalization for mental illness within 7 days)
- Opioid prescribing (e.g. extended daily dosage of opioids greater than 120mg morphine equivalent dose)

New Hampshire case study

New Hampshire is currently conducting a five-year demonstration with IDNs across seven regions.

These IDNs will receive payments for performance based on key milestones and quality indicators. During year three (2018) of the demonstration, IDN payments were also tied to measures related to access, quality and utilization.

To promote accountability across each region, IDNs are measured using both state-specific and IDN-specific metrics. During the demonstration, IDNs are at risk for losing funds for poor performance, up to 15% of funds or $4.5 million, through year five.

By meeting process and quality measures, IDNs can see large cost savings on top of the performance payments. One IDN in the demonstration has already reported **savings in 2017 of nearly $1.2 million**.[27]

25 Moriarty, A. (2017, Sep). *The Pivotal Role of Health care IDNs in Purchasing and Population Health.* Retrieved from https://blog.definitivehc.com/health care-idns-population-health

26 Ibid.

27 McCullough, B. (2018, Oct). *Integrated Delivery Networks Aim to Transform Behavioral Health for New Hampshire Medicaid Beneficiaries.* Retrieved from https://www.urac.org/blog/integrated-delivery-networks-aim-transform-behavioral-health-new-hampshire-medicaid

28 New Hampshire Department of Health and Human Services. (2017, Mar). *Review of DSRIP Outcome Measures.* Retrieved from https://www.dhhs.nh.gov/dphs/oqai/documents/dsrip-idn-rep-measure-rev-032317.pdf

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Prescription Drug Monitoring Program (PDMP)

A Prescription Drug Monitoring Program (PDMP) is an electronic database that collects and tracks data on controlled substance prescriptions for a specific population. These programs are operated at the state level and can be queried along with PDMPs in other states, HIEs and Carequality to allow healthcare provider organizations and pharmacists to see a consumer's complete medical history regardless of where services or prescriptions were provided.[29] PDMPs aim to improve the quality of care for individuals by informing clinical practice and protecting at-risk consumers.[30] A PDMP can alert provider organizations to potential dangers when making treatment decisions and aid law enforcement agencies in the detection and prevention of fraud, drug use and criminal diversion of controlled substances.[31]

PDMPs offer the industry a valuable resource for improving quality measurements related to treatment decisions and prescribing by offering state and sometimes multi-state-wide data collection of prescriptions. These programs can also improve CMS MIPS scores, as PDMP use falls under the improvement activities category, which counts for 15% of a provider's final score. Other activities related to the PDMP also increase scoring, as both consultation of (weighted high) and registration in (weighted medium) your state's PDMP are subcategories in Patient Safety and Practice Assessment.[32]

Tips and tricks

- Improve the impact of PDMPs by ensuring your system is accessible to relevant parties.
- Ensure your system can collect real-time data and provide timely analysis.
- Reduce the chances of data errors by integrating PDMP data with all other technology systems, including the EHR, health information exchanges and electronic prescribing systems.
- Ensure PDMPs can be queried as part of the clinical workflow.

These unique programs enable provider organizations to make sound clinical decisions to help prevent controlled substance use and misuse.[33] By ensuring prescription-controlled substances aren't misused, PDMPs improve health outcomes for both individual consumers and communities. PDMPs become even more useful to communities when data is made available in a timely manner as part of the clinical workflow.

Since PDMPs can work together and with other organizations, there is an increased need for data standardization and sharing. Increased data sharing and standardization would create more complete, accurate and timely prescription histories available across all provider organizations for the best chance at improving prescribing practices and reducing prescription drug misuse. PDMPs become increasingly effective as provider organizations adopt best practices, such as collecting data on method of payment including cash, using a proven method to match/link the same person's records, and integrating PDMP reports with health information exchanges.[34]

PDMP best practices categories

- Data collection and data quality
- Data linking and analysis
- User access and report dissemination
- Enrollment, outreach, education and utilization
- PDMP promotion
- Inter-organization coordination
- PDMP usability, progress and impact

29 Centers for Disease Control. (2017, Oct). *What States Need to Know about PDMPs.* Retrieved from https://www.cdc.gov/drugoverdose/pdmp/states.html

30 Ibid.

31 Pennsylvania Department of Health. *Prescription Drug Monitoring Program Questions & Answers (Q&A).* Retrieved from https://www.health.pa.gov/topics/programs/PDMP/Pages/QA.aspx

32 Lutz, J. (2018, Oct). *MIPS and PDMP Usage: How they work together. AffirmHealth.* Retrieved from https://www.affirmhealth.com/blog/mips-and-pdmp.-how-they-work-together

33 *Clark, T., et al. (2012, Sep). Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices.* Retrieved from https://www.pewtrusts.org/~/media/assets/0001/pdmp_update_1312013.pdf

34 The Prescription Drug Monitoring Program Training and Technical Assistance Center & Brandeis University The Heller School for Social Policy and Management. (2017, Mar). *Tracking PDMP Enhancement: The Best Practice Checklist.* Retrieved from http://www.pdmpassist.org/pdf/2016_Best_Practice_Checklist_Report_20170228.pdf

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Medicaid Managed Long-Term Services and Supports (MLTSS)

MLTSS refers to the delivery of long-term services and supports (LTSS) through capitated managed care programs. Through these programs, states contract with health plans to deliver support and services to individuals with disabilities of all ages who need assistance to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs) to ensure these individuals can live independently in the setting of their choice. LTSS services can be provided in care facilities, such as a nursing homes and intermediate care facilities, as well as in home and community-based settings.[35]

There are no standardized measures required for programs providing LTSS, but a set of measures has been established by the National Committee for Quality Assurance (NCQA) and Mathematica Policy Research through contract with the Centers for Medicare and Medicaid Services (CMS).[36] These measures, while not required by CMS, can be used by states, managed care plans and other stakeholders for quality improvement. The measures focus on aspects of care related to assessment, care planning and care coordination for organizations providing LTSS services.[37]

Without comprehensive and standardized data points and collection methods, linking payments to plan performance and quality of care becomes increasingly difficult. With an industry shifting to value-based care, the trend to link payments to performance and quality will likely move into the MLTSS field soon.[38]

Tips and tricks[21]

- Improve the impact of MLTSS by ensuring your system is collecting relevant clinical and financial data.
- Ensure your system can collect and analyze data to uncover meaningful information and determine quality care and outcomes.
- Conduct data sharing or create data exchanges with other providers in your integrated care network to ensure each consumer is receiving whole-person care in the lowest acuity setting.

Organizations must be prepared to not just collect data on their consumers and services, but analyze this data and determine changes needed to ensure each consumer is receiving high-quality care. This kind of data and collection standardization will allow organizations to prove their value and empower consumers to make more informed choices about the care they and their loved ones receive.[39]

LTSS measures[40]

- Long-term services and supports comprehensive assessment and update
- Long-term services and supports comprehensive care plan and update
- Long-term services and supports shared care plan with primary care practitioner
- Long-term services and supports reassessment/care plan update after inpatient discharge
- Screening, risk assessment and plan of care to prevent future falls
- Long-term services and supports admission to an institution from the community
- Long-term services and supports minimizing institutional length of stay
- Long-term services and supports successful transition after long-term institutional stay

35 Lutz, J. (2018, Oct). *MIPS and PDMP Usage: How they work together. AffirmHealth.* Retrieved from https://www.affirmhealth.com/blog/mips-and-pdmp.-how-they-work-together

36 Centers for Medicare & Medicaid Services. (2018, Sep). *Measures for Medicaid Managed Long Term Services & Supports Plans: Technical Specifications and Resource Manual.* Retrieved from https://www.medicaid.gov/medicaid/managed-care/downloads/ltss/mltss_assess_care_plan_tech_specs.pdf.

37 Lutz, J. (2018, Oct). *MIPS and PDMP Usage: How they work together. AffirmHealth*. Retrieved from https://www.affirmhealth.com/blog/mips-and-pdmp.-how-they-work-together

38 Pena, C. (2018, Aug.). *New Measures Help LTSS Providers.* National Committee on Quality Assurance. Retrieved from https://blog.ncqa.org/new-measures-help-ltss-providers/

39 Ibid.

40 Lutz, J. (2018, Oct). *MIPS and PDMP Usage: How they work together.* AffirmHealth. Retrieved from https://www.affirmhealth.com/blog/mips-and-pdmp.-how-they-work-together

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The Comprehensive Child Welfare Information System Rule

The Comprehensive Child Welfare Information System (CCWIS) rule is designed to help child and family service organizations improve outcomes, enhance data collection and modernize technology and information systems. Data drives outcomes, therefore, CCWIS places a strong emphasis on case management data collection, which has lacked sufficiently in child and family agencies in the past compared to other behavioral health entities.

CCWIS replaces the Statewide or Tribal Automated Child Welfare Information System (S/TACWIS) regulations, which were initially created in 1993. This former rule aimed to help child and family staff manage their caseloads and abide by federal reporting requirements. However, these systems acted as a "one-size-fits-all", function-based approach that did not meet the unique and individual needs of different agencies across the country.

CCWIS gives child and family agencies the ability to use technology that best serves their programs and allows them to share information with multiple systems. Organizations who decide to transition into a CCWIS model will experience more flexibility and customization when it comes to their information technology and can better support their program and client needs through data collection and sharing. Although optional, agencies who implement CCWIS will receive extra federal funding and more favorable reimbursements to ensure requirements are being met while creating interventions to help children and families where necessary. It is essential for child and family services providers gather and share health information in order to improve outcomes, adjust programs based on needs and prove operational measurements.

System enhancements necessary to meet CCWIS requirements

- Bi-directional data exchange with courts
- Bi-directional data exchange with education systems
- Bi-directional data exchange with the Medicaid Management Information System
- Data quality plan

Required data exchanges

A CCWIS must support collaboration, interoperability, and data sharing with a new data exchange that is efficient, economicaland effective. Data exchanges are required for the following entities:

- Courts
- Education
- Medicaid
- Child welfare contributing system
- Ancillary child welfare systems used by agency staff

Source: The Comprehensive Child Welfare Information System Final Rule (https://www.acf.hhs.gov/sites/default/files/cb/ccwis_faqs.pdf)

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Health Homes

Health homes aim to improve outcomes for consumers with chronic conditions by coordinating services across the spectrum of care, including physical health, behavioral health, and sometimes long-term services and support (LTSS) and social support services. As of January 2019, 37 unique health home models have been developed across 22 states and the District of Columbia. Each model focuses on improving care coordination and care management for consumers in order to improve healthcare quality and reduce costs.[41]

These person-centered models allow provider organizations to deliver services in a variety of settings, as long as care is coordinated and managed by the care team.[42] To follow current payment and care delivery reform efforts, a set of core quality measures have been developed for health homes to assess consumer health outcomes.[43] These core measures include eight quality measures and three utilization measures that health home provider organizations are required to report on in order to receive payment.[44] The measures focus on behavioral health and preventive care, as well as areas of care related to screening, care coordination and disease management. While provider organizations are required to report on each core measure, the full set of core metrics will be reported in aggregate at the state level.[45]

Tips and tricks

- Ensure technology systems are optimized for integrated care with the ability to link and share data between all care providers.
- Incorporate technology into workflows to ensure accurate and timely data collection.
- Increase the impact of health home services by ensuring your technology can analyze consumer data across providers and send alerts for any preventive care needed.

With this push toward providing integrated care and increasing care coordination, behavioral health provider organizations must ensure they have systems in place that can accurately share data between all provider organizations and care team members. Provider organizations in the physical and behavioral health industry, as well as those providing long-term services and support, will need workflows in place to ensure data is collected and shared with all organizations that are part of the consumer's care team.[46]

Along with the core health home measures provided by state programs, CMS also expects to receive data on specific goals and measures identified by the state. This reporting will allow for consistency across states for benchmarking and comparison, while also allowing states to use their individual quality metrics to determine health home outcomes.[47]

Health homes place a large focus on promoting access and coordination of care, improving care management and outcomes, and reducing costs, all while remaining person-centered and providing team-based care.

2019 health home care set of quality measure[48]

- Initiation and engagement of alcohol and other drug abuse or dependence treatment
- Controlling high blood pressure
- Screening for depression and follow-up plan
- Follow-up after hospitalization for mental illness
- Plan all-cause readmissions
- Adult Body Mass Index Assessment
- Prevention Quality Indication (PQI) 92: Chronic Conditions Composite

2019 utilization measures

- Admissions to an institution from the community
- Ambulatory care: ED visits
- Inpatient utilization

41 National MLTSS Health Plan Association. (2017, Apr.). *Model LTSS Performance Measurement and Network Adequacy Standards for States.* Retrieved from http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf.

42 Ibid.

43 Centers for Medicare & Medicaid Services. (2019, Jan.). *Medicaid Health Homes: An Overview.* Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

44 Department of Health & Human Services. Center for Medicare & Medicaid Services. (2013, Jan.). *Re: Health Home Core Quality Measures.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-001.pdf.

45 Centers for Medicare & Medicaid Services. (2019, Jan.). *Medicaid Health Homes: An Overview.* Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

46 National MLTSS Health Plan Association. (2017, Apr.). *Model LTSS Performance Measurement and Network Adequacy Standards for States.* Retrieved from http://mltss.org/wp-content/uploads/2017/05/MLTSS-Association-Quality-Framework-Domains-and-Measures-042117.pdf.

47 Centers for Medicare & Medicaid Services. (2019, Jan.). *Medicaid Health Homes: An Overview.* Retrieved from https://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-home-information-resource-center/downloads/hh-overview-fact-sheet.pdf.

48 Department of Health & Human Services. Center for Medicare & Medicaid Services. (2013, Jan.). *Re: Health Home Core Quality Measures.* Retrieved from https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-001.pdf.

Building the right technology infrastructure to maximize your organization's success

Technology plays a key role in successfully operating under varying care delivery models. Without the right technology, organizations will struggle to succeed in a value-based environment. The right tools and technology will allow organizations to easily capture, calculate and report on the varying quality measures required from multiple payers across the behavioral health care industry.

The optimal tool organizations can use to maximize their success is a robust EHR that provides unique fields for quality measurement reporting integrated into workflows. While most provider organizations already have an EHR, how do you know if it has the features you need? What functionality should you incorporate and use to maximize your success? There are six key features that your EHR system needs to have in order to optimize your ability to manage performance and improve outcomes:

1	**A shared EHR platform across all users:**
	By implementing a shared EHR platform across all users in your system, care can be coordinated across settings and throughout your organization. This allows all members of the care team to receive a whole-person view of each consumer's care record, including medical history and treatment plans. By granting all members of a care team access to the whole-person view, they can take a coordinated approach to improving each aspect of a consumer's care—improving quality and outcomes.
2	**Integrated workflows across all clinical, financial and operational staff:**
	Having your EHR integrated into daily workflows across all clinical, financial and operational staff allows your organization to reduce duplicative tasks and data entry while simultaneously increasing efficiency. This boost in efficiency could contribute greatly to improvements in quality and outcome measurement scores for your organization and care delivery system.
3	**Customizable measures for each type of contract:**
	Each contract an organization has secured will have its own requirements and quality measures. To fulfill those contractual obligations, organizations need to have the capability to collect data and report on each of those measures. The system should have common measures included but also allow for customization for each type of contract and reporting structure your organization has. With customizable measures, your EHR enables easy data collection and analysis to simplify the complex calculations necessary for reporting on each of the unique quality measurements required.
4	**Ability to proactively identify gaps in care:**
	In a value-based environment with a large focus on improving the quality of care provided, gaps in care are a major area of concern for clinical teams and organizations. Identifying these gaps in care can be incredibly difficult for organizations without an EHR that supports predictive analytics. Analytics that are incorporated into workflows along the care path can easily pinpoint gaps in care and alert clinical teams so those gaps can be addressed. By integrating predictive analytics into your workflow, an EHR can offer clinical teams a reminder about assessments or questions to eliminate gaps in care before they occur.
5	**Robust reporting and visual dashboards:**
	In an environment focused on improving quality, outcomes are at the heart of the system. While your EHR is already collecting data, simple data collection isn't enough. An EHR built to empower your organization needs to include robust reporting and visual dashboards to allow organizations to conduct outcomes management. Visual dashboards allow easy viewing and identification of the positive and negative status of measures over time without the need to sift through large amounts of data to get there. Robust reporting produces insights into clinician caseloads and allows organizations to review performance from an outcomes management perspective. With real-time data visible in dashboards, data is displayed in a way that appeals to most users, so the headache of conducting complex calculations for measures is removed, allowing staff more time to focus on providing quality care.

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6	**Calculate measures in real-time:** If your EHR is collecting and monitoring real-time data, it absolutely needs to calculate measures in real-time. Organizations can't operate from an outcomes management perspective without the ability to always know what those quality and performance outcome scores are. Real-time calculation of measures enables organizations to be proactive with their approach to care, instead of needing to be reactive to fix the problem after it's already cost your team valuable dollars. These real-time measurement calculations can be used across the organization to identify areas of improvement so they can be addressed as quickly as possible. Without these calculations, your staff will lose out on time providing services to spend conducting complex calculations for your measure reporting.

The case is clear. Without the ability to easily collect, calculate and report on performance and quality measures, an organization is in for a long, tough journey in this new value-based environment. Make sure you have the right EHR with all the necessary functionality to succeed.

Demonstrating your value to gain competitive advantage

As VBR adoption and competition in the market continue to grow, the ability to measure performance and demonstrate value will be key to competitive advantage. The first strategic question for executive teams of behavioral health organizations is what to measure. These organizations have many customers: payers, health plans, consumer advocacy organizations, consumers and families, regulators, and donors, to name just a few. Selecting critical indicators of performance is crucial.

The second strategic issue is creating the technology platform that automates the measurement of these performance indicators. A flexible system that can aggregate information in a way that is useful to executives, managers and service professionals alike is essential.

Lastly, executive teams need to develop a strategic approach to use these performance measures. Internally, performance measures fuel process improvement and the refinement of best practices across the organization. Externally, the ability to demonstrate performance—and value—is the critical differentiator.[49]

The shift to consumer-centric and value-based care is ongoing and ever-evolving. Building new partnerships and developing the technology infrastructure you need now will help to prepare your organization to build a sustainable strategy for the future.

49 Kaiser, L.S. & Lee, T. H., M.D. (2015, Oct). *Turning Value-Based Health care into a Real Business Model.* Harvard Business Review. Retrieved from https://hbr.org/2015/10/turning-value-based-health-care-into-a-real-business-model.