

Clinical Roundtable Outcomes and Quality Agenda
January 14, 2015
9-11 a.m.

Participants: Kathy Coate-Ortiz; Rick Shepler; Elieen McGhee; Kay Spergel; Wendy Williams; Becky Baum; Steve Nauman; Carol Carstens, Doug Smith

- I. Review summary of minutes from last meeting.
- II. Prioritize areas for ongoing discussion
- III. Identify key barriers to quality mental health services and outcomes (clinical, system, service barriers, etc.). Identify areas for technical assistance.
- IV. Develop recommendations to larger group

Rick reviewed a summary of the minutes from our last meeting.

Today's meeting focused on our outcomes recommendations.

Carol Carsten from OMHAS joined our call and offered technical assistance for our discussion.

Carol gave a brief history of the Ohio Outcomes systems (individual client level outcomes) that operated from 2004-2009. There were concerns that the Ohio Scales (particularly for adults) did not measure what was needed and there was significant burden for the providers.

Lessons learned:

- Create a system that has the ability to risk adjust and to evaluate outcomes at the program level.
- Balance the feasibility and the burden of data collection. Outcomes should be realistic and doable.
- It is important to consider the time frame for measurement (Episode of care versus measurement over time). Once consumers reach a baseline of progress--- they may not make much more progress. Functional scales may only show small change over time.
- Carol: in general what we found that 1/3 of the consumers got better, 1/3 stayed the same and 1/3 got worse. Therefore, it is important to have realistic expectations.
- Requesting any additional data collection is hard to accomplish
- Recommendations of using what we do have might be a better strategy

Currently OMHAS gathers NOMS data on employment/school; housing status; and arrests in the past 30 days. These outcomes are aligned with the drug and alcohol NOMS.

- Carol explained that NOMS are what SAMHSA requires from the state for treatment services paid for by block grant dollars (services that are not reimbursable through non-Medicaid/non-insurance)
- **Carol:** OMHAS will continue to collect MH NOMS
- Becky asked what does SAMHSA do with this data?
- SAMHSA has developed national thresholds
- Kay and Carol: data reliability is variable between states

- Becky Baum: How relevant are the NOMS to pediatric population? Is there anything else that is utilized/can be utilized for non-school age children? Are there global outcomes for younger children?
- Kay shared the difficulty of obtaining reliable NOM data.
 - 98% of consumers will not have new court charges
 - Kay's county is focusing on measuring health and wellness.
 - Went to a more functional assessment: are people becoming healthier over time? Persons receive a wide range of service. We are less focused on outcomes for individual programs and instead focus more on the outcomes for the individual over time and across services.
- Question: Are there standardized tools for measuring health and wellness?

Rick posed the question: What are the limitations of not having a statewide outcomes systems ? What can't we do based on what we don't collect/know?

- Answer: We are missing true clinical outcomes—improvement in functioning.
- Becky: We can't do any do any serious statewide QI.
- Becky: We don't know if collectively persons are getting better
- Carol: we are missing a pre- post functioning measure for children and adults;

Rick: What do we want statewide outcomes to do for us- what **function** would they serve? For what purpose?

- Kay: General message to public--- if you participate in this service—you will get better.
- Public health messaging: We can demonstrate you will feel better.
- Kay: our discussion has been focusing on measuring outcomes driven by funding—but does it really answer our question? Is there any way to measure an integrated health outcome?
- Becky: Outcomes are the foundation of quality improvement--- is what you are doing working? Need the current state of the problem we are fixing. We then try to figure what we are trying to improve. Then we determine whether what we are doing is working – or showing improvement.
- Kay: Develop a unified way across our communities to determine if what we are doing is working?
- Kay: The global outcomes we look to achieve/measure: is the consumer safe, well, and happy—with no big risk in the community. Can you keep the bad from happening in the community? Local legislators want to know: How are you saving money to our community? Funders like the idea of functioning.

Rick: **What outcomes do we need to answer what questions?**

- Wendy suggested that we think about tools with cross-system support that are useful at the provider level, while tying in base health measures.
- Wendy: National Quality Measures and behavioral health. Tied to depression and ADHD – and general health measure (diabetes for SMD; hypertension). It is very complicated to measure functional progress with behavioral health issues.
- Becky: are there some things we can measure imperfectly that would be helpful?
- Becky: Should we be making our recommendations based on changes in funding/Medicaid/managed care in the next 3-5 years?
- Carol: the future—HEDIS measures for managed care—
- Becky: need more than just HEDIS
- Eileen: need adequate quality measures; health home model funds care coordinators- but does not incentivize primary care doctors to participate; quality indicators are needed

What do we want to measure/collect?

Becky suggested three main buckets of information to collect:

1) Symptom reduction; 2) functioning; and 3) cost.

Other suggestions from the group: 4) overall health; 5) safety/risk (longitudinal)

- **Carol:** Some reporting of cost needs to happen---
- **Kay:** What does stable look like and what does it cost?

How do we measure cost?

- Medicaid; non-Medicaid cost;
- How do we measure the risk management piece? Short term cost- is high—long term cost is low.
- Becky: Cost —imperfect but accessible measures--- Example: pharmacy costs coupled with hospitalization costs, i.e. what is the potential negative outcome of the person not filling or not taking their medications?
- Managed care based on risk and needs assessment

Safety: measuring improved safety/risk may be more of a longitudinal outcome.

- Safety is hard to measure: KAY: Strong Families, Safe Communities grant- proactive use of tax dollars. Measure number of kids served and number of family/community incidents
- Mental Health First Aid—the more you educate the public—the more likely persons can identify signs and symptoms—the more likely they will call/ refer youth for services
- We operate under the assumption that the better we manage a program to fidelity the better the result down the road
- Becky: What we are talking about is low incident, high impact events. Can we look at statewide data on these low impact- high impact items?

Discussion about the importance of making recommendations regardless of the barriers. Becky suggested that we can also list out the potential barriers as well.

The group suggested that we recommend stepwise change for developing outcomes system.

- Becky: Implement what is feasible now—with a wish list for the future (real vs ideal)
- Becky: move forward with recommendations—creative and innovative
- Recommendation: Need statewide data system. Need to draft argument.

Who are we making the recommendations to? To OMHAS? OHT? The State?

Potential strategies

- **Kay:** we only offer a partial strategy to solve an overall problem. We need to involve schools, courts to address issues and to measure outcomes.
 - **Overall community strategies:** overall state cross-system strategies at the state level for gathering outcomes and data sharing
 - Carol: There is some cross-system information sharing (Medicaid; SACWIS; OHT; individual data set requests), Medicaid data- OHT level?
- **Kay** Partnering for positive change: Partner with providers so that does it not become an impossibility

- **Becky:** need to align incentives to outcome collections; quality benchmarks; pay for performance
- What can we do now given the limitation we have now—and what can we do for the future?

Potential barrier

- **Wendy:** provider variability in terms of outcome sophistication. Some providers would need to develop or take away something they have already have developed or paid for in the EHR

Summary of Focus Areas for Clinical Roundtable Outcomes and Quality (from first meeting)

1. Statewide outcomes

- Need feasible, reliable and valid outcome tools that measure youth and adult behavioral wellness and health.
- Need to define what audience will be looking at the data and for what purpose?
 - Need to differentiate between process measures (HEDIS) and clinical outcomes. Need to determine what is most important to collect, for what purpose
 - One suggestion: Focus on the federal requirements (National Outcome Measures)
 - Global outcomes for funders (e.g. no new criminal charges)
 - How do we utilize the data to inform practice and quality assurance efforts?
 - Integrated health care outcomes
- Request TA from OMHAS on lessons learned about gathering statewide data (collecting the data, purpose, helpfulness, burden, etc.). What is the state mandated to report to SAMHSA? We need to have clarity around what these are so that we can help make recommendations on outcomes.
- Problem solving barriers (funding, etc.)
- Possible usages: pay for performance
- Performance report card to incentivize quality of care (pay for performance).
- Need a way to measure outcomes across systems. **System alignment between child serving** (adult serving) systems around outcomes. Could create a cross-system outcomes system with unique identifier for youth for purpose of measuring cross-system impacts of initiatives, policies, and programs.
- Identify key cost impact/benefit areas to measure progress. For example: If we know that behavioral health pharmacy is 40% of our cost, can we measure if behavioral health treatment works, does behavioral health pharmacy costs go down?

2. Quality Improvement

- State lacks the framework for funding CQI related activities.
- Concern: Funding for behavioral health continues to shrink and administrative requirements continue to grow.
- CQI activities come at the expense of clinical care time
- Lack of reimbursement for quality (still based on QUANTITY)
- Lack of statewide continuous quality improvement activities or framework for the child welfare and mental health systems.

3. Clinical Care: Good and Modern Benefit Package-

- Taking Evidenced-Based Practices to Scale
- Barrier: agencies often lose money providing evidence-based practices
- Modernize the Medicaid behavioral health benefit package including service offerings and payment methodology.
- Integration between BH and primary care- Integrate with medical system

4. Funding

- State –level discussion on cross-system funding streams for providers for services that benefit other systems
- Implement a system like ODYS' RECLAIM funding that is cross-system. For example, for every child that communities do not place in residential placement/more restrictive placements, the dollars saved would go back to the community for services and supports.
- Medicaid payments rates for behavioral health services are not modernized and are instead built on a 20 year old fee for service system.

5. Communication between agencies

- How well do we share information when it needs to be shared for quality services
- Information sharing agreements
- **TA request:** Statewide guidance on intersystem/interagency communication (HIPAA, 42CFR Part 2, etc.)

6. Increasing Complexity of the clinical population.

- Complexity of needs, risks, and safety issues increasing
- Increasing risk and safety of staff who serve persons with complex needs

7. Continuum of care and levels of care:

- **Level of care needs** –Do we have the complete level of care and related services to meet the needs of the complex needs of the community?

8. Patient follow-up

- Getting clients back for their month follow-up visit
 - Can we do something like an adolescent well check visit?
 - Health Homes have a positive impact on follow-up consistency, but is not adequately funded

9. Human Resources

- In publicly funded, community mental health, it is hard to find and retain qualified professionals. Many professionals are opting to work at higher paying positions in other systems.

Participants from the initial sub-group meeting identified three priority focus areas for workgroup:

1. Statewide outcomes
2. Funding:
3. Statewide guidance on intersystem/interagency communication