

**Clinical Roundtable Outcomes and Quality Team Minutes**  
**October 1, 2014**  
**9-11 a.m.**

**Participants:** Rick Shepler, Facilitator; Wendy Williams, Kay Spergel, Ben Kearney, Jeff Greene, Eileen McGhee, and Rebecca Baum

**Prioritize key areas for discussion and problem solving.**

**1. Statewide outcomes discussion:**

- Becky: Lack of feasible, well established, meaningful quality measure
- Difficulties with data collection (e.g., not reimbursed, not integrated with emr)
- Quality metrics
- Implement pay for performance
- Clarified what kind of statewide outcomes were collected in the past (Ohio Scales for adults and youth).
- Ben thought it would be helpful to ask OMHAS about lessons learned about gathering statewide data (collecting the data, purpose, helpfulness, burden, etc.).
- Current status of outcomes collection: agencies have the ability to choose their outcome based on their accreditation requirements. No statewide reporting to a centralized portal.
- Question on why we are no longer collecting outcomes statewide:
  - There were concerns about the length, reliability, and validity of the tools utilized, and the burden to the provider.
- Currently the state has to report on the National Outcome Measures (NOMS)
  - OMHAS track this information in different ways (see addendum)
- What would you measure?: For youth, Eileen would measure global outcomes: better school attendance; less days in the detention; less hospitalizations; less days in hospital
- Jeff: Once the behavioral health Medicaid system is integrated into managed care, providers will be focused on HEDIS measures(see attachment sent by Wendy), which managed care organizations are required to track for the Ohio Department of Medicaid
- Kay: numerous issues in collecting the NOMS: while face valid, the level of reliability of the information collected is variable (client report, provider report, versus actual school, court, hospital data, etc.) and time consuming to collect.
- Kay: Need to keep it simple. What can we collect that is reliable and valid to measure youth and adult behavioral wellness and health?
- Kay: SAMHSA is looking to redesign the NOMS; SAMHSA did some threshold development in the past but apparently this is on hold for now
- Rebecca shared that it is difficult to choose the right outcome tool and equally challenging to utilize the data to inform practice and quality assurance efforts. Currently collect HCAHPS data- satisfaction with services.
- Wendy recommends that we do national requirements
- Kay and Wendy: State collects demographics; BHMOD data
- Discussion on the Ohio Scales: too cumbersome
- Ben: We need to know who is the audience that will be looking at the data and for what purpose?

- Kay: is the state moving away from the MHSIP?; MHSIP: self-report tool about people's functioning, contacts with emergency rooms, school attendance (see attachment)
- Kay: Locally, we are moving to measure functionality and to figure out what tools providers can use to report more accurately to us
- Kay: As a funder I just want to know is the client getting better.
- Wendy: need to measure integrated health care outcomes;
- Becky: Partners for Kids (PFK): Accountable Care Organization- capitated system for Medicaid; PFK- performance report card: utilizes HEDIS- quality of care; incentivized HEDIS measure- follow up 7 days post discharge from hospital.
- Ben: HEDIS measures process variables. Need to differentiate between process measures versus clinical outcomes. Need to determine what is most important to collect, for what purpose
- Eileen: Problem with the process measures in the HEDIS is that we don't have control over what patient does. We are being held accountable for someone else's behavior.
- Jeff: Part of the intention of the HEDIS measures is to push providers to change how we do practice and programming.
- Becky: Challenges us to see if we can do things differently; utilize care coordination, for example to facilitate follow-ups.
- Becky: can we use incentives to help staff make changes that is otherwise hard to do?
- Jeff: Greg Moody of the Office of Health Transformations: Could all systems use the same outcome measures? For example, ODJF is piloting use of the Child and Adolescent Needs and Strengths (CANS) instrument; ODYS is also considering use of the CANS. Is this a question of **system alignment between child serving** (adult serving) systems around outcomes and around increasing communication about client needs and strengths- for planning and treatment? OMHAS could explore the value of incentivizing more providers to use the CANS instrument. Dozens of providers, Project ENGAGE, and the ODJFS child welfare pilot program agencies are using the tool. It could be used as an outcome measurement tool for both systems. Adult versions of the tool exists as well.
- Need a way to measure outcomes across systems.
- **Create a cross-system outcomes system with unique identifier for youth**
- Create a central identifying system in the state: tracking client—across systems—to measure cross-system impacts of a certain program; need to be able to follow these kids via a unique identifier.
- Becky: 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?
- **Wendy: 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.**

## 2. Quality Improvement

- Jeff: Lack of statewide continuous quality improvement activities or framework for the child welfare and mental health systems.

- Issue: Eileen stated that staff never see the outcome data collected. Therefore, staff can't use the data to inform treatment.
- Becky: Quality improvement activities, and other activities that help agencies retain accreditation and certification are not funded. These efforts come out of clinical care and productivity time. We get paid for seeing patients—not for participating in these events (CQI activities). These activities come at the expense of clinical care time. State lacks the framework for funding CQI related activities.
- Lack of reimbursement for quality (still based on QUANTITY)
- **Wendy:** How do you structure what you are doing (CQI) in terms of incorporating it into your care? Concern: Funding for behavioral health continues to shrink and administrative requirements continue to grow.
- Ben: Management at his organization has adopted a culture of evaluation and quality improvement. This is how we do work. How do you efficiently and effectively provide care to your clients?

### 3. Clinical Care: Good and Modern Benefit Package

- Modernize the Medicaid behavioral health benefit package including service offerings and payment methodology.
- Use the “Good and Modern” framework established by SAMHSA as a starting point. The department put a lot of effort and attention to this framework a year ago but has not followed through on making any policy changes.
- **Taking Evidenced-Based Practices to Scale**
- Ben: The state does not have the money to take evidenced based practices to scale. He does not see the state covering EBP's beyond what Medicaid already covers. He shared that his agency loses money providing Functional Family Therapy.
- EBP's – implementing and not losing money is difficult
- Lack of integration between BH and primary care- Integrate with medical system
- improve access to evidence-based psychosocial interventions;
- Jeff: tools and practices we should try to take to scale: CANS; IHBT – Intensive Home Based Treatment; MDTFC – Multi Dimensional Treatment Foster Care; MST – Multi System Therapy; NMT – Neuro Sequential Model of Therapeutics; Other evidence based trauma informed interventions included on the SAMHSA registry; Initial training and ongoing technical assistance to providers

### 4. Funding

- Rick shared opinion that agencies shouldn't have to lose money for providing quality services that communities are requesting.
- Do we need to revisit cross-system funding streams for providers for services that benefit other systems?
- Could we implement a system like ODYS' RECLAIM funding in other systems? 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.

- Jeff: Payment rates from county children service agencies to foster care and residential treatment providers is often less than actual incurred costs, which impairs the ability of out of home care providers to arrange for adequate care and supportive services.
- Seeking reimbursement from Medicaid for intensive home based treatment for youth with behavioral health challenges is difficult and costly as it involves billing multiple units of different services.
- Seeking reimbursement from Medicaid for integrative physical and mental health care for children is challenging. There are few methods to do so, one of which, the Health Home Medicaid service, offers very low payments rates and tough regulations.
- Medicaid payments rates for behavioral health services are not modernized and are instead built on a 20 year old fee for service system.
- Behavioral health and out of home care providers are not eligible for incentive of bonus payments for producing positive outcomes.
- Payers of behavioral health and out of home care services do not do an adequate job of communicating measured outcomes to providers

#### **5. Communication between agencies:**

- Can we improve the communication between hospitals with community providers (psychiatrists)?
- Becky: Challenge of privacy issues: excluding behavioral health in release—HIE- very few behavioral health providers are included;
- How well do we share information when it needs to be shared for quality services
- Is there a benefit – for education for example- and MH to have an information sharing agreement?
- **Statewide guidance on intersystem/interagency communication**

#### **6. Increasing complexity of the clinical population.**

- **Complexity of needs and risks** of clients: co-occurring issues; risk and safety issues increasing
- **Increasing risk and safety of staff** who serve persons with complex needs in the community

#### **7. Continuum of care and levels of care:**

- **Level of care needs** –If a community does not have a complete level of care and access to it- how do we deal with the negative outcomes? What are the consequences and who are they a consequence for? 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**

- Eileen: Population changes phone numbers; transportation; communication are barriers
- Ben: Give me a number of someone in your family that has never changed
- Eileen: Getting people back for their month follow-up-

- Can we do something like an adolescent well check visit? Is there a way to pay the patient to attend the well child visit for adolescents?
- Health Homes – the concept of health homes can have a positive impact on follow-up consistency, but has to be adequately funded
- NYU: parent engagement group- helps other parents engage in treatment
- NW: parent partners- linked to crisis stabilization unit

## **9. Human resources**

- Wendy- 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.
  - Child psychiatric shortages
  - Qualified mental health professionals
- Jeff: Difficult in arranging for access to quality psychiatric care for children.
- Difficult to attract a quality direct service workforce; competition with larger providers such as hospital systems.

### **Three priority focus areas for workgroup:**

1. Statewide guidance on intersystem/interagency communication
2. Outcomes
3. Funding: Pricing system of Medicaid for mental health treatment in Ohio—including Health Homes; cross-system funding opportunities

### **Next Steps:**

- Present summary of today's discussion to larger Clinical Roundtable group and get feedback
- Meet again to work on recommendations for the three priority areas
- Meet in person after the clinical roundtable meetings & utilize phone conferencing for other months
- Rick will send out notes for review
- Rick will send out electronic scheduling

### **Addendum Information from OMHAS website:**

OhioMHAS uses and reports the National Outcome Measures (NOMs), which are required by the Substance Abuse and Mental Health Services Administration (SAMHSA) for Block Grant and discretionary grants funding. The NOMs are defined by [ten broad domains](#) to which specific measures apply, depending on whether the service outcomes are for mental health and substance abuse treatment or prevention and wellness promotion.

#### ***Aggregated NOMs for Treatment***

Five NOMs related to treatment are collected by Ohio MHAS and reported in aggregate form:

- Access and Retention (Substance Abuse)
- Client Perception of Care (Mental Health)
- Symptom Reduction (Mental Health)
- Social Functioning (Mental Health)
- Cost Effectiveness (Substance Abuse and Mental Health)

The substance abuse access and retention NOM is calculated with service event data. Performance management reporting on retention and disposition at discharge at the provider and board level is available through the [Ohio Behavioral Health \(OHBH\)](#) system. Mental health client perception of care, symptom reduction and social functioning are collected through annual randomized surveys called the [MHSIP](#) and [YSS-F](#), with results ( [MHSIP-YSSF Report\\_2011](#), [MHSIP-YSSF Report\\_2012](#), [2012 Consumer Survey Supplemental Report](#)) made publically available. The cost effectiveness NOM for substance abuse treatment is based on average cost by level of care, and the corresponding mental health NOM is based on number of persons receiving evidence-based practices and number of such practices provided.

#### ***Client-level NOMs for Treatment***

The Department collects three client-level NOMs from treatment providers that apply to both mental health and substance abuse services:

- Employment/Education
- Stable Housing
- Criminal Justice Involvement

The Department collects three other client-level NOMs that are unique to either substance abuse or mental health services:

- Abstinence (Substance Abuse)
- Social Connectedness (Substance Abuse)
- Use of Evidence-Based Practices (Mental Health)

The client-level NOMs and other demographic information are reported each year to SAMHSA in files called the Treatment Episode Dataset (TEDS) for substance abuse treatment and the Treatment Episode Outcomes (TEO) for mental health.

## **Web Portal and Ohio Behavioral Health (OHBH) System**

OhioMHAS uses a web-based application called the Ohio Behavioral Health (OHBH) system to collect client-level information about treatment outcomes for recipients of mental health and substance abuse services. The OHBH is one of several applications hosted on the [web-based portal](#) developed by the former Ohio Department of Alcohol and Drug Addiction Services. As one of several applications on the web portal, the OHBH is specifically designed to collect client-level treatment NOMs through the creation of admission, update and discharge records. The OHBH has several features, including a support area with documentation, batch upload facility, online data entry forms and reports. A training environment is available to give providers and boards an opportunity to experience the OHBH application.