New York State Office of Mental Health
Performance Measurement Expert Panel Meeting, April 14, 2017

Executive Summary

NYS is implementing multiple Medicaid reform initiatives aiming to fundamentally transform the behavioral (BH) system of care. Major changes include transferring oversight responsibility for BH populations to mainstream Medicaid Managed Care Organizations that have little BH experience and shifting the majority of provider payments into value-based arrangements. Given the combination of rapid, substantial system change and relative lack of adequate BH quality and performance measurement strategies, there is a significant risk of unintended adverse outcomes. It is critical for NYS to define and maintain a focus on quality and value in BH care during a massive system transformation.

To address this issue, the New York State (NYS) Office of Mental Health's Center for Practice Innovation convened a panel of NYS and national experts in BH performance measurement at the NYS Psychiatric Institute on April 14, 2017. The Panel reviewed the multiple reform initiatives underway in the NYS Medicaid Program and explored strategies to support a BH Performance Measurement Program that will: 1) Allow NYS oversight agencies to effectively monitor NYS goals for BH system clinical transformation; 2) Enable NYS providers, networks, and managed care organizations to identify key quality gaps and opportunities; and 3) Facilitate the State's transition to a value-based payment (VBP) reimbursement model. This Executive Summary is followed by a detailed review of the Panel discussions and recommendations.

The Panel recommended that NYS develop an ongoing capacity for innovation in behavioral health quality and performance measurement. NYS is in a position to create a comprehensive BH Performance Measurement Program involving cross-agency collaboration between DOH, OMH, OASAS. This Program should also leverage clinical and research expertise at OMH-affiliated academic institutions, the Nathan Kline Institute and the NYS Psychiatric Institute. This Program would review and recommend measurement approaches that best support the NYS Roadmap for Medicaid Payment Reform. As such, it would provide ongoing examination of BH performance measurement practices from NYS and identify innovative/best practices from other states and at a national level. The following Report Summary lists specific activities that a NYS BH Performance Measurement Program could pursue to accomplish the Panel's recommended goals:

Goal 1: Propose standards for BH providers related to Electronic Health Record (EHR) capabilities, consent and confidentiality regulations, and data sharing.
Goal 2. Identify strategies to leverage existing NYS data sets and information platforms to support performance measurement and quality improvement activities for both children and adults.
Goal 3: Explore new approaches and technologies for capturing data regarding patient experience of care and care coordination activities.
***Goal 4*:** Identify performance measurement approaches that promote uptake of integrated care models.
Goal 5: Establish guidelines for prioritizing existing measures and for developing new quality and performance measures for integrated care.
***Goal 6*:** Create a core set of recovery measures that includes person-centered measures.

Goal 7: Identify process and outcome measures of functioning and recovery for the BH population with serious mental illness.
Goal 8: Identify testing and review procedures that allow for functioning and recovery measures to progress from exploratory status to use in accountability and quality improvement programs.
Goal 9: Develop a performance measurement strategy that addresses disparities and includes equity measures involving BH populations and conditions.

To accomplish these goals, this BH Performance Measurement Program would have the following responsibilities:

1. Set and monitor standards for data analytic approaches to understanding trends and outcomes in the NYS public BH provider system of care;
2. Propose and monitor provider technical assistance and reporting standards related to BH performance and quality measurement;
3. Provide ongoing guidance to managed care organizations and provider networks regarding BH quality and performance measures and strategies most likely to support the NYS Roadmap for Medicaid Payment Reform;
4. Advise the NYS Medicaid Clinical Advisory Groups regarding BH performance measures to be included in the State's VBP Program;
5. Examine whether and when the NYS Medicaid Program should consider stewarding BH performance measures for endorsement;
6. Prepare reports summarizing the impact of NYS Medicaid Managed Care redesign on BH service use and BH quality of care in NYS; and
7. Prepare reports summarizing the impact of the NYS Medicaid VBP program on BH service use and BH quality of care in NYS.

Detailed Summary

The day-long session included introductory comments from Dr. Harold Pincus of Columbia University followed by a keynote address titled "Evolution of Quality Measurement in Mental Health" from Dr. Helen Burstin, Chief Scientific Officer, National Quality Forum. Following an overview of NYS Medicaid Program reform initiatives, the afternoon session consisted of breakout work groups focusing on: 1) Data Infrastructure for Performance Measurement; 2) Promoting Integrated (Medical-Behavioral Health) Care; and 3) Measuring Functioning and Recovery. The work groups were asked to identify goals and activities related to NYS Medicaid Program BH performance measurement that could be accomplished in upcoming 3-5 years.

Preliminary Comments: Harold Pincus, MD

Dr. Pincus outlined key issues in behavioral health performance measurement including:

- It is important to have a balanced portfolio of measures across the quality continuum of structure, process, outcome, patient experience, and resource use.
- Developing new quality measures requires significant resources and expertise;
- Measures serve different purposes including:
    1) Understanding systems and populations (variation analysis)
    2) Internal continuous quality improvement
    3) Accountability (including value-based payment models)
- Meaningful performance measurement requires collaboration from multiple stakeholders including evidence, guideline, and measure developers along with measure endorsers and users (including consumers, families and providers).
- Supporting the uptake of measurement-based care requires a multi-pronged focus on measures (importance, usability, validity and feasibility), accountability strategies, and Health Information Technology (including registry capabilities, interoperability and connectivity).
- In Integrated Care models, measurement strategies should support shared accountability among primary and behavioral health providers.
- The population of individuals with a serious mental illness should be considered a disparities category. Stratification of existing performance measures for this population will identify important and feasible opportunities to improve quality and outcomes.

Keynote Address: Helen Burstin, MD, MPH

Major points from Dr. Burstin's address:

- The National Quality Forum has identified five current priorities:
    1) Reduce unnecessary measurement
    2) Move toward patient-centered outcome measures
    3) Address measurement science
    4) Fill prioritized measurement gaps
    5) Address disparities in all performance measurement activities

- To reduce unnecessary measurement, prioritize measures that are outcome-focused, will drive improvement, are meaningful to patients and caregivers, and support integrated care.
- High-impact outcomes include functional status/well-being, patient experience, harm/complications, healthy behaviors, and value/access/equity of care.
- Key measurement science areas of investigation include:
    1) The impact of social determinants (for many of which reliable data are not available)
    2) Patient-related vs. healthcare-related determinants of health status
    3) The need to move beyond claims data for risk assessment/risk adjustment
    4) Attribution of outcomes in accountability programs
- Significant measurement gaps exist in BH relative to general medical health, i.e., lower performance rates on most endorsed measures for the BH population.
- The measurement field needs greater involvement/interaction with providers to identify processes and outcomes that matter.
- Disparities can be addressed by focusing on measures that are patient-centered (e.g., longitudinal, patient-focused episodes; patient reported outcomes; and cross cutting measures such as care coordination). The field needs health equity measures to identify disparities and provide incentives to providers to address them.

Workgroup 1: Data Infrastructure for Performance Measurement

Discussion Themes:

- To increase efficiency of the measurement process, NCQA is encouraging health plans to report HEDIS measures using Electronic Clinical Data Systems (ECDS). Plans can reconfigure their systems to support automated, bidirectional sharing of clinical quality information. Measurement programs will increasingly require these automated processes.
- At the same time, the lack of uniform Health Information Technology (HIT) standards is a major impediment to effective data sharing. Regarding electronic health records (EHRs): Health care is unusual in that advances in technology have so far created greater burden and have not made it easier for providers to care for patients.
- Many small- and medium-size providers (which include the majority of community-based organizations providing BH services) still lack the financial and technical resources to even implement EHRs.
- Consent issues, especially related to 42 CFR Part 2, create significant obstacles to data sharing.
- NYS has a tremendous amount of data but existing databases are not linked and lack of interoperability is a major limiting factor. An example involves Regional Health Information Organization (RHIOs): NYS has a statewide network of RHIOs as well as an organizing network (SHIN-NY), but BH providers have very low rates of connectivity.

Recommended Goals and Activities:

Goal 1: Propose standards for BH providers related to Electronic Health Record (EHR) capabilities, consent and confidentiality regulations, and data sharing.

Activities recommended to accomplish Goal 1:

1.1. Perform an environmental scan of publications from private (e.g., National Council) and public (e.g., Office of the National Coordinator for Health Information Technology) entities regarding proposed EHR standards for BH providers.
1.2. Identify and define core data elements related to patient identification, social determinants, functioning, and health status that should be recorded in BH provider EHRs to support quality and performance measurement.
1.3. Recommend minimum core capabilities for EHRs used by BH providers in NYS.
1.4. Screen and identify HIT vendors with BH EHRs that meet minimum standards.
1.5. Continue to work with NYS Department of Health on procedures to standardize consent process and confidentiality guidelines wherever appropriate to support data sharing for quality and performance measurement.
1.6. Develop resources to educate BH providers about consent regulations and requirements, and encourage/incentivize BH providers to share data on NYS Regional Health Information Organizations (RHIOs).

Goal 2. Leverage existing data sets and information platforms to better support quality and performance measurement activities for both children and adults.

Activities recommended to accomplish Goal 2:

2.1. Work with NYS Department of Health to ensure that DSRIP/VBP dashboards include relevant BH measures and can be accessed by BH providers (including medium and small BH providers).
2.2. Identify and test strategies for making dashboard data available to providers at point of care to support treatment.
2.3. Continue to promote PSYCKES as platform to support continuous quality improvement activities as well as for provider monitoring of performance measures used in accountability programs.
2.4. Expand PSYCKES capabilities to include provider reporting of data to support quality and performance measurement.
2.5. Pursue a pilot project to extract data on Medicaid enrollees from NYS RHIOs for quality and performance measurement related to care coordination (e.g., rates of providers accessing and posting care plans on RHIOs). Consider linking RHIOs to PSYCKES and/or other data management platform for this purpose.
2.6. Identify strategies to leverage existing and new NYS data warehouses (e.g., Altarum, Clinical Data Mart, 3M grouper and pricing data, All Payer Database) to support quality and performance measurement.
2.7. Pursue cross-systems collaborations to link data from health platforms with data from criminal justice, housing, and education authorities (e.g., Ohio example of making school attendance data available to mental health providers).
2.8. Identify funding sources to support leveraging big data and EHRs, e.g., CMS HITECH program.

Goal 3: Explore new approaches and technologies for capturing data regarding patient experience of care and care coordination activities.

Activities recommended to accomplish Goal 3:

3.1. Identify strategies that incentivize providers to input data into platforms, e.g., link payment for services to required data submissions (example: no payment for depression care visit without a PHQ entered into registry).

3.2. Explore strategies for using patient reported data from mobile mental health support applications.

3.3. Leverage PSYCKES for collection of self-report data.

3.4. Periodically re-convene the Data Infrastructure Work Group from the 4/14/17 expert panel meeting to create a clearinghouse of best practices for EHR/HIT standards, reporting, consent and confidentiality standards.

Workgroup 2: Promoting Integrated Care

Discussion Themes:

- Successful implementation of integrated care models requires rigorous monitoring of processes and outcomes accompanied by systematic quality improvement efforts.
- Measurement programs should aim to support both: 1) quality and performance measurement/improvement; and 2) point-of-care decision making.
- Poor access and limited ongoing engagement in BH services are major current challenges that should be monitored with relevant process measures.
- There are many more NQF-endorsed process measures than outcome measures and there is a robust debate in the field about the merits of focusing on outcome measures only (which can incentivize adverse selection of patients) vs. emphasizing process and fidelity measures (which can limit provider flexibility and innovation).
- A balanced portfolio of structure, process and outcomes measures is needed.
- Integrated care models have focused largely on depression in primary care settings and the field needs to consider strategies to support integrated care for anxiety and substance use disorders as well as for children.
- More work is needed to integrate preventive/primary care and chronic general medical disease care with specialty BH care for SMI populations.

Recommended Goals and Activities:

***Goal 4*:** Promote provider uptake of integrated care models.

Activities recommended to accomplish Goal 4:

4.1. For providers in settings with low infrastructure and implementation capabilities, develop technical assistance programs focusing on alternative models (e.g. telemedicine, Extension for Community Healthcare Outcomes (ECHO), non-physician providers) for integrating BH and primary care.

4.2. For providers in settings with high infrastructure and implementation capabilities, continue to support existing integration models (e.g. IMPACT model).

4.3. Tailor technical assistance and other support activities using a 2X2 framework identifying high vs. low infrastructure BH settings as well as high vs. low infrastructure primary care settings.
4.4. Use the upcoming CCBHC demonstration project to explore strategies for IT, personnel, payment, regulations, accountability, and recognizing best reverse-integration practices.
4.5. For all models and settings, identify key elements of technical assistance programs that will: 1) address barriers to implementation (e.g. personnel, regulations, professional culture, etc.); and 2) provide resources to support HIT, billing, and registry templates.

Goal 5: Establish guidelines for prioritizing existing measures as well as for developing new quality and performance measures for integrated care in the NYS Medicaid Program.

Activities recommended to accomplish Goal 5:

5.1. Applying the 2X2 framework above, identify measure sets specifically targeted for low infrastructure and high infrastructure providers (with separate sets for BH and PC settings in each of these categories) that include structural, process, and outcome measures most likely to promote uptake.
5.2. For primary care settings integrating BH care, identify measurement opportunities for BH disorders other than depression.
5.3. Establish procedures to examine existing NYS administrative and clinical data systems to explore the reliability, validity, and feasibility of currently endorsed and potential new measures within the NYS Medicaid Program.
5.4. Develop guidance to managed care organizations and provider networks regarding integrated care quality and performance measures and strategies most likely to support the NYS Roadmap for Medicaid Payment Reform (NYS VBP Roadmap).

Workgroup 3: Measuring Functioning and Recovery

Discussion Themes:

- Reliable and valid measures of functioning and recovery exist. However, measure stewards/funders have not promoted these measures for endorsement. This is beginning to change as the field recognizes the importance of social determinants and person-centered outcomes.
- NYS should implement existing measures of functioning and recovery for individuals with serious mental illness with confidence that they can be used effectively, and should not wait for measures to be endorsed by NQF. It can take years to get a measure endorsed and systems like the NYS Medicaid Program have narrow timelines for VBP and other reform initiatives that require performance measures.
- Concerns about using non-endorsed measures will be raised by stakeholders including managed care organizations. Providers and networks will also raise concerns about measurement burden. But these cannot prevent NYS from taking the appropriate actions to promote measurement of these critical outcomes.
- Workgroup members highlighted Maryland's experience with recovery measurement. Maryland used a participatory process to design a set of measures that include

symptoms and functioning. The measures have been widely implemented and used for quality improvement and resource allocation.

- Process measures may also be more useful than outcome measures when the provider network has less experience and fewer resources. In this situation, NYS should emphasize process and fidelity measures to ensure the providers are appropriately implementing evidence based practices. This is a common scenario in community behavioral health nationally. E.g., successful uptake of the collaborative care model for treatment of depression in primary care improved significantly when the model added a requirement for submission of depression screen score in order for providers to get reimbursed for the service.
- These themes and the goals/activities below are also relevant for non-BH population of patients with chronic medical illnesses.

Recommended Goals and Activities:

***Goal 6*:** Create a small core set of recovery measures that covers the largest possible clinical population and also includes person-centered measures.

Activities recommended to accomplish Goal 6:

6.1. Perform an environmental scan of data and measures used in different NYS programs and agencies. Perform a similar environmental scan of other states.

6.2. Consider expanding the conception of recovery measurement to include social connectedness & isolation, spirituality, and perception of choice. For children, promote measures of resiliency, protective factors, and school performance.

6.3. Consider person-centered measures utilizing data reported directly by service recipients via surveys or other methods.

6.4. Use a participatory process to choose key metrics. Engage stakeholders in discussions; be open to alternative approaches/perspectives. Ensure collaboration with NYS OASAS and DOH.

6.5. Review and test risk adjustment approaches for the selected measures.

6.6. Create guidelines to allow for expansion of this core measure set of functioning and recovery measures for specific programs, e.g., Personalized Recovery Oriented Services (PROS) or Assertive Community Treatment.

Goal 7: Adopt structure, process and outcome measures of functioning and recovery. Find a balance between outcome measures vs. measures that promote uptake of best practices and support point-of-care decision making.

Activities recommended to accomplish Goal 7:

7.1. Identify value priorities related to functioning and recovery for managed care organizations and for providers.

7.2. Consider adopting elements of Maryland's approach, which measured and incentivized fidelity for selected evidence based practices.

7.3. Test longitudinal measures that capture changes in functioning and recovery domains over time.

Goal 8: Outline the steps needed to move functioning and recovery measures from exploratory status to use in specific accountability and quality improvement programs.

Activities recommended to accomplish Goal 8:

8.1. Educate key NYS stakeholders (including managed care organizations and providers) about currently available measures of functioning and recovery.

8.2. Develop a staged approach that initially incentivizes timely and accurate collection of data regarding functioning and recovery.

8.3. Outline processes for using new, non-endorsed measures in VBP arrangements and moving gradually from pilot (e.g., Pay for Reporting) to full accountability (e.g., linked to shared savings) status.

8.4. Develop procedures to test selected measures for reliability, validity, and feasibility using NYS data. Consider Develop guidelines for an incremental approach in which validation research is concurrent with implementation of functioning and recovery measures.

8.5. Develop guidelines for a tiered approach similar to that used by CMS with Medicare ACOs, in which MCO/provider networks with established reporting capabilities and mature clinical services are encouraged to link shared savings to functioning and recovery measures earlier than entities with less mature capabilities.

Goal 9: Develop a performance measurement strategy that addresses disparities and includes equity measures involving BH populations and conditions.

Activities recommended to accomplish Goal 9:

9.1. Examine existing data sets to identify quality and performance measures that should be stratified for BH subgroup(s).

9.2. Review existing literature and approaches regarding measures of equity of care that involve BH populations and make recommendations about testing and including these measures in the NYS VBP initiatives.

Next Steps

The expert panel recommended that NYS continue its innovative performance measurement work. Panel members noted that current federal oversight priorities are shifting such that states will have greater authority and flexibility to manage their health care programs. The NYS Medicaid Program is a large and important system of care that can serve as a model for other states. The panel strongly endorsed the recommendation that NYS develop an ongoing capacity for innovation in behavioral health quality and performance measurement by creating a BH Performance Measurement Program that leverages collaborations and expertise in BH performance measurement and services research across NYS DOH, OMH, and OASAS and also utilizes NYS and national BH services research and policy expertise.

This report is respectfully submitted June 12, 2017.

Thomas Smith, MD, Associate Medical Director, NYS OMH
Marleen Radigan, DrPH, MPH, MS, Director, Office of Performance Measurement and Evaluation, NYS OMH

Expert Panel Members

Facilitators

Thomas Smith, MD, OMH
Marleen Radigan, DrPH, MPH, MS, OMH

Participants

Expert Consultants
Yuhua Bao, PhD, Cornell
Helen Burstin, MD, MPH, NQF
Frank Ghinassi, PhD, Rutgers
Howard Goldman, MD, PhD, University of Maryland
Michael Hogan, PhD
Michael Lardieri, LCSW, Northwell
Joe Parks, MD, National Council
Harold Pincus, MD, Columbia
Mark Salzer, PhD, Temple
Sarah Scholle, DrPH, MPH, NCQA
Bonnie Zima, MD, MPH, UCLA

NYS Partner Agency Collaborators
Jeanne Alicandro, MD, MPH, IPRO
Andrew Cleek, PsyD, NYU
Lindsay Cogan, PhD, MS, DOH OQPS
Doug Fish, MD, DOH OHIP
Belinda Greenfield, PhD, OASAS
Myla Harrison, MD, MPH, NYC DOHMH
James Kirkwood, MPH, DOH
Dawn Lambert-Wacey, OASAS
Charles Morgan, MD, OASAS
Charlie Neighbors, PhD, CASA
Kathy Pike, PhD, Columbia
Anne Schettine, RN, DOH OQPS
Boris Vilgorin, NYU
Meng Wu, PhD, DOH OQPS

NYS Provider and Managed Care Organization Collaborators
Donna Colonna, SUS
Sabina Lim, MD, MPH, Mount Sinai
Jorge Petit, MD, Beacon
Harvey Rosenthal, NYAPRS
Ian Shaffer, MD, Healthfirst
Scott Wetzler, PhD, Montefiore
David Woodlock, MS, ICL

NYS OMH Collaborators
Maria Abraham, MD, MPH
Josh Berezin, MD
Jay Carruthers, MD
Neal Cohen, MD
Michael Compton, MD, MPH
Lisa Dixon, MD, MPH
Molly Finnerty, MD
Jennifer Humensky, PhD
Adriana Joseph, MPH
Margaret Kurk, MS
Emily Leckman Westin, PhD
Crystal Lewis, PhD
Mingjie Li
Xian Li, PhD
Robert Myers, PhD
Mark Olfson, MD, MPH
Maria Pangilinan, PhD
Sapana Patel, PhD
Qin Qin
Adrienne Ronsani, MS
Lloyd Sederer, MD
Brigitta Spaeth-Rublee, MA
Scott Stroup, MD, MPH