# Integrated Care Metrics: Deep Dive

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HEALTHTHINK

# Metrics & Measurement: Love 'Em or Hate 'Em

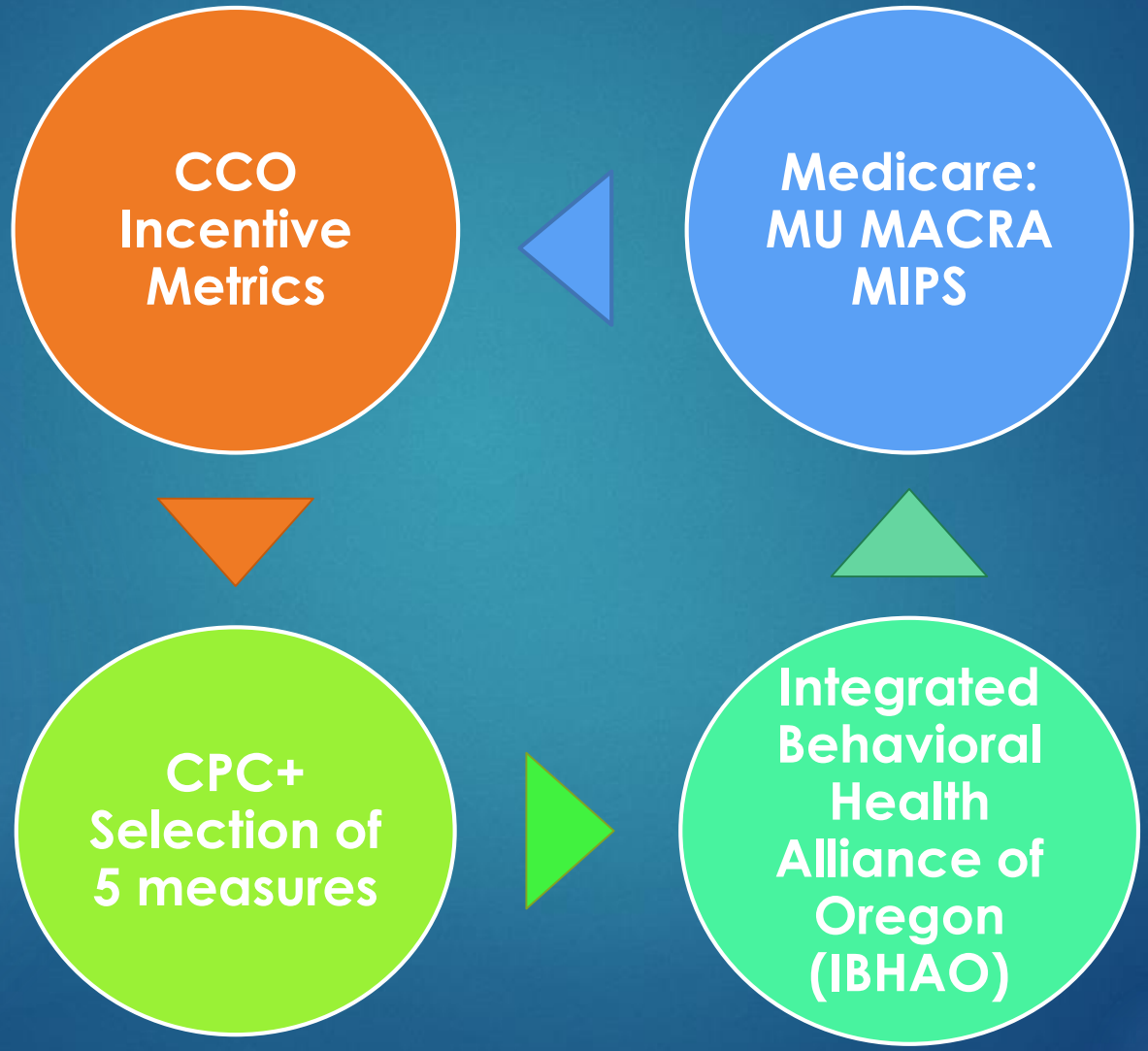
- The use of metrics in healthcare is fascinating for some as healthcare affects *everyone* and focus on saving lives, improving care and addressing cost.
- Collecting data is time-consuming, cumbersome, requiring expensive IT builds and/or maintenance of extensive data-collection spreadsheets.
  - AND THERE ARE SO MANY…

# Integrated Medical Homes – Measures within and across Care

# Metrics: Varied and Variables

| | Providers | Patients | Payers | Accreditors |
|---|---|---|---|---|
| **Financial** | X | | O | |
| **Utilization** | X | | O | |
| **Cost/Productivity** | X | | O | |
| **Clinical Performance** | X | X | X | X |
| **Patient Safety** | X | X | X | X |
| **Patient Satisfaction** | X | X | X | X |

# Metrics for Integrated Care



# Measures: Behavioral/Physical

| Oregon Health Authority Behavioral Health Measure Library<br>February 2017 (Samples) | |
|---|---|
| **NQF #** | |
| 0105 | **Antidepressant Medication Management** |
| 0108 | **Follow-up Care for Children Prescribed ADHD Medication** |
| 0418 | **Depression Screening and Follow-up Plan** |
| 1879 | **Adherence to Antipsychotic Medications for Individuals with Schizophrenia** |
| 1933 | **Cardiovascular Monitoring for People with Cardiovascular Disease & Schizophrenia** |
| 1934 | **Diabetes Monitoring for People with Diabetes & Schizophrenia** |
| 2599 | **Alcohol Screening and Follow-up for People with SPMI** |
| 2600 | **Tobacco Use Screening and Follow-up for People with SPMI or AOD** |
| 2602 | **Controlling High Blood Pressure for People with Serious Mental Illness** |

http://www.oregon.gov/oha/analytics/MetricsDocs/Behavioral-Health-Measures-Library.pdf

# CCBHC Reporting Measures

**BHC-Reported Measures Measurement Periods (MPs) for CCBHCs -- Demonstration Years (DY) 1 & 2**

| | Factor and Time Period |
|---|---|
| (ROUT) | Routine Care Needs |
| (I-EVAL) | Time to Initial Evaluation |
| (TX-EVAL) | Time to Comprehensive Person- and Family-Centered Diagnostic and Treatment Planning Evaluation |
| (SUIC) | Deaths by Suicide |
| (DOC) | Documentation of Current Medications in the Medical Record |
| (BMI-SF) | Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up |
| (WCC-BH) | Weight Assessment for Children/ Adolescents: Body Mass Index Assessment for Children/ Adolescents |
| (CBP-BH) | Controlling High Blood Pressure |
| (TSC) | Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention |
| (ASC) | Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling |
| (SRA-BH-C) | Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment |
| (SRA-BH-A) | Adult Major Depressive Disorder (MDD): Suicide Risk Assessment |
| (CDF-BH) | Screening for Clinical Depression and Follow-up Plan |
| (DEP-REM-12) | Depression Remission at Twelve Months |

# CCBHC Reporting Measures

## State-Reported Measures Measurement Periods (MPs) for CCBHCs -- Demonstration Years (DY) 1 & 2

| | Factor and Time Period |
|---|---|
| (HOU) | Housing Status |
| (SU-A) | Suicide Attempts |
| (PEC) | Patient Experience of Care Survey |
| (Y/FEC ) | Youth/ Family Experience of Care Survey |
| (FUM) | Follow-up After Emergency Department Visit for Mental Illness |
| (FUA) | Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence |
| (PCR-BH) | Plan All-Cause Readmissions Rate |
| (SSD) | Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications |
| (SMI-PC) | Diabetes Care For People With Serious Mental Illness: Hemoglobin A1c (Hba1c) Poor Control (>9.0%) |
| (APM) | Metabolic Monitoring for Children and Adolescents on Antipsychotics |
| (SMC) | Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia |
| (AMS-BD) | Adherence to Mood Stabilizers for Individuals with Bipolar I Disorder |
| (SAA-BH) | Adherence to Antipsychotic Medications for Individuals With Schizophrenia |
| (FUH-BH-A) | Adult Follow-up After Hospitalization for Mental Illness |
| (FUH-BH-C) | Child Follow-Up After Hospitalization For Mental Illness |
| (ADD-BH) | Follow-up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication |
| (AMM-BH) | Antidepressant Medication Management |
| (IET-BH) | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment |

# Clinic/Site Tracking

| MEASURE | Process | Intermediate Outcome | Outcome |
|---|---|---|---|
| | **Frequency** | **Frequency and Volume** | **Results** |
| **WARM HANDOFF** | How many occurred | How may occurred and resulted in added Service | How many occurred and resulted in service and reduced/increased xxx |
| **SCREENING** | | | |
| **OTHER: Describe** | | | |

# IBHAO Recommended Measures

**IBHAO Recommended Measures: Primary Care Behavioral Health Integration-November 2016**

| Integration Concept | Process Measures → | Intermediate Outcome Measures → | Outcome Measures |
|---|---|---|---|
| Access and Quality of Care | Behavioral health screening rates (e.g., SBIRT, PHQ-9, etc.) | 1. Depression screening and follow-up plan (e.g. NQF-0418) including integrated care plan involving interdisciplinary team members<br><br>2. Identification & Intervention With Target Sub-Populations: Percentage of a sub-population of patients who could benefit from BHC involvement that received a BHC intervention during the reporting period. (e.g., patients with positive PHQ-9 or CRAFFT, or patients with new ADHD or Functional Abdominal Pain diagnoses) | 1. Treat to target scores, such as decrease in PHQ-9 scores (Percentage of patients with 50% decrease in scores or PHQ 9 ≤ 10)<br>2. Aggregated comparison of shift in scores for those who received behavioral health interventions with those who did not receive integrated behavioral health interventions on health measures such as:<br>- Patient-Reported Outcomes (e.g., quality of life surveys CDC HRQOL- 4) |
| | Percent of completed referrals to outside specialty behavioral health services | Access to Integrated Behavioral Health Services: Percentage of unique patients with a direct patient contact by BHC during the reporting period | Access to Integrated Behavioral Health Services: Sustained evidence of reaching a benchmark population penetration |
| | Progress toward meeting IBHAO recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 | Identified Process with goal of meeting the IBHAO recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 | Verified documentation of meeting the IBHAO recommended minimum standards for PCPCHs providing integrated care or 2017 PCPCH Standard 3.C.3 |
| Utilization & Cost | Fiscal sustainability measures have been identified | Documentation of meeting or exceeding the standards for current behavioral health metrics recognized by Oregon e.g.:<br>- Follow up after hospitalization for mental illness<br>- Avoidable emergency department visits | Established analytics to track the total cost of care prior to behavioral health integration and with behavioral health integrated services |
| Patient Experience of Care | Patient and family experience receiving integrated care (e.g. CAHPS PCMH item set 3.0) | Patient and family experience receiving integrated care (survey data) Percentage sent and returned | Patient and family experience receiving integrated care (survey data) Comparison of aggregated survey results between those who received integrated behavioral health care with those that did not receive integrated behavioral health care |
| PCP Retention/ Satisfaction | | Systematic evaluation of PCP satisfaction with integrated behavioral health care at practice | Systematic and standardized comparison of PCP retention rates in integrated PCPCHs vs those without BHC |

# Thank you!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