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CHIP Title: Getting to the Heart of Behavioral Health Quality: A Measurement Based Care Quality Improvement Program (QIP)

Project Description:
The overall purpose of this CHIP was to implement a measurement-based care (MBC) program, utilizing four validated assessment tools: the PHQ-9 (depression), GAD-7 (anxiety), ACEs (trauma), and BAM-7 (addiction and social determinants of health). This program had two phases: (1) establishing a common data collection platform across a diverse range of (largely rural) behavioral health providers, and (2) providing targeted clinical summaries and connection to educational opportunities for clinicians participating in this program. The program was funded by Partnership HealthPlan of CA, with funding obtained through behavioral health grants as well as ongoing incentive payment quality improvement initiatives.

Improving the quality of behavioral health care is particularly challenging, given that much of this care is provided behind closed doors and the typical outcome measures can be highly subjective and contextual. One common (and often unsuccessful) approach to assess quality in behavioral health care is to offer (or mandate) various validated screening or assessment tools (such as the PHQ9 or GAD7), but often the clinicians administering these tools are neither trained in how to interpret these results nor how to incorporate these findings into their treatment planning. As a Medi-Cal managed care plan (MCP), Partnership HealthPlan of CA is responsible for the non-specialty mental benefit for its members, and to meet this benefit Partnership contracts with and delegates the administration of this to Carelon (formerly Beacon). Partnership, therefore, has a vested interested in ensuring that high quality behavioral health care is being offered through Carelon to its members.

Group behavioral health practices (“providers”) with over $100,000 in annual claims were identified and offered the opportunity to participate. Of 44 eligible providers, 8 agreed to participate in the program. Participating providers were offered incentive payments on a quarterly basis based on volume of participation, with most providers averaging $30,000-40,000 per quarter. Based on claims review, the most common behavioral health conditions seen in the behavioral health network were identified as anxiety, depression, trauma, and substance use. These diagnoses allowed us to be intentional in selection of the MBC tools we decided to use: PHQ9, GAD7, ACEs, BAM7. Carelon and Partnership contracted with BrightHeartHealth (a telebehavioral health company with a novel measurement-based care quality program) to work with participating clinics to establish a common data collection platform. Phase 1: Participating providers worked with BrightHeartHealth to integrate MBC tools into existing clinic workflows, which involved development of both up front data collection strategies and back-end feedback (aggregate data for clinic administration and clinical summaries to individual clinicians). Monthly technical support and progress reviews were conducted with each provider, and quarterly learning collaboratives were conducted with all providers. Participating members filled out the PHQ9, GAD7 at each visit. The BAM7 was discontinued due to provider feedback that it was too complicated to administer. ACEs were obtained once at the beginning of program engagement.

Adoption rate by clinic varied from 20 to 55% (percentage of Medi-Cal beneficiaries who participated), with an observed drop off in adoption after the first quarter that was corrected by more frequent technical assistance and introduction of learning collaboratives. Nearly 2,000 assessments were conducted. Of those participating, anxiety and depression scores dropped significantly (70% and 67%, respectively) over the course of six months of the program. Impacts were also noted outside of the MBC tools themselves, with decreases noted in reported family/friend conflicts (77%), average days in pain (60%), insomnia (50%). The majority of participants were white, unmarried, women with at least some college education. Qualitatively, providers reported finding the dashboard and clinical summaries provided by BHH to be helpful in guiding their clinical care, especially treatment and discharge planning. These data were also helpful in structuring supervision, and providers noted that this program positively impacted provider resilience (giving a sense of trackable accomplishment and hope).

Key Findings and Lessons Learned:

- Seamless integration of the MBC assessment tools into existing clinic workflows was crucial. To achieve this, we had to work with each clinic individually, and partnering with BrightHeartHealth was invaluable since they had experience in this space and could provide technical assistance.
- Provider burnout in behavioral health care is real, and providing clinicians with a program that connects them with other providers (learning collaboratives, aggregate data provided in clinical summaries) and gives an observable structure and direction to the work can mitigate burnout and foster resilience.
- Learning collaboratives work! Providers were incredibly creative in how they were managing symptoms and were willing to share these approaches with the broader community.
- Using MBC in the context of clinical supervision can be very effective in helping clinicians improve the care that they deliver.
- The amount of administrative support that a clinic can put toward a quality improvement project is directly proportional to how well that program will be adopted, and the quality of the outcomes observed.

Next Steps:

- Continue program for another year and invite additional behavioral health providers to participate.
- Dive further into claims and utilization data to examine possible broader program impacts.
- Further refine the feedback loop from BrightHeartHealth to the individual clinicians with links to specific trainings that might be helpful in overcoming clinical challenges that the MBC approach brings to light.