

Population Health Management Resource Guide for Behavioral Health

RESOURCE GUIDE



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Table of Contents

	About NCQA and Janssen Scientific Affairs, LLC	5
	Acknowledgments	5
	NCQA Staff	6
	Janssen Scientific Affairs, LLC Staff	6
	Introduction	7
	Overview: The Behavioral Health Resource Guide	7
	The NCQA PHM Conceptual Model	8
	Population Health Management	8
	Population Health Management and Behavioral Health	8
	NCQA, Population Health Management and Behavioral Health	9
	Context for the Current Behavioral Health Landscape	10
	Stigma	10
	Substance Use Disorders and the Opioid Epidemic	10
	COVID-19 Pandemic	11
	Common Terms	12
	Component 1: Understanding and Assessing the Population	13
	Data Integration	13
	Understanding the Population	15
	Individual Screenings and Assessments	17
	Social Determinants of Health	19
	Stratifying the Population for Targeted Interventions	20
	Using a Population Health Management Approach for Behavioral Health	20
	Component 2: Creating a PHM Strategy to Deliver Integrated Behavioral and Physical Care	22
	Developing a Population Health Management Strategy	23
	Integrated Care Models	23
	Transformation, Engagement and Integrated Care	25
	Payer Coordination and Alignment for Integrated Care	27
	Value-Based Payment	29
	Practitioner Shortages and Access	30
	Opportunities to Address Stigma Through Integration	31
	Using a Population Health Management Approach for Behavioral Health	32
	Common Q&As	33

**Component 3: Planning and Delivering Targeted, Person-Centered Interventions** 34

Targeted Interventions and Care Planning	35
Individuals With Complex Needs	36
Populations With Specific Cultural Needs	38
Substance Use Disorders	39
Pediatric Populations	41
The Role of the Community Setting	42
The Role of Digital Health	43
Using a Population Health Management Approach for Behavioral Health.	46
Common Q&As	46

**Component 4: Measurement and Impact** 49

Types of Performance Measures	49
Measure Types	50
Experience Measures	51
Behavioral Health-Specific Performance Measures	52
Tools to Evaluate Impact	54
PDSA Cycle	54
Root Cause Analysis	54
Using a Population Health Management Approach for Behavioral Health.	55

**References** 56



About NCQA and Janssen Scientific Affairs, LLC

The National Committee for Quality Assurance (NCQA) is a leading not-for-profit organization dedicated to improving health care quality through measurement, transparency and accountability. Since its founding in 1990, NCQA has been central in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda.

NCQA created this *Population Health Management Resource Guide for Behavioral Health* with sole sponsorship funding from Janssen Scientific Affairs, LLC (Janssen). Janssen provided no input into either the structure or the content of the Resource Guide. Both Janssen and NCQA believe that the future of health care delivery requires collaboration between diverse areas of health care.

The *Population Health Management Resource Guide for Behavioral Health* will help organizations use population health management to manage their population with behavioral health conditions.

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Introduction

➔ OVERVIEW: THE BEHAVIORAL HEALTH RESOURCE GUIDE

The *Population Health Management Resource Guide for Behavioral Health* is, first and foremost, for organizations, particularly practitioners and practices, that are working to integrate behavioral health care and physical care. Second, it is for managed care organizations and others—population health organizations, wellness organizations, digital behavioral health solutions (such as app companies) and payers such as states or employer organizations—that are trying to improve access and outcomes for a population with behavioral health conditions.

This guide covers how integrated care can support individuals with behavioral health conditions, coordinate within the delivery system and result in better outcomes. The guide describes the structures and processes needed to support management of the health of the whole person in terms of the population's health.

This guide combines NCQA's expertise with information about behavioral health integration gleaned from the literature and from conversations with over 30 patient centered medical homes (PCMH), managed care and digital health solution organizations described how they manage their populations, the challenges they face and their approach for the future. It was also steered by expert testimony from the Behavioral Health Leadership Roundtable, which included practitioners, digital health solution organizations and health plan payers.

This guide uses the NCQA Population Health Management (PHM) Conceptual Model (p,8) to highlight key activities needed to perform PHM. Components feature central aspects of a comprehensive PHM strategy that includes behavioral healthcare. Each component answers these questions, with examples:

- How does this information relate to population health management?
- Why is this information important for managing populations with behavioral health conditions?
- How do the interviewed organizations approach this aspect of managing a population with behavioral health conditions?

SUBSET	SUBSET DESCRIPTION
Resource Guide Components	<ul style="list-style-type: none">• Component 1: Understanding and Assessing the Population• Component 2: Creating a PHM Strategy to Deliver Integrated Behavioral and Physical Care• Component 3: Planning and Delivering Targeted, Person-Centered Interventions• Component 4: Measurement and Impact
In-the-Field Examples and Tools	Unique, component-specific best practices.
Views From the Top	Insights from the Behavioral Health Leadership Roundtable.
Common Q&As	Our answers to frequently asked questions.
COVID-19 Considerations	Aspects of care or operations that changed in response to the pandemic during a snapshot in time (March–September 2020).

➡ THE NCQA PHM CONCEPTUAL MODEL

The PHM Conceptual model can be applied to any entity interested in comprehensive application of population health management strategies. At the core of the model is the population of interest as defined by the entity. The model is flexible and can be applied to many care settings. Its seven critical components are represented in the illustration as surrounding and supporting the population and will be discussed throughout this guide.



➡ POPULATION HEALTH MANAGEMENT

Population health management is a model of care that addresses individuals' health needs at all points along the continuum of care through participation, engagement and targeted interventions for a defined population. Its goal is to maintain or improve people's physical and psychosocial well-being and address health disparities through tailored, cost-effective solutions. [1] A PHM strategy can be used to manage an entire population or focus on specific populations.

An organization's PHM program should provide care that addresses patients' needs, preferences and values. [2]

➡ POPULATION HEALTH MANAGEMENT AND BEHAVIORAL HEALTH

In 2020, health care expenditures accounted for 18% (around \$4 trillion) of the United States' gross domestic product. [3] Although the United States spends a larger share of resources on health care than any other high-income country, health outcomes are poorer and overall life expectancy is lower. This is particularly true for individuals who experience behavioral health conditions, which encompass mental illness and substance use disorders (refer to Common Terms in this section).

Despite the prevalence of behavioral health conditions, behavioral health has traditionally received a smaller share of resources and attention than physical health, including financing of, access to and quality of care. These disparities have directly resulted in even poorer outcomes for the individuals impacted by these conditions: Suicide was the 10th leading cause of death in the United States in 2020 and [4] the life expectancy of individuals with serious and persistent mental illness is 10–25 years lower than average. [5] These individuals also have a high rate of physical health comorbidities contributing to the overall cost of their care: Adults with depression have a 40% higher risk of developing chronic conditions like cardiovascular and metabolic disease. [6]

For organizations that manage or deliver health care to individuals with behavioral health conditions, who frequently have co-occurring conditions and complex needs, implementing a PHM framework and strategy can lower costs and improve outcomes.

➡ NCQA, POPULATION HEALTH MANAGEMENT AND BEHAVIORAL HEALTH

NCQA began measuring and Accrediting health plans more than three decades ago with a focus on care delivered to health plan members, and has become the premier evaluator of quality of health plans, practices and other care organizations. NCQA flagship programs promote population health management through measurement, transparency and accountability.

Healthcare Effectiveness Data and Information Set (HEDIS®) ¹	HEDIS creates accountability and benchmarks to improve patients' health and the quality of care they receive. Almost 200 million people are enrolled in health plans that report quality results using HEDIS. The HEDIS measure set contains measures related to behavioral health, including screening for common behavioral health conditions; access to and monitoring effectiveness of care through adherence to evidence-based management and treatment; and attention to comorbid chronic conditions that reduce life expectancy among people with serious mental illness. HEDIS is described in detail in Component 4.
Patient-Centered Medical Home (PCMH) Recognition	The medical home model is a person-centered framework for organizing primary care that meets individuals' needs by providing "the right care at the right time." NCQA's PCMH Recognition program is the most widely used medical home model: NCQA has recognized more than 13,000 practice sites and 67,000 practitioners. Practices that have earned Recognition demonstrate that they have laid the groundwork for understanding the behavioral health needs of their patient population by screening for and measuring behavioral health conditions in the primary care setting.
Distinction in Behavioral Health Integration	NCQA's Distinction in Behavioral Health Integration helps practices that have earned NCQA PCMH Recognition demonstrate that they deliver comprehensive, whole-person care that identifies and intervenes upon behavioral health needs in the primary care setting, resulting in better overall health outcomes. Behavioral Health Integration Distinction is described in detail in Component 1.
Health Plan Accreditation	NCQA's Health Plan Accreditation is the only performance-based evaluation of a health plan's structures and processes for quality improvement, population health management, utilization management, network management, practitioner credentialing and member experience. It outlines a set of requirements for coordination and utilization of behavioral health services. More than 173 million people are enrolled in NCQA-Accredited health plans.
Managed Behavioral Healthcare Organization Accreditation	MBHO Accreditation is for organizations managing behavioral healthcare on behalf of health plans, employers or regulators. Key areas include care coordination, complex case management and data exchange between health plans and behavioral healthcare organizations to support clinical quality and the patient experience.
Population Health Program Accreditation	PHP Accreditation is for organizations that manage a population on behalf of a payer (health plan, state, employer). These organizations often provide programs that address specific populations (defined by age, demographics or payer) or chronic conditions (behavioral or mental health conditions). Provider organizations, accountable care organizations (ACO), integrated delivery networks (IDN), health systems and other population health companies are eligible to earn this Accreditation.

Consistent with NCQA's commitment to addressing behavioral health across these programs, the Population Health Management Resource Guide for Behavioral Health explores population health management and its application in behavioral healthcare.

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➡ CONTEXT FOR THE CURRENT BEHAVIORAL HEALTH LANDSCAPE

Behavioral health is a broad topic that is impacted by current events and prevalent and historical attitudes. Three issues provide context for this guide and are worth exploring: the stigma of behavioral health issues, substance use and abuse and the COVID-19 pandemic. Organizations interviewed for this guide described these as common themes impacting their operations or care delivery. These themes are highlighted below as context for later references.

Stigma

Although there are many barriers to care, the stigma associated with behavioral health is the most pervasive and multi-faceted: It is a barrier externally imposed by public or cultural attitudes about behavioral health, self-imposed by the individual's internalization of public or cultural attitudes, reinforced by political and private institutions whose policies limit opportunities and funding for individuals with behavioral health conditions, and perpetuated by existing health care payment and delivery infrastructures. [7] Society often treats behavioral health disorders—including mental health and substance use disorders—as something to be ignored or ashamed of. Behavioral health issues can be perceived as a moral, constitutional or intellectual failure on the part of the sufferer. This can make individuals confuse “feeling bad with being bad” [8] and lead to delay or avoidance of treatment.

Strategies for overcoming stigma at the individual level include talking openly about behavioral health, educating patients and the community, being conscious of how behavioral health conditions are described and being open about the need for treatment. [9] In the healthcare delivery system, some strategies may be working toward integration of behavioral and physical health care, funding and technological infrastructures, acknowledging the role of healthcare professionals in perpetuating stigma and educating staff about the importance of behavioral health for the patients they serve. Component 2 explores the role of integrated care settings in addressing stigma.

Substance Use Disorders and the Opioid Epidemic

Substance use disorders happen “when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.” [10] Although such disorders include a variety of drugs and alcohol, opioid use has garnered the most public attention. Opioids are a class of drugs that include heroin, synthetic opioids (such as fentanyl) and prescription pain relievers (oxycodone, hydrocodone, codeine, morphine). [11] The opioid overdose epidemic has grown steadily since the late 1990s. In 2016, 11.4 million people misused prescription opioids, 2.1 million had an opioid use disorder and 47,600 died from an opioid overdose. [12] In 2018, 2 out of 3 drug overdose deaths involved an opioid. [13] More than 20 million Americans 12 years of age or older experienced a substance use disorder in 2019, including alcohol use disorder and illicit drug use disorder, [14] yet only 4.2 million received any substance use treatment.

While the opioid epidemic has shone a spotlight on substance use disorders as a widespread problem, it also offers an opportunity to bring funding and public attention to how the health care delivery system must change in order to improve outcomes for individuals who experience them. Integrated behavioral and physical health care plays an important role for these individuals, who often have a complex set of interconnected medical, mental health or social needs that compound their disorder and pose barriers to their treatment. Component 3 details the importance of person-centered, targeted interventions for this population.

Individuals with substance use disorders are also particularly affected by the perception that substance use is a moral failure, and often seek treatment for substance use disorders in general health care and primary care settings rather than in specialty treatment settings. Yet, according to the Surgeon General, “The current substance use disorder workforce does not have the capacity to meet the existing need for integrated health care, and the current general health care workforce is undertrained to deal with substance use-related problems.” [15]

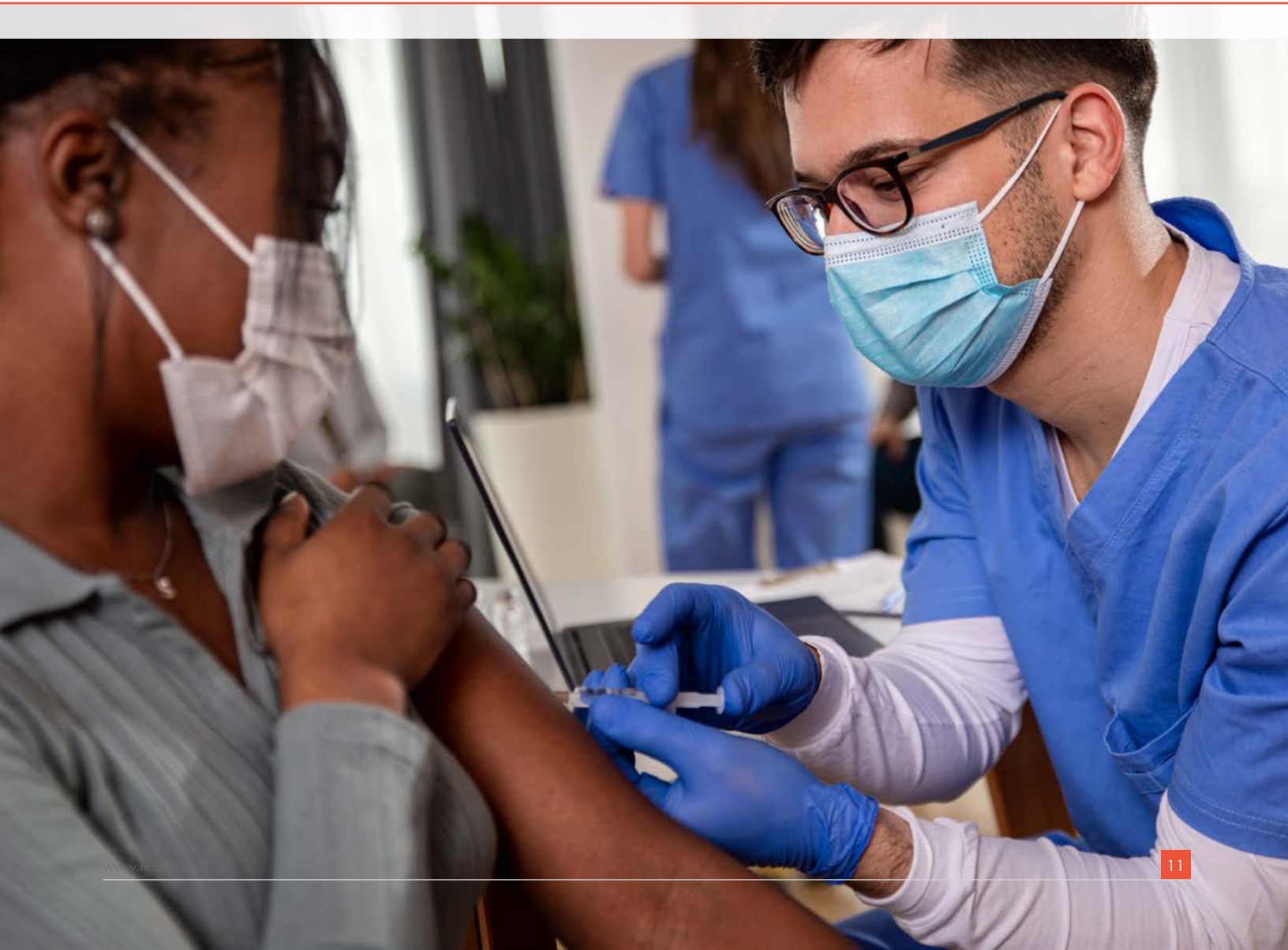
Organizations interviewed for this resource guide highlighted the importance of screening for these disorders and having resources or expertise to deliver interventions.

COVID-19 Pandemic

The COVID-19 pandemic has disrupted American society since the first public health measures were implemented in March 2020. It has limited how healthcare professionals traditionally manage and deliver care (in person), driving increased utilization of telehealth and digital health tools, particularly for behavioral healthcare. Interviewed organizations said that disruption of in-person services, especially, jeopardized health outcomes for individuals with chronic behavioral or physical health conditions. One interviewed organization said that use of its digital health tool for managing stress and anxiety increased 1,500% in the 6 months after the pandemic began.

The financial and social losses caused by the pandemic—through unemployment, disrupted education and social isolation—have also exacerbated the behavioral health epidemic. From June 2019 to January 2021, the proportion of adults reporting symptoms of behavioral health issues rose from 1 in 10 to 4 in 10, [16] driving demand in a delivery system that had struggled pre-pandemic to deliver adequate access to behavioral health services. Although digital modalities removed some barriers to access (e.g., transportation, stigma, geographic provider shortages), interviewed organizations highlighted concerns about unequal access to technology creating new health disparities.

This guide uses call-out boxes labeled COVID Considerations to highlight how COVID-19 has affected organizations' operations and processes. Boxes include real world examples of solutions to challenges associated with socially distant care that can be retained even in the post-pandemic "new normal"—activities and processes to consider for a population health management approach to manage the impact of the pandemic.





➔ COMMON TERMS

These terms appear throughout the guide.

Behavioral healthcare	Evaluation and treatment of psychological/mental and substance use disorders.
Clinical team	Includes physicians, advanced practice registered nurses, other registered nurses, physician assistants, clinical pharmacists and other health care professionals. [17]
Health system	Includes organizations combined horizontally (e.g., a hospital system) or vertically (e.g., a multihospital system that also owns practices and post-acute care facilities). [18]
Practitioner	A health care professional or a team of professionals (e.g., physicians, nurse practitioners, physician assistants) who manage an individual's care.
Serious mental illness	"A mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities. The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI." [19]
Substance use disorder	"The recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home." [10]
Value-based payment	Health care purchasers (government, employers, consumers) and payers (public and private) hold the health care delivery system (physicians, practitioners, hospitals and others) accountable for the quality and cost of care. [20]



Component 1: Understanding and Assessing the Population

A good PHM strategy begins with understanding the needs of the population. Organizations should have a process in place to routinely:



Collect and integrate data from a variety of sources, including external partners or agencies.



Screen and assess individuals to identify their physical, behavioral and social needs.



Identify subgroups within the population who share characteristics and needs.



Assess which services are significant to population subgroups.



Stratify and identify individuals for eligibility in relevant programs and for services.



Identify gaps between the resources and programs individuals need and those that the organization offers.

How these activities are performed can depend on an organization's resources, the extent of its clinical and technological integration, how much data—and which kinds—it can access and its capability for data collection and analysis.

Component 1 highlights the role each activity plays in understanding individual patients' needs and the needs of the population as a whole, establishing the foundation for interventions and quality improvement.

➡ DATA INTEGRATION

Data integration is the combination of data from multiple sources or systems (e.g., electronic health records [EHR], health information exchanges, claims, laboratory reports, digital health platforms, demographic/census databases) across sites of care (e.g., medical home, inpatient setting, community-based organization, home) and across disciplines (medical, behavioral, pharmacy, social). Data sharing involves exchanging patient information with organizations that are not part of the same health system or health plan and do not share the same EHR. Which data are integrated depends on the organization's goals and its uses for the data.

Integrating data is the first step in the process of population assessment and stratification and is also important in other components of the PHM strategy. Having access to a variety of data sources and types allows organizations to construct a more holistic and complete understanding of their population's physical, behavioral and social health. For the care team, access to this data helps them connect individuals to the right care at the right time. For organizations that deliver behavioral health services or manage specialized behavioral health populations, it is the foundation of their PHM strategy.

Note: This guide does not replace the PHM category of standards in NCQA Health Plan Accreditation, MBHO Accreditation, PHP Accreditation, PCMH-Behavioral Health Distinction or any other NCQA Accreditation, Certification or Recognition, or dictate additional requirements that must be met for an NCQA survey or integrated care.

Because different organizations have access to different pieces of the data puzzle, there is a need for improved data coordination between community-based organizations and the health care delivery system. For example, MBHOs have behavioral health claims, health plans have medical claims, practitioners have care plans and notes in electronic medical records and community-based organization often have information on social services provided outside the practice setting. Community-based organizations that offer targeted services for housing, substance use and food insecurity often collect vital data that can inform whole-person care. [21]

Interviewed organizations (including PCMHs, Federally Qualified Health Centers [FQHC] and MBHOs) overwhelmingly identified data integration and data sharing—especially when accessible to all care team members through a single EHR—as having the most impact on their ability to execute population health management activities and effectively deliver whole person care. Incomplete or absent data was identified as one of the most serious barriers. Organizations cited paths to achieving an integrated EHR, such as starting with a limited number of services or referral pathways, locations or capabilities (e.g., integrating prescriptions); some purchased a fully integrated EHR at the beginning of their integration journey. Component 2 explores strategies to facilitate integration.

Interviewed organizations leveraged integrated data and advanced EHR capabilities to perform an array of impactful activities:

- Give care team staff and practitioners timely access to necessary information (e.g., notes, care plans, test results, medication lists) to deliver appropriate clinical decisions and care.
 - Track changes in assessment scores over time for individuals and the population.
 - Stratify individuals into risk categories or cohorts targeted for specific assessments, programs, interventions or community resources.
 - Generate reports to support population assessments and forecast future resource needs. This capability supports quality improvement initiatives and decisions about additional resources or partnerships.
 - Make and track referrals between physical and behavioral healthcare teams.
 - Prompt practitioners to conduct specific assessments and—based on an individual’s score—deliver specific interventions, refer to other practitioners or escalate to higher levels of care.
- Note: This capability may include an extra layer of confidentiality or permissions for sensitive behavioral health information.

While the activities described above are performed by organizations with advanced capabilities, they don’t represent the activities of an average organization that is constrained by less sophisticated data capabilities, less integrated EHRs or less streamlined data sharing arrangements. Organizations that deliver behavioral health services or manage specialized behavioral health populations have traditionally operated in data silos, independent of organizations that manage physical health. Although physical and behavioral health integration is increasingly a goal of care organizations, payers and states, interviewed MBHOs and digital health platforms said that the extent and timeliness of their access to nonbehavioral health data still depends on the preference of their partners or customers (e.g., health plans, physical health providers, states), limiting their ability to deliver appropriate and timely interventions. Some states are building their own data warehouses and HIEs to help overcome these barriers, support measurement and oversee interventions.

There are unique barriers to data sharing in behavioral healthcare, such as the federal privacy law 42 CFR part 2, which limits the use and disclosure of sensitive health information, particularly for patients with substance use disorders. It requires a court order for disclosure of part 2-protected information for subpoenas, search warrants or law enforcement requests, protecting patients who seek treatment from legal ramifications. Part 2 requires signed patient consent authorizing disclosure of substance use disorder records for treatment, payment or other health care operations. [22] Organizations can ask patients to fill out authorization forms at intake to facilitate care coordination and avoid delays later. Integrated EHRs should have additional security for viewing this sensitive information.

➔ UNDERSTANDING THE POPULATION

Population assessment is systematic assessment of a population's significant defining characteristics and needs to identify services, programs and resources that can adequately meet those needs. Organizations use this assessment to determine whether additional resources are needed and to improve the services and programs they offer. Timely, integrated data ensure a comprehensive picture of a population's needs.

When conducting population assessment, an organization identifies subpopulations in its patient population based on defining characteristics and needs, including social determinants of health (SDOH). Characteristics that define a subpopulation may include:

- Federal or state program eligibility (e.g., Medicare or Medicaid, dual-eligible).
- Multiple chronic conditions (behavioral and/or physical).
- Age.
- Sexual orientation or gender identity.
- Behavioral health diagnoses or conditions (e.g., depression, anxiety, substance use disorder, autism spectrum disorders, ADHD).
- Conditions requiring special care coordination (e.g., schizophrenia, intellectual/developmental disability).
- Socioeconomic status (e.g., housing status, employment status, food insecurity, social isolation).
- Refugee status.
- Migrant status.
- Language.
- Ethnicity.
- Geography.
- High utilization of ER or inpatient settings.

Some interviewed PCMHs that have integrated behavioral health use assessments based on these characteristics to inform decisions about:

- Adding programming and resources, including, but not limited to, types of partnerships and relationships to cultivate in the community (e.g., housing authorities, food banks, homeless shelters, specialty behavioral healthcare).
- How many resources and personnel to make available for patients who speak a given language.
- Types of additional staff to hire (e.g., pediatric psychiatrists, care coordinators, community health workers).
- Topics to develop for educational programs.

Some interviewed organizations use a combination of characteristics to reveal gaps they may not otherwise identify from evaluating a single characteristic—for example, a high number of refugees who need access to educational materials about depression, written in their language.

IN-THE-FIELD EXAMPLE

Organization: Rainbow Pediatric Center, Jacksonville, FL

Problem: 10% of the population has an established diagnosis of ADHD, anxiety and/or depression. The prevalence of behavioral diagnoses has continually increased over the past 5 years and there is a significantly higher proportion of individuals who see their primary care practitioner for behavioral health issues before diagnosis. Rainbow saw this as an opportunity to facilitate preventative behavioral health care.

Process: Rainbow hired a mental health practitioner to:

- Train practitioners in behavioral health concerns when screening for and addressing behavioral and mental health issues.
- Provide patient education materials and a list of resources.
- Be an onsite resource for individuals who need intervention.
- Be an in-house referral for complex behavioral health patients for medication and therapy management (collaborative care).

Rainbow also implemented a sub-team of primary care practitioners who received in-depth training on behavioral and mental health issues. It acquired parent resources for practitioners to share, including books, handouts, web/app resources and community resources, and held community seminars for parents of children with anxiety.

Result: Primary care practitioners are more comfortable screening for and addressing anxiety, depression and ADHD. Time is set aside for the practitioner to address issues at an early stage to minimize the need for further stressors in the family's life. Rainbow created an in-house referral source to psychiatry services and implemented educational materials and lectures for the practice in general. The expectation is that early intervention will have a significant impact on mitigating and potentially reversing the progression of behavioral diagnoses among pediatric populations. This approach will also educate them on tools/ techniques to manage and cope with stressors, enabling them to grow into emotionally healthy adults.



➡ INDIVIDUAL SCREENINGS AND ASSESSMENTS

Screening tools, often checklists or questionnaires, quickly identify the possible presence of behavioral health conditions and the need to refer an individual for further assessment. Screening tools do not determine a diagnosis. **Assessment** is the comprehensive process conducted by a treatment professional to make a diagnosis and determine intervention needs. [23]

Effective population health management requires that organizations screen and assess individuals systematically, implementing a process to identify unmet psychosocial needs, including for SDOH. Screenings and assessments incorporated into clinical and operational workflows direct individuals to the right members of the care team to ensure appropriate interventions and care. Interventions are described in more detail in Component 3.

To identify possible behavioral health conditions, interviewed organizations routinely used standardized, evidence-based screening tools and assessments such as:

- **Two- and nine-item Patient Health Questionnaires (PHQ-2 and PHQ-9)** for depression. Organizations can use the quick PHQ-2 and then administer the more sensitive PHQ-9 to determine likelihood of depression. The Patient Health Questionnaire Modified for Teens or PHQ-9M is the adolescent modified version of the PHQ-9 for the pediatric population. [24]
- **Seven-item Generalized Anxiety Disorder questionnaire (GAD-7)** for assessing the prevalence and severity of anxiety. [25]
- **Eight-item Short Post-Traumatic Stress Disorder Rating Interview (SPRINT)** for assessing post-traumatic stress disorder. [26]
- **Columbia-Suicide Severity Rating Scale (C-SSRS)** for assessing the immediate risk of suicide; primarily used in acute care settings. [27]
- **The Pain, Enjoyment of Life and General Activity scale (PEG scale)** for quickly assessing and monitoring chronic pain. [28]
- **The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)** for assessing and understanding SDOH. [29]
- **Pediatric specific assessments and screening tools** such as screeners for adverse childhood events; the modified checklist for autism in toddlers (M-CHAT-R/F); the 35-item pediatric symptom checklist (PSC-35) for a variety of behavioral health concerns. [30] [31] [32] Some tools, such as for adverse childhood events, are answered by the child; others, such as the PSC-35, are answered by the caregiver.

Note: This list is not exhaustive and only describes tools mentioned during interviews.

IN-THE-FIELD EXAMPLE

Organization: WindRose Health Network, Inc., Trafalgar, IN

A WindRose behavioral health community health worker helped a hearing-impaired patient receive a caption phone, which immediately improved the individual's quality of life.

Problem: Hearing-impaired individuals need access to a phone that is affordable, easy to use and has captions if needed for phone calls and voice messages.

Process: WindRose Health Network ran a report to identify hearing-impaired patients across our network through data collected in the electronic medical record. The behavioral health team contacted these individuals to ascertain need for and interest in a CaptionCall phone with these features:

- Phone and services at no cost
- Free delivery, installation, training and support
- Caption capability for phone calls and voice messages
- Speakerphone, answering machine and custom audio
- Hearing-aid friendly
- Bluetooth connectivity
- Captioning for iPad and iPhone with the CaptionCall Mobile

Results: To date, 6 of 28 identified individuals begun using the CaptionCall phones. They report this as a "life changing event" that has drastically improved their quality of life and access to care. The behavioral health team's goal is to make the phone available to all hearing-impaired patients and staff.

Organizations often administer condition-specific screening tools or assessments only if triggered during initial intake or during conversations with a patient. Some integrated PCMHs emphasized the importance of training their multidisciplinary care team to listen for cues during routine physical health encounters that a patient may require consultation for additional services (e.g., mentioning a major life change, crisis or loss, expressing concern about housing or food).

Some interviewed digital behavioral health platforms and MBHOs rely on technological solutions to screen and “listen” through:

- Algorithms that identify high-risk patients.
- Artificial intelligence, such as natural language processing, that can identify signs of risk through the semantic tone of patients’ writing during journaling or text-based counseling.
- Self-assessment questionnaires in a behavioral health digital application that routinely prompt individuals to complete.

COMMON Q&A

How did interviewed PCMHs incorporate screenings and assessments for behavioral health conditions and SDOH into their workflows?

- Universally, as part of the routine visit or new patient intake process.
- Annually, as part of a wellness visit.
- Monthly, as part of an ongoing treatment plan.

IN-THE-FIELD EXAMPLE

Organization: Waimānalo Health Center, Waimānalo, HI

Problem: In 2014, only 10.44% of patients of Waimānalo Health Center (WHC) were receiving mental health services, below known mental health disorder prevalence rates.

Solution: WHC successfully improved participation of mental health services by implementing the following workflows:

- **Electronic screening for mental health concerns.** All adult patients are screened every 4 months for depression, anxiety, trauma, smoking, alcohol misuse, drug and opioid use and suicidal ideation. Screening is done through OTech tablets, which automate documentation of completed screenings into the EHR.
- **Hiring full-time primary care psychologists.** Embedding primary care psychologists allowed WHC to make automatic referrals for a same-day appointment with a mental health practitioner after a positive screen. Primary care psychologists are fully integrated into the primary care setting: on the same scheduling system and EHR, in the same daily huddles regarding patient care, in the same office as primary care medical practitioners. Individuals are seen in the medical exam room, which helps reduce stigma for mental health services and helps them see mental health services as a routine part of care.
- **Use of electronic messaging to provide integrated and collaborated care.** WHC has a HIPAA-compliant electronic messaging system that allows staff to communicate securely. Warm hand-offs to mental health services can be done through electronic messaging.
- **Implementation of data-driven reporting and analytics through Azara Healthcare.** Azara Healthcare’s tools allow WHC to create visit planning reports to identify individuals who are due for a mental health screening. Azara also allows creation of reports for individuals who screen positive but have not received mental health services. This lets staff follow up with individuals via telehealth services or in person at their next medical appointment.

Results: Since introducing these workflows, WHC more than doubled the percentage of patients receiving mental health services—to 23.95% in 2019—highest among FQHCs in Hawaii and almost three times the national average of 8.65%.

A routine process and workflow to assess behavioral health and social needs in the primary care setting is crucial to identifying individuals who are not directly seeking services and resources they need (sometimes due to stigma). One interviewed integrated PCMH shared an anecdote about an individual who received a routine suicide screening during a visit for a physical health concern, only to admit that he had long felt suicidal but prior to the screening had never been asked about it.

Interviewed MBHOs, digital solutions and integrated PCMHs agreed that the industry lacks standardized quality measurement for demonstrating the impact and outcomes of behavioral health interventions. In the absence of such measures, it is common to regularly screen patients and to measure changes in their screening scores to:

- Track and monitor the progress of conditions.
- Assess the needs of the population as one data point leveraged for population assessment.
- Gather evidence that particular treatments, practices and interventions have better outcomes than others, with the intent to:
 - Demonstrate the organization's value and ROI to payers and potential customers.
 - Improve quality by replicating effective treatments, practices and interventions elsewhere in the organization.

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health are the conditions in which people live, work and play—they are the forces and institutions shaping the conditions of daily life, including political systems, public policies and social norms. Social, economic and physical environmental factors play a fundamental role in the health of every individual, [33] but have particular significance to and influence on behavioral health. [34]

While policymakers and the broader health care ecosystem have only recently begun exploring the importance of addressing SDOH as a strategy to reducing long-term health care costs and improving equity, the bidirectional relationship between behavioral health and socioeconomic factors has long been known: Behavioral health issues can lead to reduced opportunities for income and employment, which in turn can increase the risk of developing a behavioral health issue. [34] Americans with the most acute behavioral health issues are often among the lowest-income and most vulnerable populations, which are disproportionately affected by SDOH. Medicaid is the primary payer of behavioral health services in America, [35] serving an estimated 26% of adults with serious mental illness and 17% of adults with substance use disorders. [36] An estimated 10.8% of Americans with mental illness are uninsured. [37]

The interviewed integrated PCMHs and MBHOs that serve these vulnerable populations stated that a regular process for screening and collecting data on social needs is an important—and practical—part of their strategy to improve physical or behavioral health outcomes: Individuals are less likely to prioritize health care over more immediate environmental concerns (e.g., food, housing, financial insecurity) and are less likely to engage in managing their chronic conditions if they are constrained by barriers to accessing care (e.g., lack of transportation, childcare, digital access).

↑ VIEWS FROM THE TOP

Care delivery organizations recognize the need to address their populations' social risk factors. Leaders described how they are meeting those needs:

- **SDOH assessment.** Most organizations said they use standardized screening tools such as PRAPARE. Assessments can shed light on an individual's needs.
- **Community health workers.** Some organizations use community health workers to address SDOH.
- **Case management.** Some organizations use case managers to help with care coordination, including coordinating community resources and social services, to meet the needs of the whole person.

Interviewed organizations select SDOH screening tools that align with the needs of their population. Some use standardized, validated screenings such as the PRAPARE tool; [38] some develop homegrown screening tools (e.g., including questions about environmental stressors for both the child and the family). Organizations reported that SDOH screenings are typically performed at times of transition (e.g., before admission or discharge from the inpatient setting, during intake/triage at FQHCs).

For more information about SDOH assessment and interventions, refer to NCQA's publication *Social Determinants of Health Resource Guide*.

➡ STRATIFYING THE POPULATION FOR TARGETED INTERVENTIONS

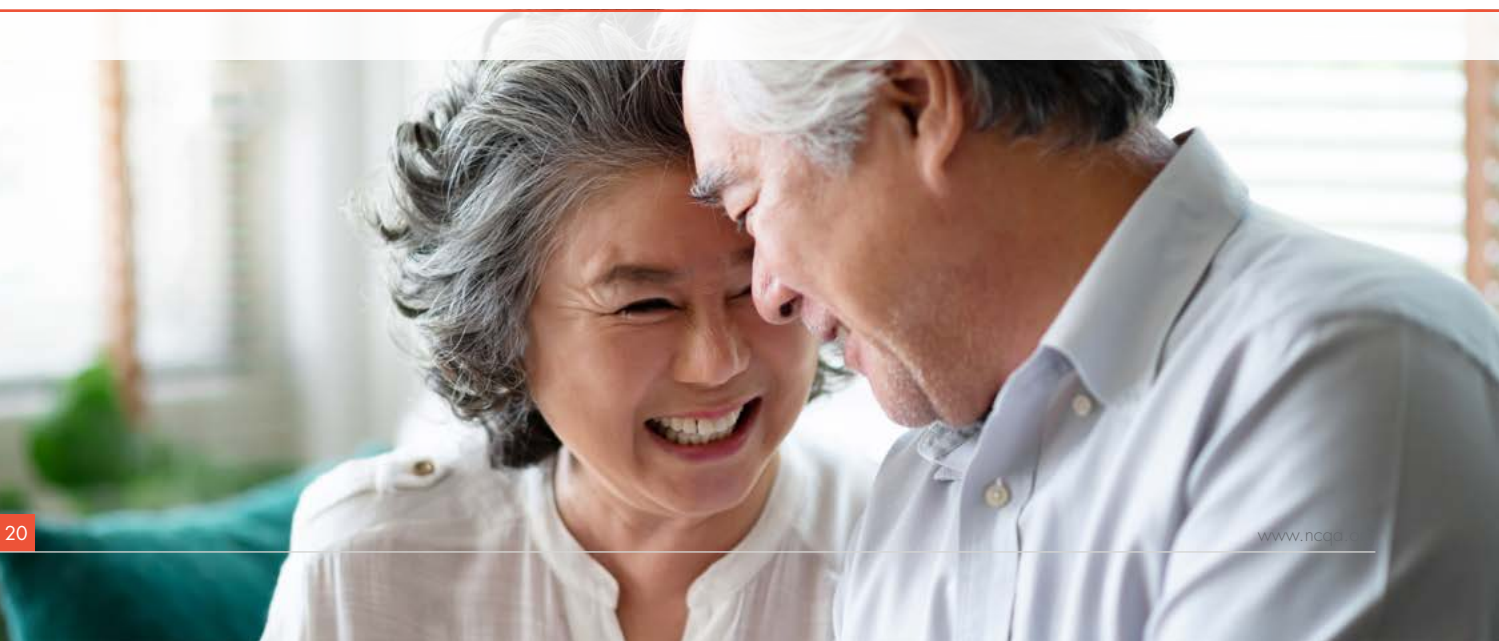
Effective population health management requires that organizations develop the capacity to utilize data from various sources to stratify/segment patients into groups [39] for targeted interventions as part of a regular, cyclical process.

Population segmentation is the process of dividing the population into meaningful subsets—patients who share specific needs, characteristics or behaviors [40]—using information collected through population assessment and other data sources. **Risk stratification**, a method similar to population segmentation, separates populations into risk groups or categories, [41] which are then used to assign individuals to tiers or subsets. Some organizations further segment broad risk categories (e.g., “high risk, high need”) into subgroups with similar needs. [42] The goal of population segmentation and risk stratification is to categorize the population into distinct groups of similar characteristics, complexity or care needs [43] to determine eligibility for programs or services.

Risk status should include behavioral health and social risks to formulate comprehensive segmentation and stratification. There are many ways to stratify/segment individuals based on risk status, but regardless of the method used, stratification requires assessment and integration of data to determine population subsets and the programs and services for which they are eligible.

➡ USING A POPULATION HEALTH MANAGEMENT APPROACH FOR BEHAVIORAL HEALTH

Understanding the population and stratifying individuals into subsets are the first steps in population health management. These steps are universal for all populations. Before an organization can intervene and treat identified individuals, it must first develop a strategy that lays out goals and promotes teamwork between physical and behavioral healthcare. The next components will describe setting strategies, integration and targeted interventions.



IN-THE-FIELD EXAMPLE

Organization: Gerald L Ignace Indian Health Center, Milwaukee, WI

Problem: James is a 61-year-old male diagnosed with severe depression and PTSD. He was established in the Gerald L Ignace Indian Health Center's behavioral health department before the start of the COVID-19 pandemic. James has a variety of socioeconomic stressors that directly affected his ability to access behavioral health services even before the pandemic. He is homeless, unemployed, struggles with chronic physical pain, has limited access to transportation and becomes easily confused in instances where he needs to self-advocate. He has been denied for social security disability benefits several times. He frequently expresses suicidal ideation to his therapist. With the advent of COVID-19, the clinic began the transition to telehealth, but James' government phone did not support video telehealth and was unreliable as a means of getting in touch with him. He became hard to follow and assess. Traditional telehealth services were not working for individuals such as James, who make up a significant percentage of the clinic's population.

Solution: In response to this unmet need, GLIHC's behavioral health department designated a room for providing access to onsite telebehavioral health services, including therapy and psychiatric medication management. Clients without reliable access to a phone can schedule an in-person appointment to use the clinic's technology in order to connect with their therapist and/or prescriber, while still ensuring everyone's safety. This solution avoids having the clinic's most vulnerable clients fall through the cracks.

Increased use of the department's telehealth room also provides an opportunity to ensure that client consent forms and other important documents remain up-to-date during the pandemic. The clinic also administers brief mental health screens (e.g., PHQ-9, GAD-7, SPRINT) in the telehealth room that offer clues about clients' baseline symptoms or, for established clients, assesses progress made in treatment. James continues to struggle, but the telehealth room at GLIHC means that he can connect with his care team regularly and be reminded that he is not alone during this challenging time.

VIEWS FROM THE TOP



Digital health solutions can be uniquely positioned to be vigorously data- and measures-based. Digital health leaders explained the data they collect and measures they use to guide care:

- A digital health platform can automatically **prompt PHQ-9 and GAD-7 screenings** at certain cadences and track scores over time to report on improvements or setbacks.
 - Some platforms allow practitioners to see a dashboard or graph of measures over time to improve their ability to react to fluctuations in scores. This flexibility may result in changed treatment protocols, including medication management.
 - Screening tools should not be overly burdensome to the individual, who should understand how—and why—screeners are used.
- **Artificial intelligence** can track themes in practitioner notes and an individual's journal to enhance continuity of care. It can also result in more-focused therapy sessions: AI can give practitioners insight about the individual without having to ask, "How have you been?" throughout a session.
- Digital health tools can leverage the **perceived stress scale, a brief resilience scale and subjective well-being scale** to determine if the solution is helping individuals manage everyday stress and anxiety and improve overall well-being.
 - For health promotion interventions, it is important to not only consider reducing stress or anxiety, but also maintaining the reduction to **prevent future issues**.
- Some solutions also measure **practitioner engagement**, noting that the more engaged a practitioner is, the more patients improve.

Practitioners and organizations that see data provided through these solutions want to **how to use the data**, not why they should use it. They want to know how it fits into their workflow and if it will save them time. Most practitioners are open to using new tools that improve delivery of care.



Component 2:

Creating a PHM Strategy to Deliver Integrated Behavioral and Physical Care

A PHM strategy provides a roadmap for how an organization determines, communicates and achieves its goals and how it uses available resources to meet the needs of its population. It should be unique to the organization and the needs of its population, but should encompass all aspects of the NCQA PHM Conceptual Model by defining how each member of the care team is involved in activities and how their role relates to PHM goals.

For organizations that seek to manage the behavioral health conditions of their population, strategies increasingly focus on integrated behavioral health and physical health or “whole person” care, which incorporates integrated care into a PHM framework. For health plans, an integrated care strategy may involve care coordination, benefits and networks that include behavioral health practitioners or community-based organizations and settings. For PCMHs and other provider organizations such as health systems or integrated delivery networks, it may involve delivery or coordination of integrated care across a spectrum of arrangements, from coordination with external physical or behavioral health services to co-located or fully integrated coordination within the same practice and/or EHR.

There are many approaches to integration—and many barriers. This component describes how a PHM strategy can be used to provide integrated care, as well as the challenges and considerations it must address to meet integrated care goals. It does not prescribe an exact strategy, but highlights:



Integrated care models.



Transformation, engagement and integrated care.



Payer coordination and alignment for integrated care.



Value-based payment.



Practitioner shortage and access.



Addressing stigma through integration.

Note: This guide does not replace the PHM category of standards in NCQA Health Plan Accreditation, MBHO Accreditation, PHP Accreditation, PCMH-Behavioral Health Distinction or any other NCQA Accreditation, Certification or Recognition, or dictate additional requirements that must be met for an NCQA survey or integrated care.

➔ DEVELOPING A POPULATION HEALTH MANAGEMENT STRATEGY

An organization's PHM strategy covers its entire population. It is driven by a deep understanding of the population (Component 1) and specific and measurable goals (Component 4). It specifies how an organization assesses the population, how it uses data integration to execute population health management functions (which are measurable so they can be tracked and improved), and how it stratifies the population for interventions. The PHM strategy also describes how the care delivery system meets goals and executes interventions, how the organization addresses community involvement (including the PCMH as the locus of care, as well as other patient-centered practices and sites within the medical home neighborhood) and how it interacts with payers to support its populations.

Interviewed organizations have strategies with specific behavioral health goals, which are often executed through integrated care models and targeted, data-driven interventions.

NCQA'S PCMH DISTINCTION IN BEHAVIORAL HEALTH INTEGRATION

NCQA's PHM Conceptual Model includes a "piece" for the care delivery system, signifying the importance of practitioner involvement in care and in reaching population health goals.

NCQA's PCMH Distinction in Behavioral Health Integration is a framework for delivering integrated care based on the Collaborative Care Model, an evidence-based approach to care coordination and care management, regular/proactive monitoring and treatment using validated clinical rating scales, systematic psychiatric caseload review and consultation for patients who do not show clinical improvement. [45]

➔ INTEGRATED CARE MODELS

A true PHM strategy covers the entire population: Behavioral health must be addressed with physical health. However, practitioners and organizations are sometimes ill-equipped to deal with behavioral health needs. Integrating management, coordination and/or delivery of behavioral health and physical health can ensure that care is provided with a whole-person perspective.

Determining which integrated care model is the best fit requires research and understanding the needs of the population. Interviewed organizations used a variety of models.

- **Collaborative Care Model.** [44] [45] This is a team-based care model led by the primary care practitioner and includes behavioral health practitioners and care managers, who are all encouraged to work at the top of their license. The model has five essential elements:
 1. Patient-centered team care. Care plans that incorporate patient goals are shared between primary care and behavioral health practitioners.
 2. Population-based care. A defined population is shared between team members.
 3. Measurement-based treatment. Care treatment plans are guided by patient goals and clinical outcomes.
 4. Evidence-based care. Care is based on researched, well-supported practice guidelines or care protocols.
 5. Accountable care. Quality and good clinical outcomes are reimbursed.
- **Behavioral Health Home Model.** [46] This model focuses on people with serious and persistent mental illness. It facilitates close collaboration between patients, practitioners, community-based or government-sponsored social organizations and health plans (particularly Medicaid managed care organizations). Organizations that followed the model in Pennsylvania saw an almost 2-point overall increase in patient activation scores and a 36% increase in primary care or specialty care use by patients.

- **SAMHSA-HRSA Standard Framework for Integrated Care.** [47] This framework moves organizations from collaboration to true integration through three categories and six levels of collaboration/ integration:
 - o Coordinated Care:
 - Level 1, Minimal Collaboration: Primary care and behavioral health practitioners work at separate facilities and have separate systems; communication is based on a practitioner's need for information.
 - Level 2, Basic Collaboration at a Distance: Practitioners work at separate facilities and have separate systems. They communicate about specific issues of their shared patients; behavioral health is viewed as specialty care.
 - o Co-Located Care:
 - Level 3, Basic Collaboration Onsite: Practitioners are co-located at the same facility but may not share the same practice space. They use separate systems but may communicate more due to their close proximity, with a higher success rate for referrals.
 - Level 4, Close Collaboration With Some System Integration: Integrated care begins through some shared systems and in a primary care setting with an embedded behavioral health practitioner.
 - o Integrated Care:
 - Level 5, Close Collaboration Approaching an Integrated Practice: Primary and behavioral health practitioners function as a true team and communicate frequently. There may not be an integrated EHR, but information is shared in person.
 - Level 6, Full Collaboration in a Transformed Practice: Practitioners view the organization as a single care system treating the whole person. This often requires payment integration.

This list is not exhaustive. Organizations should assess their populations (Component 1), know their capabilities and evaluate community or state-led initiatives to determine the path to integration that is appropriate for them.

VIEWS FROM THE TOP

Leaders of care delivery organizations (integrated PCMHs, FQHCs, risk-based managed care organizations) explained why they integrated behavioral health care:



- Create a more **complete picture of the individual** and address the root cause of complex health needs.
- **Take care of [the] mind, body, soul, all in one spot.**
- Meet the demands of the community and maintain the organization's mission. There is a lack of access to behavioral health; integration allowed the practice to address everyone's needs during a visit.
- **Reduce stigma** by addressing all needs in one setting. Co-location can make individuals more comfortable seeking behavioral healthcare without others in the community knowing the type of treatment they are receiving. Warm hand-offs and assessments by the PCP help people feel more comfortable sharing and make it **easier to navigate** the health care system.
- Allow the organization to **focus on long-term outcomes** and **achieve better outcomes**, including reductions in morbidity, inpatient admission and medical costs in the last 12 months of life.
- **Make work easier** for physical and behavioral health practitioners. Integrated practitioners said that, once established, they were able to work together to create better outcomes for the patient.

COVID CONSIDERATIONS

Interviewed practices described how their care delivery changed drastically during the first 6 months of the COVID-19 pandemic:

- **Shift to digital or telehealth services.** The pandemic provided an impetus to establish telehealth and remote care infrastructures, helping practices overcome barriers that had prevented them from making the transition. Many practices shifted some—or all—behavioral health services to remote, amid concerns about care access issues for vulnerable populations. Practices experimented with the right balance of services to meet the behavioral health needs of their population: in person, remotely or through referrals to in-person community care.
- **Disruptions to communication.** Discontinuing in-person services during the pandemic disrupted communication and connection between practitioners and individuals with behavioral health conditions, negatively affecting their treatment.
- **Impact on revenue and public dollars.** Fewer in-person visits resulted in fewer claims, leaving many practices without the support of a steady revenue stream. Some practices and public payers reported that money previously earmarked to address the opioid epidemic had been shifted to respond to the COVID-19 pandemic. With the opioid epidemic still a problem, practices expressed concern that resources must be devoted to both.
- **The standstill of community-based programs.** Practices often rely on community-based programs to provide social services such as housing, food assistance or employment assistance. Many of these programs were interrupted or suspended in an effort to control the spread of COVID-19. Practices described this as an added stressor because it is difficult for patients to adhere to treatment plans when their basic needs are not met.
- **Practitioner shortage.** Some practices reported that practitioners left or moved elsewhere in response to the pandemic, exacerbating the shortage of behavioral health practitioners.

➞ TRANSFORMATION, ENGAGEMENT AND INTEGRATED CARE

An essential part of an organization's strategy for delivering integrated behavioral and physical care must be a plan to transform its infrastructure and culture. Interventions require collaboration of a care team encompassing a variety of disciplines that may not have previously worked in tandem or shared workflows: primary and specialty care practitioners, psychiatrists and psychologists, social workers, community health workers, licensed counselors, peer navigators—and even digital apps.

Interviewed organizations identified the biggest challenges to their integrated care transformation as securing buy-in from all team members, building integrated care into workflows, the complexity of the transformation process and limited or inconsistent funding to invest in the staff and technology necessary to support integrated care. But these organizations also offered strategies that helped them overcome transformational challenges and improve engagement of the care team:

- **Create a collaborative culture.** Integrated PCMH practices emphasized the importance of practitioner buy-in and alignment with common goals. Because behavioral health practitioners might not be used to coordinating with physical health practitioners (and vice versa), it's important that all practitioners clearly understand their role and know when they should be consulted. (Situations that trigger a consultation can be recorded and reviewed regularly.)
- **Team-based care.** Many practices have daily "huddles" or frequent staff meetings to review upcoming visits and discuss services patients might need (including behavioral health and social services). These meetings help facilitate a team atmosphere and a patient "game plan"—in addition, staff learn how to best serve the practice's diverse patients. Over time, meetings improve practice culture and staff buy-in; delivering integrated care becomes second nature.

- **Behavioral health training.** In addition to having clearly defined roles, practices recommended continuous, ongoing training in behavioral health services and integration for all care team members. Education can (and should) occur even in a well-integrated practice, focusing on the benefits of behavioral health integration for the entire practice and its patients.
- **“No wrong door.”** Practices and organizations said that it’s important to have a framework where patients with co-occurring medical and behavioral health conditions have multiple avenues to seek and access behavioral healthcare. This framework allows referrals to come from the primary care practitioner, specialists, intake assessments, Emergency Departments or hospitals, community-based organizations or local government agencies or institutions (e.g., the criminal justice system). This creates pathways for care and a collaborative environment among stakeholders.
- **Integrated EHRs.** Many practices and organizations rely on shared or integrated EHRs that allow patient information to be shared seamlessly across practitioners. Advanced EHRs have a single interface and log-in point; all practitioners have access to notes, care plans and referrals. EHRs should follow the Certified EHR Technology (CEHRT) standards which help improve interoperability for the capture and exchange of health information [48]. EHRs that meet CEHRT are in a better position to share information between physical and behavioral health. Having complete data allows practices to better assess their population’s needs, identify gaps and view opportunities for improvement. Health plans and multi-site provider organizations said they use reporting functions from integrated EHRs to identify practices that perform well, and shared insights from those practices with others to improve patient experience and outcomes.
- **Information sharing.** Even without an integrated EHR, the intent—sharing information about the patient—is still important. Practices and organizations that have processes for sharing information between practitioner types (especially for referrals and care plans) are better integrated and their patient care is more streamlined.
- **Community relationships.** Successful integration involves partnerships and relationships between practices, organizations and the community. One practice established relationships with local government agencies to get its patients added to public service lists (such as for housing), supporting better behavioral and physical outcomes. Some practices created relationships with community-based organizations to address social needs that are barriers to patient success. Some local governments or state agencies have care coordination services, freeing practices from this task. Building relationships is crucial to knowing what resources are available and which of them can benefit patients most.

VIEWS FROM THE TOP

Leaders of care delivery organizations described their biggest challenges in delivering robust behavioral health care:

- **Shortage of behavioral health practitioners.** Specifically, psychiatric prescribers.
- **Managing workflows.** What one care team member impacts the next care team member’s ability to treat the patient. This requires cohesion and teamwork.
- Payers are moving to **value based-care**, which can be difficult with patients who have complex behavioral health needs.
- **Securing reimbursement** for resources needed to deliver integrated care is a constant challenge. Practices may not receive reimbursement for providing integrated behavioral healthcare and highlighted that it is part of the culture of integrated care to do it without charge because that is best for the population.
- **Communication and coordination.** Even with integrated EMRs, it takes collaborative effort and shared goals between behavioral and physical staff to maintain relationships and deliver cohesive care.

- **Creativity.** Many practices said that integration often comes down to creativity. They ask, “What is the best way to address the patient’s needs and share information?” Sometimes there is no ready answer, which means that the practice has to think outside the box. It’s important to stay open to creative problem solving and to document successes so they can be reproduced.
- **State leadership.** State payers and integrated practices agreed that states have a role in promoting integration through payment models and demonstrations. States providing payment for behavioral health can encourage integrated care while providing funding and education on integrated models and using contracts to codify expectations for integrated care.

➡ PAYER COORDINATION AND ALIGNMENT FOR INTEGRATED CARE

A foundational piece of an organization’s ability to deliver integrated care is securing the payment, resources and funding to transform and maintain the infrastructure and staff necessary to deliver integrated care. Interviewed PCMHs noted that there is often inconsistent and limited funding and, when integrated care is begun under a grant, it’s difficult to continue once the grant funding has ended. These challenges are exacerbated by differences between the infrastructure or goals of the care delivery organization and payer.

It can be difficult for care delivery organizations to convince payers to support the necessary resources required to integrate care. Proving that behavioral healthcare saves money can be difficult when there is not always an immediate return on investment. Traditional payment rules, such as limiting reimbursement for the number of visits or services provided in the same day, can conflict with the workflows and goals of organizations that deliver co-located integrated care: Individuals with complex needs may have multiple appointments or interventions during the same visit to a co-located or fully integrated practice. Payers may not reimburse wraparound and support services that address social risks.

Integrated care models pose a different set of challenges for payers such as state Medicaid agencies, health plans and MBHOs. Thirteen states (and the District of Columbia) “carve out” (exclude) behavioral health services from Medicaid managed care contracts and risk arrangements so that services are funded or provided either as fee-for-service (FFS) or through a separate MBHO. Like carve-out states, some health plans delegate management of behavioral health benefits and membership to an MBHO. This carve-out relationship can make it difficult to know which entity is responsible for

VIEWS FROM THE TOP

Health plan payers explained challenges they face to supporting behavioral healthcare:



- There isn’t much economic basis for whole person health, yet it is **fundamental to health equity**.
- Behavioral health **should be treated no differently** than other enhanced services, yet it is often carved out and treated separately.
- The difficulties in managing behavioral health care are often **system design issues**, such as building a network, contracting, paying claims and managing utilization, which can be more difficult to overcome than clinical complexities in the behavioral health population.
- Building a network can be particularly difficult due to **behavioral health practitioner shortages**. It’s important that everyone practice to the top of their abilities.
- Behavioral health practitioners were **left out of federal funding to establish EHRs**, leaving behavioral health behind the curve on digital documentation and communications.
- Figuring out which telehealth or **digital health service to offer**. Some solutions are great and others are not—it’s difficult to figure out which to contract with.
- **There is a lack of patient-centered measures and assessments** that allow individuals to avoid having to tell the same story or taking the same screener multiple times. There may be opportunities to leverage predictive analytics to address this issue.

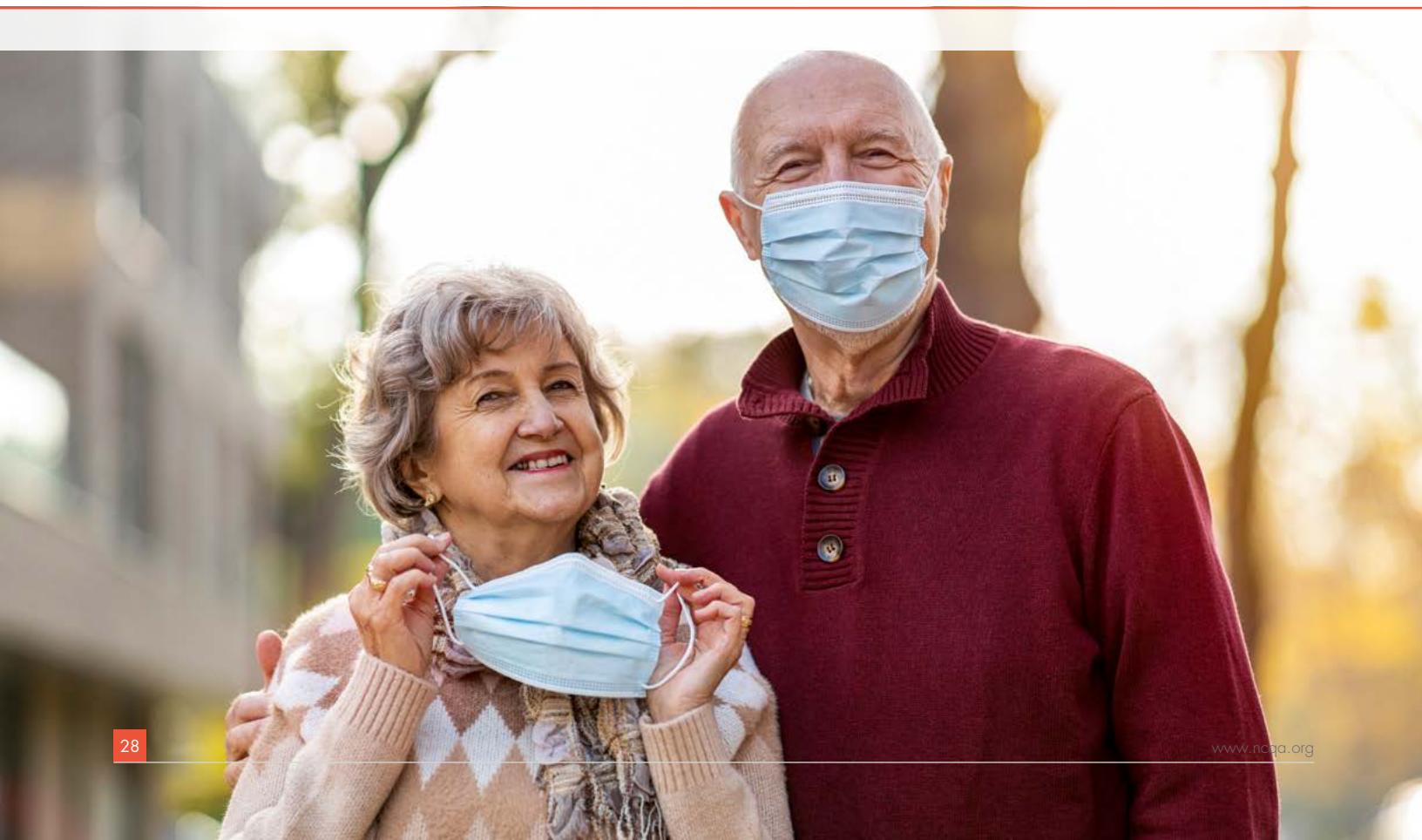
which benefit. It also perpetuates the traditional separation or “silos” of behavioral health patient data from physical health data, which interviewed PCMHs and MBHOs cited as major barriers to coordinating integrated care for their behavioral health patients. Last, although there are national parity laws (refer to Common Q&As), parity is not the same as integration—when behavioral health is separate, it is not equal.

Many Medicaid carve-out states adopting managed care models where a single entity is responsible for both behavioral and physical health services. [49] [50] For example, the Washington State Health Care Authority is on the way to providing 1.6 million Medicaid enrollees with both physical and behavioral health services—including primary care, pharmacy, mental health and substance use treatment. Incumbent behavioral health organizations will either cease operations or convert to a behavioral health administrative service organization (BH-ASO) in regions where integrated managed care is implemented. Medicaid MCOs will be required to subcontract with BH-ASOs under the contract. [51]

As stated in the previous section, state payers have an important role in promoting integrated and/or behavioral health focused initiatives and models of care. Forty-one states have at least one behavioral healthcare coordination initiative that includes PCMHs, health homes, ACOs, dual demonstration and certified community behavioral health clinic models. [52] These initiatives are conducted by payers and providers to help close the gap between physical and behavioral health needs.

Health plans can encourage and act as a conduit for integration between behavioral health and primary care practitioners by paying for and providing coordination of care, which can be plan-sponsored case management or a consultation service to help practices connect patients to behavioral health services. [53] They can also support integrated care by:

- Facilitating data sharing among themselves, their business partners and their network providers (Component 1).
- Providing care coordination services to members.
- Incentivizing adoption of integrated practices.
- Modifying payment policies to encourage coordination. [53]



➔ VALUE-BASED PAYMENT

Value-based payment (refer to Common Q&As) is being used to tackle several of the biggest structural challenges of integrated care by:

- Encouraging care coordination across payers and care delivery organizations.
- Addressing the role of traditionally low reimbursement in the current shortage of behavioral health professionals.
- Providing funding that incentivizes practices to integrate or encourages them to offer services that would not traditionally be reimbursed in an FFS arrangement.

Pay-for-performance is currently the most popular value-based payment model in the behavioral health space: 93% of health plans use a pay-for-performance component to behavioral health practitioner partner models. [52] These payment types incentivize integration and participation in the network because practitioners can qualify for bonuses based on performance.

Some Medicaid managed care states are at the forefront of emerging value-based payment arrangements to incentivize practitioner acceptance of Medicaid, engage community resources to overcome shortages and access barriers and encourage integration.



Arizona

Arizona's three regional behavioral health authorities operate through a specialty managed care arrangement to provide integrated behavioral and physical health services to Medicaid enrollees with serious and persistent mental illness. During the arrangement's first year, authorities qualified for bonuses by using HEDIS measures of reduction in inpatient and Emergency Department admissions and patient follow-up with a behavioral health practitioner within 7 days post-discharge. [54] One authority used measures related to SDOH to incentivize and track integration and whole-person care.



Tennessee

In 2016, TennCare, Tennessee's Medicaid authority, launched the Tennessee Health Link, which offers compensation beyond traditional FFS. Participants are care teams associated with a behavioral health setting to provide whole-person, coordinated behavioral and physical health care for an assigned panel of members. [54]



Pennsylvania

In 2016, Pennsylvania launched its Integrated Care Plan Pay-for-Performance (ICP P4P) Program to improve quality and reduce expenditures through care coordination across physical and behavioral health managed care organizations and practitioners for individuals with serious and persistent mental illness. [54] Organizations earn incentive payments based on annual compliance with three process improvements tied to five performance measures: member stratification, integrated care plan/member profile, hospitalization notification, coordination, payments. [55]

➡ PRACTITIONER SHORTAGES AND ACCESS

Entwined with the challenges of establishing, reimbursing and delivering integrated care is a multifaceted issue: the shortage of behavioral health professionals. About 50% of Americans live in a Health Professional Shortage Area where there are not enough behavioral health practitioners to meet patient demand and need. [56] The Substance Abuse and Mental Health Service Administration (SAMHSA) estimates that by 2026, the United States will have a shortage of 15,400 psychiatrists; 10,470 marriage and family therapists; 26,930 mental health counselors; 48,540 social workers; 57,490 psychologists; and 78,050 school counselors. [57] Increased demand is also affected by retirement: More than 60% of practicing psychiatrists are over 55. [58]

The biggest driver of the shortage is reimbursement—payment parity between behavioral health and physical health. On average, behavioral health practitioners are reimbursed 20% less than primary care practitioners and 16% less than physical health specialists. [59] Even in areas that do not have a shortage of mental health professionals, lower reimbursement can result in limited networks, reducing affordable access to care for individuals who cannot afford the out-of-pocket treatment.

Greater awareness of mental and behavioral health conditions has resulted in higher demand for services. Although reduced stigma and increased awareness are better for the overall health of the population, the growing demand can lead to long wait times for appointments or practitioners unable to accept new patients.

These challenges were echoed in the interviews conducted for this guide; organizations shared concerns about behavioral health professionals' availability, long wait times for appointments and lack of professionals, particularly in rural areas and for specialized disciplines such as pediatric psychiatry and medication assisted treatment (MAT).

Solving or mitigating shortage and access issues is a priority across the medical industry. As detailed in the previous section, states, health plans and MBHOs are leveraging payment arrangements to incentivize care delivery organizations to recruit and maintain behavioral health staff as they adopt integrated care models. Some care delivery organizations are directly addressing shortages through recruitment to residency programs; for example, the University of Nebraska Medical Center is focusing on high-quality psychiatry clinical rotations and mentorship, which includes psychiatric residents video-chatting with high school and college students about their careers. [58] Other organizations are extending their ability to offer behavioral health services by cultivating relationships with community partners and adopting digital health modalities.

COVID CONSIDERATIONS

Practices plan to keep some changes they implemented during the pandemic:

- **Telehealth and digital health are here to stay.** As adoption of digital health services accelerated during the first 6 months of the COVID-19 pandemic, practitioners and patients enjoyed having it as an option, particularly for behavioral health.
- **Keeping behavioral health staff off site.** For organizations with limited rotating behavioral health staff, video calls have been a beneficial and flexible way to provide same-day interventions. Social workers and care coordinators have found that they can see more patients when they work remotely because it eliminates the commute between the multiple practice locations they serve.
- **Offering hybrid access.** Post-pandemic, some organizations and practices envision a blend of telehealth and digital health services and traditional in-office services to accommodate individuals' preferences, which can vary depending on level of need or ability to access telehealth services.

IN-THE-FIELD EXAMPLE

Organization: Plateau Pediatrics, Crossville, TN

Cognitive Behavior Therapy Across the Cumberland Plateau

Problem: As of May 2020, services for cognitive behavior therapy were extremely limited in the region surrounding Plateau Pediatrics. There were little to no options in a near-100-mile radius from the practice.

Process: The practice chose the COPE (Creating Opportunities for Personal Empowerment) program to help alleviate this problem. Two of the practice's certified pediatric nurse practitioners completed the program and began seeing patients in July.

Results: The program provides actions that children can take to address their mental health difficulties and allows medications and/or other pertinent and much-needed mental health support to serve as an adjunct to care. Multiple patients have benefited from the service. One provider's patient saw near-immediate results in only three sessions. Because the program is in its infancy at Plateau Pediatrics, patient volumes will be continuously monitored and an update on the program's growth will be available in the future.

As of September 2020 the program had been in place for 3 months.

➡ OPPORTUNITIES TO ADDRESS STIGMA THROUGH INTEGRATION

In this guide's introduction, we highlighted stigma as a major barrier to behavioral healthcare access and treatment. In fact, overcoming apprehensions about seeking or accepting behavioral healthcare is often the first step in a patient's treatment—and can be the most difficult barrier to overcome.

Primary care practitioners are often the first point of contact for patients, making them the de facto mental health treatment system in the United States. [60] Component 1 outlined how organizations that provide integrated care can identify a variety of unmet psychosocial needs in patients who are not directly seeking these kinds of services. They are also positioned to leverage the primary care setting's position of trust to overcome patients' apprehension about accepting care and resources.

Integrated PCMHs interviewed described their primary care practitioners as "[giving] their patients permission to feel" and accept the behavioral healthcare they need. The primary care team plays an important role in normalizing the experience of behavioral health issues or unmet social needs and for creating the perception that screening for these issues is a routine part of care. By offering treatment in the same setting as primary care, patients are encouraged to perceive that behavioral health issues are like any other treatable chronic health condition. [61]

An integrated care setting can also significantly reduce the stigma for patients who are directly seeking behavioral healthcare. One interviewed PCMH, which integrates behavioral health through a partnership with a network of separately owned behavioral health clinics, reported that behavioral health appointments at the PCMH site had sometimes double the attendance of the dedicated behavioral health clinics. The PCMH attributed this to the lesser stigma of seeking care through a medical office vs. a behavioral health clinic, and has since made similar arrangements to integrate behavioral healthcare at additional primary care practices.

➡ USING A POPULATION HEALTH MANAGEMENT APPROACH FOR BEHAVIORAL HEALTH

An organization's PHM strategy begins with setting goals based on needs identified in its population assessment (Component 1) and using those goals and an understanding of the population to determine resources and interventions offered (Component 3), and ends with an assessment of its programs through measurement (Component 4). The process is cyclical: The organization uses what it learns from measuring its performance to reevaluate and adjust goals.

The PHM strategy articulates the organization's goals and the resources it needs to achieve them, how resources will be secured (e.g., through grants, relationships with payers, streamlined workflows that offset costs) and how care team members will collaborate to meet both the organization's goals and the population's needs. For organizations seeking better outcomes for an entire population—especially the subset of their population with behavioral health conditions—, coordinating or integrating physical and behavioral health care and management is an essential part of the PHM strategy.

Component 3 will describe strategies and special considerations necessary to deliver care through care-planning and targeted interventions.



➔ COMMON Q&AS

What Is an MBHO?

An MBHO, or managed behavioral healthcare organization, manages, administers and provides behavioral health benefits. Often, benefits are offered and managed through the MBHO on behalf of a health plan or other payer, such as an employer or state.

What Is Behavioral Health Parity?

In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) required private group plans to provide parity for mental health and substance use disorder benefits. [52] The Affordable Care Act (ACA) required parity for individual and small group plans. This is often referred to simply as “parity.” Parity requires that mental health and substance abuse benefits are not more restrictive than medical/surgical benefits. Restrictiveness is measured through financial requirements and quantitative and nonquantitative treatment limits.

Common Value-Based Payment Arrangements

The Centers for Medicare & Medicaid Services (CMS) defines these common value-based payment arrangements: [62]

- **Pay-for-performance.** Payment is for individual units of service and is triggered by delivery of care (as with FFS), but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related to performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared savings.** Payments are FFS, but providers/practitioners who keep medical costs below established expectations retain a portion (up to 100%) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the proportion of total savings.
- **Shared risk.** Payments are FFS, but providers/practitioners whose medical costs are above established expectations are liable for a portion (up to 100%) of cost overruns.
- **Two-sided risk sharing.** Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based payment.** Payments are not tied to delivery of services, but take the form of a fixed per member, per unit of time sum paid in advance for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/population-based payment amount and retains all (or most) savings if costs fall below that amount. Payments, penalties and awards depend on care quality.



Component 3: Planning and Delivering Targeted, Person-Centered Interventions

Targeted, person-centered interventions let individuals receive the right care at the right time, improving their experience and population health. After an organization has assessed and stratified (Component 1) its population, it can identify the most appropriate interventions and services for individuals. Behavioral health interventions might vary in intensity and might be offered in different modalities or settings that accommodate a specific diagnosis and situation, care goals and other needs (e.g., cultural, environmental, clinical). Delivering person-centered interventions to individuals with behavioral health conditions requires respect for their autonomy and an understanding of the conditions that influence, limit or exacerbate behavioral healthcare.

This component highlights areas where organizations may need to give special consideration to the roles of the community setting and digital health when identifying appropriate, person-centered interventions for individuals with behavioral health conditions, including:



**Individuals with
complex needs.**



**Populations with specific
cultural needs.**



**Individuals with
substance use disorders.**



Pediatric populations.

This component is not an exhaustive list of treatments, interventions or special populations. Rather, it represents the populations and interventions that were identified as important during NCQA's interviews with digital health organizations, integrated practices, state Medicaid agencies and health plans or MBHOs.

Note: This resource guide does not replace the PHM category of standards in NCQA Health Plan Accreditation, MBHO Accreditation, PHP Accreditation, PCMH-Behavioral Health Distinction or any other NCQA Accreditation, Certification or Recognition, or dictate additional requirements that must be met for an NCQA survey or integrated care.

➡ TARGETED INTERVENTIONS AND CARE PLANNING

Because many individuals have co-occurring medical, behavioral or social needs, interviewed organizations suggested a “no wrong door” approach to accessing behavioral health treatment. For example, individuals who participate in behavioral health programs or have received behavioral health interventions may be:

- Referred by the organization’s primary care and/or other practitioners, identified through assessments/ interviews during a visit/encounter or the intake process.
- Requested directly by individuals or practitioners in the community.
- Sent from community ERs and hospitals.
- Referred from the criminal justice and court system.

Regardless of how care is accessed, achieving positive outcomes depends on the organization’s ability to deliver care that is person-centered and tailored to specific needs. Interviewed organizations ensure that interventions are person-centered by seeking to understand the individual’s goals, definition of success and what motivates them (e.g., someone they care about, something they want to accomplish, something they want to continue doing), and creating a care plan in their own words.

Motivational interviewing is an empathetic, evidence-based technique for interacting with individuals with the intent to elicit and strengthen their reasons for and commitment to changing unhealthy behaviors. [63] Some interviewed practices said that asking motivational interviewing questions such as, “What kind of improvement do you want to see?” or “What was it like the last time you were really happy?” helps individuals articulate goals and guides creation of the care plan.

Delivering person-centered interventions and helping individuals meet their care goals may require involvement of multiple practitioners or disciplines. Having an integrated care team enhances an organization’s ability to do this, especially if medical records and care plans are accessible to all care team members through a single EHR.

Several interviewed FQHCs and PCMHs with co-located or embedded behavioral health specialists had the ability to provide same-day consultations, brief interventions and/or warm hand-offs to behavioral health staff when needs were assessed during primary care visits. The ability to offer real-time interventions or an introduction to the appropriate specialist is especially important for individuals with behavioral health conditions because:

- There is a risk that individuals will skip an appointment with a behavioral health specialist that is set at a later date. Research suggests that reducing initial wait times for behavioral health appointments is an effective strategy to reduce no-show rates in the outpatient setting. [64]
- Individuals with the most acute behavioral health issues sometimes lack basic phone or internet access, making contact and intervention difficult once they leave the site of care.
- The primary care setting occupies a position of trust. Introduction to a behavioral health specialist by the primary care provider conveys to the individual that the specialist is a trusted care team member. [65]

COVID CONSIDERATIONS

Impact on Individuals: COVID-19 has exacerbated physical, behavioral and social health problems. Interviewed organizations described the impact to their patients in the first 6 months of the pandemic:

- **More individuals seek behavioral health services.** Practices and digital health organizations saw an increase in the number of individuals seeking behavioral health care during the first 6 months of the pandemic.
- **More severe behavioral health conditions.** Not only were more individuals seeking care, the severity of their conditions increased. One digital health organization saw a 30% drop in participants' PHQ-8 score between March and July 2020. Individuals with chronic behavioral health conditions lost their support networks—friends, family, employment—and their stability.
- **Unknown future and missed milestones.** Disasters—natural or man-made—have always had short- and long-term negative effects on a population's health. The long-term effects of the pandemic are unknown, particularly for children who missed classroom education, socialization with peers and important milestones like graduation.
- **Delays in routine and chronic care.** Suspension of in-person services disrupted appointments and prescription refills for individuals with chronic conditions. Missed appointments are also missed opportunities to perform psychosocial assessments.
- **Disparities in access to remote care for high-risk and vulnerable populations.** Individuals may not have a reliable internet connection, especially if multiple family members must use it for school or work; may not have devices that support digital health services; may not have access to a telephone or a reliable phone number; may not be comfortable using digital health; may have a behavioral health condition that limits self-motivation and accountability, making it difficult to engage with digital health services; or may have a physical disability that makes them unable to use such services.

➞ INDIVIDUALS WITH COMPLEX NEEDS

Individuals with complex needs are at the highest end of the risk spectrum. They require interventions that are typically more intensive than in other risk categories and account for a large—often disproportionate—percentage of health care expenditures. The complex case management model is designed for their care. Serious and persistent mental illness and/or behavioral health conditions often co-occur with severe clinical, functional or social needs. The complex case management model is designed for these individuals' care.

The care management model for this population should emphasize engaging individuals to assess care needs, developing person-centered care plans and coordinating with other entities to close care gaps. In many cases, a member with complex needs is seen by multiple practitioners; an integrated medical home can help coordinate care.

According to results from the Medicare Coordinated Care Demonstration projects, these components of a complex case management model are most effective in reducing hospitalizations and costs:

- In-person contact.
- Access to timely information.
- Coordination between care coordinators and primary care practitioners.
- Care transition coordination and follow-up.
- Self-management support and education.
- Social supports.

Once individuals are identified for complex case management, a case manager conducts a comprehensive health assessment and then collaborates with the individual (or caregiver) on a care plan that addresses their clinical, behavioral and social needs. The case manager continually reassesses the individual's condition and updates the care plan as needed.

IN-THE-FIELD EXAMPLE

Organization: Hunter Health, Wichita, KS

Problem: Individuals were coming to Hunter Health Clinic, an FQHC, for physical medical care and identification of complex behavioral health and social needs.

Solution: Individuals who screen positive on the PHQ-9, GAD-7, CAGE-adjusted (substance use) or PRAPARE are seen the same day by an integrated care consultant (ICC), a licensed social worker who can evaluate, diagnose and create a plan of care specific to an individual's needs and requests. Hunter Health staffs teams with one ICC to every two medical practitioners to ensure access to a behavioral health specialist who can help with patient concerns.

To respond to the opioid crisis, Hunter Health ensured that masters-level social workers are trained to earn licenses in addiction. Six of its seven ICCs are licensed addiction counselors.

As a result of an increase in individuals with uncontrolled diabetes, Hunter Health added uncontrolled diabetes to its list of patients who screen for ICC use. This allows ICCs to create goal plans to ensure that individuals can learn how best to manage their diabetes care.

IN-THE-FIELD EXAMPLE

Organization: Ontrak, Inc., Santa Monica, CA

Problem: A small behavioral health population with multiple comorbid conditions was proving difficult for care managers to identify and engage for a regional, provider-sponsored health plan. The plan's traditional behavioral health solutions to address depression, anxiety and substance use disorder were not working to improve outcomes or reduce costs.

Process: To better address this complex population and improve outcomes, the health plan selected Ontrak's solution to identify members with unaddressed behavioral health needs, establish trust to improve engagement and help remove barriers to care and connect them to specialty behavioral healthcare providers.

1. Identify: Ontrak's predictive analytics, even absent a previous behavioral health diagnosis, identified approximately 3% of all Medicare and commercial members as having behavioral health conditions, representing \$158M in total annual paid claims (\$28K average PMPY, six times more costly than the rest of the population).
2. Engage: Ontrak's enrollment specialists, care coaches and community coordinators drove new program enrollment and persistent engagement—in person, via telehealth and virtually—with a whole-person approach that addressed barriers to care.
3. Guide: Members participated in up to 52 weeks of a coach-driven behavioral change program tailored to address individual health goals and inclusive of visits with therapists, psychiatrists and addiction specialists.

Outcomes:

- 41% PMPM cost savings.
- 2.5 times the return on investment.
- 26% (over a 2-year period) average program enrollment rate.
- 54% retention rate with 213 (7+ months) average days enrolled in the program.
- 43% program graduation rate.
- 43% reduction in ED use.
- 68% reduction in inpatient admissions.
- Member net promoter score of 75.

➞ POPULATIONS WITH SPECIFIC CULTURAL NEEDS

For some populations, cultural considerations must play a role in behavioral health treatment plans; therefore, it's important to communicate with and relate to individuals in a culturally and linguistically appropriate way. Interviewed PCMHs embrace cultural needs by employing staff resembling their populations' ethnic and cultural makeup and ensuring that all staff receive appropriate cultural competency training.

One interviewed Urban Indian Health Center, a type of designated FQHC that provides comprehensive primary care and related services to the American Indian and Alaska Native populations, employs a cultural advisor to incorporate cultural aspects into care options and programming and bridge the gap between practitioners, the population and the community.

IN-THE-FIELD EXAMPLE

Organization: Penn Center for Community Health Workers, Philadelphia, PA

Solution: A multidisciplinary team at the University of Pennsylvania's Center for Community Health Workers developed IMPaCT, a standardized community health worker program that addresses social determinants of health. Community health workers provide a broad range of services—advocacy, social support, navigation, health coaching—to improve health outcomes.

IMPaCT was developed by conducting in-depth interviews with more than 1,500 individuals, using open-ended questions such as What makes it hard for you to stay healthy? What should health care organizations be doing to help? The planning team also analyzed community health worker programs in the United States and abroad to develop hiring and selection strategies, supervision practices and performance management tools.

Results: IMPaCT has been tested in three randomized controlled trials [139] [140] [141] that demonstrated:

- Improvement in self-rated mental health.
- Improved control of chronic conditions.
- Improved access to preventive care.
- Higher patient-reported quality of inpatient and outpatient care.
- 65% reduction in hospital days.

An economic analysis of these outcomes found that every dollar invested in IMPaCT returns \$2.47 to an average Medicaid payer within the fiscal year. [142]

In the last five years, the Center has served over 12,000 individuals in the Philadelphia region. IMPaCT community health workers have mentored clinicians and other health care leaders on cultural humility and the impact of SDOH. The model has also been adopted by regional health systems, multi-state payers, public health departments and community health centers, making it the most widely disseminated community health worker program in the country.



➡ SUBSTANCE USE DISORDERS

Targeted, person-centered interventions are crucial for individuals experiencing a substance use disorder. These individuals often have a complex set of co-occurring medical and/or mental health diagnoses or social needs that compound their disorder and sometimes even arise as a result of it. Interventions designed to address substance use disorders must simultaneously address these interconnected, compounding needs. [66]

There is no “perfect” treatment that works for every individual, although interviewed FQHCs that offer substance use disorder treatment highlighted person-centeredness, close connection and support (including peer support) as part of a successful recovery.

This guide’s introduction highlighted the national epidemic of opioid use disorder, a pervasive aspect of substance use disorder, as a major and influential driver in the behavioral healthcare landscape. The opioid epidemic has resulted in new funding opportunities, care models and treatments for individuals with substance use disorders. For example, medication assisted treatment (MAT), combines medication with counseling and other behavioral therapies to holistically treat substance use disorder and other coexisting health conditions. [67]

Federal and state leadership, funding and legislation also play an integral role in addressing substance use disorders, including opioid use disorder. Legislation such as the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities, or SUPPORT for Patients and Communities Act of 2018 (“SUPPORT Act”), improved access to MAT by increasing flexibility for its delivery and expanding the types of allowable office-based prescribers to include nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists and certified nurse-midwives. [68] With Medicaid as the largest payer for substance use disorder treatment and recovery services—covering nearly 40% of all individuals with an opioid use disorder nationwide—state Medicaid program policies and payments determine many Americans’ access to and organizations’ delivery of substance use treatments. [69]

A well-resourced PHM strategy can improve the reach of substance abuse treatment. A comprehensive population assessment can reveal substance abuse issues or risk factors for substance abuse. Integrating physical and behavioral healthcare can help address health disparities and help treat comorbidities with substance use disorder. [70]

IN-THE-FIELD EXAMPLE

Organization: Magellan Healthcare, Inc.

Problem: Engaging with and improving the quality of life for members with behavioral health conditions who suffer with a co-occurring chronic pain diagnosis.

Solution: The Magellan Healthcare Chronic Pain Management program is a member-facing care management program that provides support and resources to members who deal with chronic pain, including those who may be at risk for opioid overuse and/or have co-occurring behavioral health disorders.

The goal of the program is to improve members' function as it relates to their chronic pain experience.

Process: Magellan Healthcare implemented this program for a large health plan in order to improve member outcomes by:

- Providing personalized coaching and motivational interviewing, enhanced by virtual coaching models, administered by registered nurses and licensed social workers.
- Implementing individualized care plans with key interventions, developed in coordination with member buy-in.
- Evaluating member needs on an ongoing basis and responding with a multi-modal pain management approach delivered by a multidisciplinary team of professionals, including those with substance abuse treatment backgrounds.
- Providing coaching, referrals, care coordination and recommendations for pain management, coping with cravings, finding support in group intervention(s) or through recovery activities, and couples and/or family therapy to enhance social supports and actively engaging in motivational interviewing techniques for self-empowerment strategies.
- When necessary, conducting pharmacy and medical interventions collaboratively with the member and provider, who can both consult with a clinical pharmacist to discuss medication concerns, questions or side effects.
- Performing a comprehensive medication review with a pharmacist to identify issues such as polypharmacy, multiple prescribers, medication adherence, duplications of therapy and inappropriate use of opioids.
- Providing personalized coaching plans of care that emphasize social determinants of health and self-management plans and focus on interventions developed in coordination with the member.
- Monitoring each member's risk score, pain severity and comorbidities to drive the frequency, level of contact and follow-up (average program duration is 2–4 months).

Results: 86% of enrolled members reported satisfaction with the care and interventions they received and would recommend the program to others. Other results included:

- 78% of members who completed initial and discharge Pain, Enjoyment, General Activity Scale (PEG) assessments reported improvement in their pain.
- 78% of high-risk members reported improvement in their day-to-day functioning.
- 36% of members had a reduced morphine milligram equivalent 90 days post-program discharge.



➡ PEDIATRIC POPULATIONS

Children can experience a variety of behavioral health conditions, including anxiety disorders, ADHD, autism spectrum disorder, eating disorders, depression, other mood disorders, PTSD and schizophrenia. [71] Although these conditions are prevalent in adult populations, they can be more difficult to diagnose and treat in children.

Interviewed organizations cited challenges and mitigation strategies with pediatric behavioral health; for example:

- There is less focus on behavioral health conditions in children than in adults.
 - Organizations can host monthly weekend workshops with children and caregivers to build relationships and offer tools to manage specific conditions. Because workshops can cover a greater number of individuals at once, they are an efficient use of resources.
- Children may wait months to see a practitioner if there are shortages of pediatric behavioral health practitioners in a practice or in the community or if their access to services is limited to weekends due to school.
 - Digital behavioral health services can enhance flexibility for appointment times.
 - NCQA-Recognized PCMHs are required to have after-hour appointments, increasing appointment availability.
 - Organizations can explore using licensed counselors, social workers, nurses or other practitioners to provide therapeutic treatments.
 - Organizations can organize and facilitate group therapy sessions that include caregivers.
- Because there are few precise pediatric assessment or diagnostic tools, it can take multiple visits and interviews to determine a diagnosis and appropriate treatment protocols. Often, primary care practitioners do not have time to explore the full range of physical, behavioral and social needs during a well-child visit, so assessment tools that can identify areas for later investigation are important (refer to Component 2 for information about assessment tools).
 - Practitioners can work with schools and caregivers to share relevant information, such as life events that may prompt behavioral changes.
- When children are affected by SDOH, support for the whole family is often required. This can be difficult to arrange with limited resources.
 - Organizations can employ or build relationships with social workers who are knowledgeable about community resources, child protection agencies and other wraparound services, and can help coordinate services to address social risks.

➡ THE ROLE OF THE COMMUNITY SETTING

Not all interventions take place in a clinical setting. Interviewed FQHCs and integrated PCMHs use the resources and services at their disposal to intervene on SDOH and social risks identified during individual assessments. Some fully integrated FQHCs offer a limited suite of onsite social services (e.g., food pantries, government assistance or financial counseling, employment workshops); others rely entirely on partnerships or relationships with community-based organizations and agencies to connect their populations to outside resources (e.g., domestic violence and homeless shelters, detox centers, crisis services, financial or legal assistance). These typically have embedded care team members such as social workers (clinical or nonclinical), care navigators or care coordinators whose role is to coordinate and connect individuals to services in the community.

Some interviewed FQHCs and integrated PCMHs provide case management and social interventions to their population in the broader community and home setting using the Individualized Management for Patient-Centered Targets (IMPACT) model, [72] which integrates community health workers into the care team. Community health workers are trusted, nonclinical individuals who come from the communities they serve and provide a broad range of services (e.g., advocacy, social support, navigation, health coaching) to improve health outcomes. [73] They act as culturally appropriate bridges between the community and the clinical setting, increasing individuals' health literacy and reducing stigma and barriers to care. [74]

The community can also be a useful setting to deliver behavioral health interventions—similar to delivery of social interventions—and enhance access for individuals who have not, or cannot, engage directly with the health care delivery system. Partnerships between the health care delivery system and stakeholders in the broader community (e.g., employers, institutions, state and local governments, community-based organizations, churches) make it possible for behavioral health screenings, services and/or programs to be embedded in settings where individuals spend the most time (e.g., workplaces, schools, community centers, the criminal justice system). [74] Interventions delivered in these settings may be preventive or acute; for example:

- Prevention programs that focus on early interventions for behavioral health risks in youths, such as alcohol or other substance use, domestic violence, depression or suicide. [74]
- Preventive school-based counseling or cognitive behavioral therapy programs, led by trained school staff, that teach emotional regulation, anxiety management and problem solving. [74]
- Membership-based, nonclinical rehabilitation organizations, such as Clubhouse International, that support individuals with mental illness and connect them to physical and behavioral healthcare, as well as to social resources. [75]
- National and local behavioral health crisis and peer-support hotlines that connect individuals to local crisis specialists and services (e.g., National Suicide Prevention Lifeline, National Alliance on Mental Illness HelpLine). [76] [77]
- Local crisis stabilization centers, which are temporary settings designed to de-escalate behavioral health crises and acute symptoms of mental illness and provide a safe environment for individuals to seek assessment, short-term care and recovery. [78]

The community setting is an important part of the framework for delivering behavioral healthcare through population health management for many reasons; chief among them is the bidirectional and complex relationship between behavioral health and socioeconomic constraints. As stated earlier, Americans with the most acute behavioral health issues are often among the lowest-income and most vulnerable populations and are disproportionately affected by SDOH. Providing whole-person care can require collaboration between multiple stakeholders; each provides part of the funding, services, leadership or expertise needed to sustain effective programs and resources. It is sometimes necessary to deliver behavioral health interventions in settings most comfortable, trusted and accessible to individuals constrained by social and environmental barriers (e.g., stigma, transportation issues, structural racism, housing insecurity), extending the approach of “no wrong door” to access care beyond the walls of health care institutions and the reach of traditional care providers.

➡ THE ROLE OF DIGITAL HEALTH

Digital health, which includes telephone or video therapy, mobile apps, digital therapeutics and other forms of telehealth, is an emerging modality, particularly for behavioral health. Interviewed digital health organizations recognized the increase in adoption of their services specifically due to the COVID-19 pandemic (refer to COVID Considerations). Digital health use was much more prevalent for in behavioral healthcare than in physical care even before the pandemic; in 2017, psychiatry made up 21% of telehealth use, compared to 13% for general practice. [79]

Digital behavioral healthcare comes in a variety of forms:

- **Psychiatry or other talk therapy counseling via mobile app, video or telephone.** Individuals are matched to the type of care that fits their needs and schedule, such as coaching, medication management, group therapy or individual therapy. Organizations sometimes offer companion services as well, such as those listed in the bullets below.
- **Extension services.** Primary care or behavioral healthcare practitioners “prescribe” use of a mobile app or program that helps manage a specific condition, such as anxiety or depression. These services often do not include therapy; they offer tools for self-management, such as journaling tools with artificial intelligence-enabled prompts or sleep management strategies. They can help practitioners monitor patients between visits—not replacing face-to-face care, but augmenting it.
- **Digital therapeutics.** Mobile apps prescribed to help treat a behavioral health condition. Digital therapeutics have FDA-approved, evidence-based treatment programs.
- **Symptom management or health promotion.** Mobile apps that help manage symptoms of behavioral health conditions or fill a prevention and maintenance role for individuals experiencing anxiety, stress, burnout, subclinical depression or sleep disturbances. These apps can often be downloaded by individuals and do not require a prescription or direction from a practitioner.

IN-THE-FIELD EXAMPLE

Organization: Charles Henderson Child Health Center, Troy, AL

Charles Henderson Child Health Center approaches pediatric behavioral healthcare management by integrating patients’ mental and physical health care needs with internal and external programs and services.

Problem: Meet mental health needs of children from birth to 6 years of age.

Solution: In 2019 Charles Henderson Child Health Center became one of three nationwide pilot sites for the Center for Youth Wellness for screening and addressing Adverse Childhood Experiences (ACE). Through screening of parents and 2–6-year-old patients at high risk for poor mental health, education and physical health outcomes can be identified before difficulties appear, and services can be offered to improve outcomes.

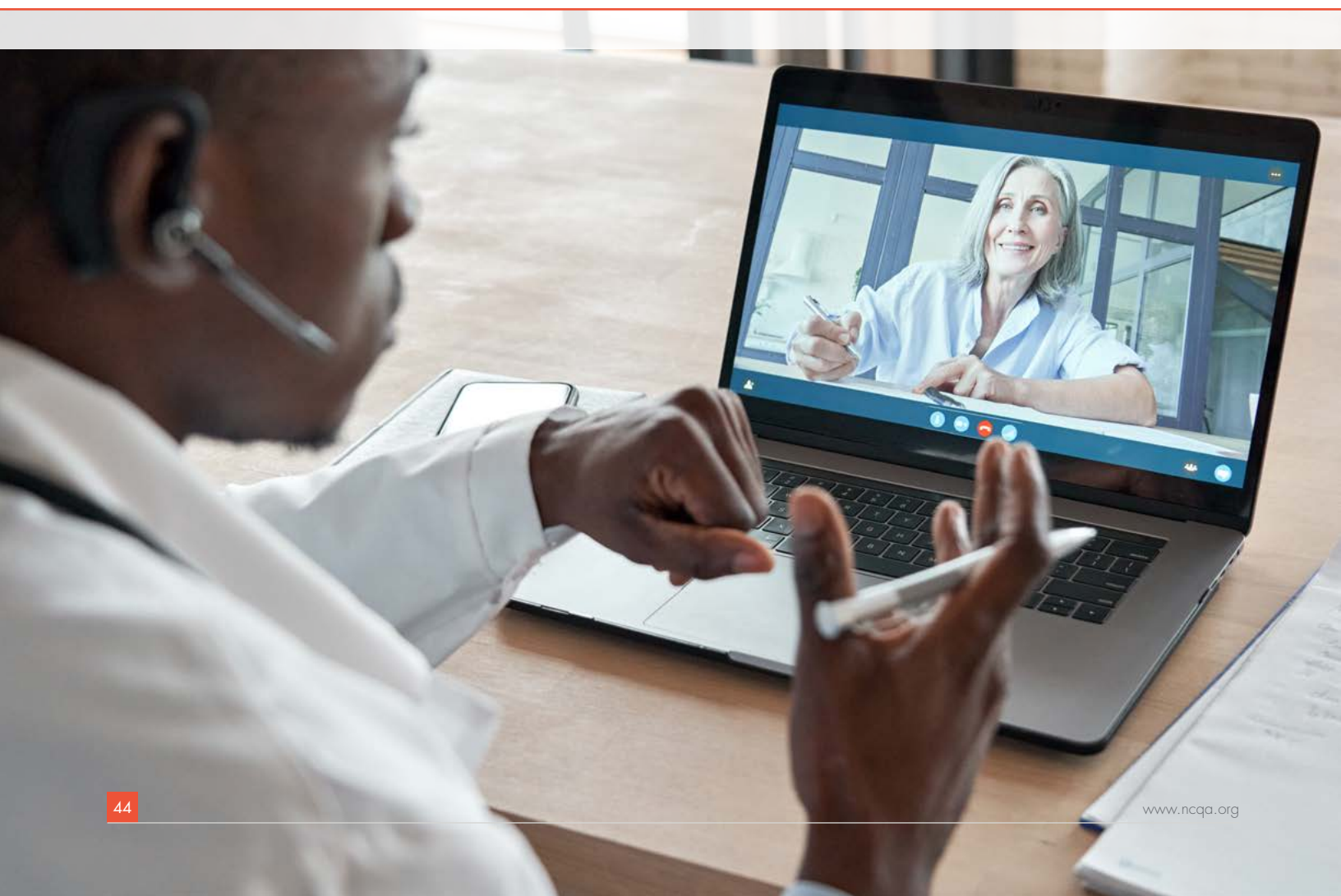
The ACE project clarified the need for more services to address the mental health needs of the birth–5 age group. Charles Henderson Child Health Center joined with its co-located mental health program to support education programs between agencies and bring knowledge and services to this age group and their parents. In fall 2020 it began the HealthySteps program, adding a team member whose dedicated role is to support and educate parents and children during the first 5 years of life. The specialist sees patients and families at 3 days old and during check-ups, as needed, and offers a support line to answer questions.

Results: Identifying and providing interventions to support the well-being of caregiver and child works to break the cycle of poverty, violence and child maltreatment while promoting child development and positive physical and mental health outcomes. The HealthySteps programs ensures that children and families have enhanced social, emotional, learning and mental health interactions and that their needs are addressed from the earliest age.

Interviewed organizations that fall in the last three modalities emphasized that their services should be used concurrently with practitioner care. Some organizations partner with delivery system organizations and practices to integrate their solution into clinical settings. Social workers, psychiatrists, pharmacists and other practitioners can prescribe or refer individuals to an integrated digital tool as part of their digital formulary. Information from the digital tool can be used as part of care. Practitioners can also track outcomes via assessment tools administered via a mobile app.

Although digital health can increase access and help individuals overcome stigma (self-management apps allow anonymity), challenges include:

- **Payment.** Payment for digital health comes in a variety of forms. Many telehealth services, such as video visits, are paid through traditional claims. Other programs or services derive revenue from fees paid through practitioners in quality or risk-based programs, mobile app services purchased by employers for their employees or out-of-pocket payment by the individual.
- **Appropriateness.** Not all screening, treatment and services are ideal for a remote setting.
- **Complex population.** Although digital tools can complement care, they may not be appropriate for complex individuals or those with serious and persistent mental illness, who might require personal contact.
- **Access to technology.** Providing digital health services is getting easier, but some individuals—such as those without smart phones for app-based programs or an internet connection—have difficulty accessing services.
- **Data sharing.** Data sharing depends on payer or contract preference and may be limited (particularly for sharing information about physical health) for digital tools that are not integrated.



IN-THE-FIELD EXAMPLE

Organization: Community Care Behavioral Health Organization (Community Care), Pittsburgh, PA

Problem: Gaps in the quality of behavioral healthcare for rural youth and families.

Response: Community Care, in collaboration with its partners in the community and behavioral health workforce, developed the Core 4 Clinical Model to increase access to and quality of services for rural members.

The model comprises four core competencies, presenting practitioners with a practical, structured approach to clinical work with children and families:

1. **Therapeutic alliance:** Focuses on relationship building between client and therapist, facilitating a healthy partnership and strengthening key clinician skills, including empathy, goal consensus and collaboration. Each subsequent component of the Core 4 supports the therapeutic alliance.
2. **Clinical formulation:** Evolves with new information to identify strengths, difficulties, patterns and family and social history.
3. **Offering:** Treatment plans are offered and adjusted on an ongoing basis, with family and stakeholder input, ensuring that caregivers have input into provision and monitoring of services.
4. **Feedback-informed implementation:** Open dialogue around treatment engagement, interventions and the clinician's understanding of the family's experience and perspective.

The Core 4 Clinical Model uses data on an ongoing basis to inform and refine treatment plans, making the treatment planning process more fluid, responsive and timely.

Results: The Core 4 Clinical Model has been delivered in 22 Pennsylvania counties through participating school districts. 82% of these counties have a shortage of mental health professionals. Caregivers report statistically significant improvement on the COS for family functioning, child functioning and therapeutic alliance.

Parent and teacher ratings of youth difficulties also demonstrate significant improvement. The most improvement was found early in treatment (from baseline to 18 months). The average rating of satisfaction by school administrators was high (8.22 on a 10-point scale).

The Core 4 Clinical Model has gradually expanded to 71 teams, 17 community behavioral health organizations, 52 school districts and 133 school buildings across 22 counties, and to other levels of care such as Behavioral Health Rehabilitation Services, family-focused treatment and residential rehabilitation.

VIEWS FROM THE TOP



Payers explained changes they are advocating to increase behavioral health access:

- Allow **"home" to be an originating site of care** for claims, to increase access and reimbursement for telehealth services.
- Allow practitioners who prescribe controlled substances to do it **without requiring an in-person visit first**.
- **Streamline registration requirements** for practitioners who facilitate MAT so they don't need a separate registration with the DEA.
- **Update privacy authorizations** to fit better with new care models, including telehealth services, and use community mental health resources.
- **Create new claim codes** to make it easier to pay for digital health solutions.
- **Pay for community-based care models**, such as peer coaches, and advocate for Medicare to pay for these models.

➞ USING A POPULATION HEALTH MANAGEMENT APPROACH FOR BEHAVIORAL HEALTH

Targeted, person-centered interventions are the heart of population health—all other aspects support these interventions and the relationship with the organization's population. One practice or organization cannot solve every behavioral health condition or intervene in every condition. It takes coordination, different methods or treatments and meeting people “where they are.” Population health management can help practices and organizations by providing the care model for understanding populations and individuals and aligning strategies. To determine if this approach is working, organizations must measure the impact, as described in the next component.

➞ COMMON Q&AS

What Is a Care Transition?

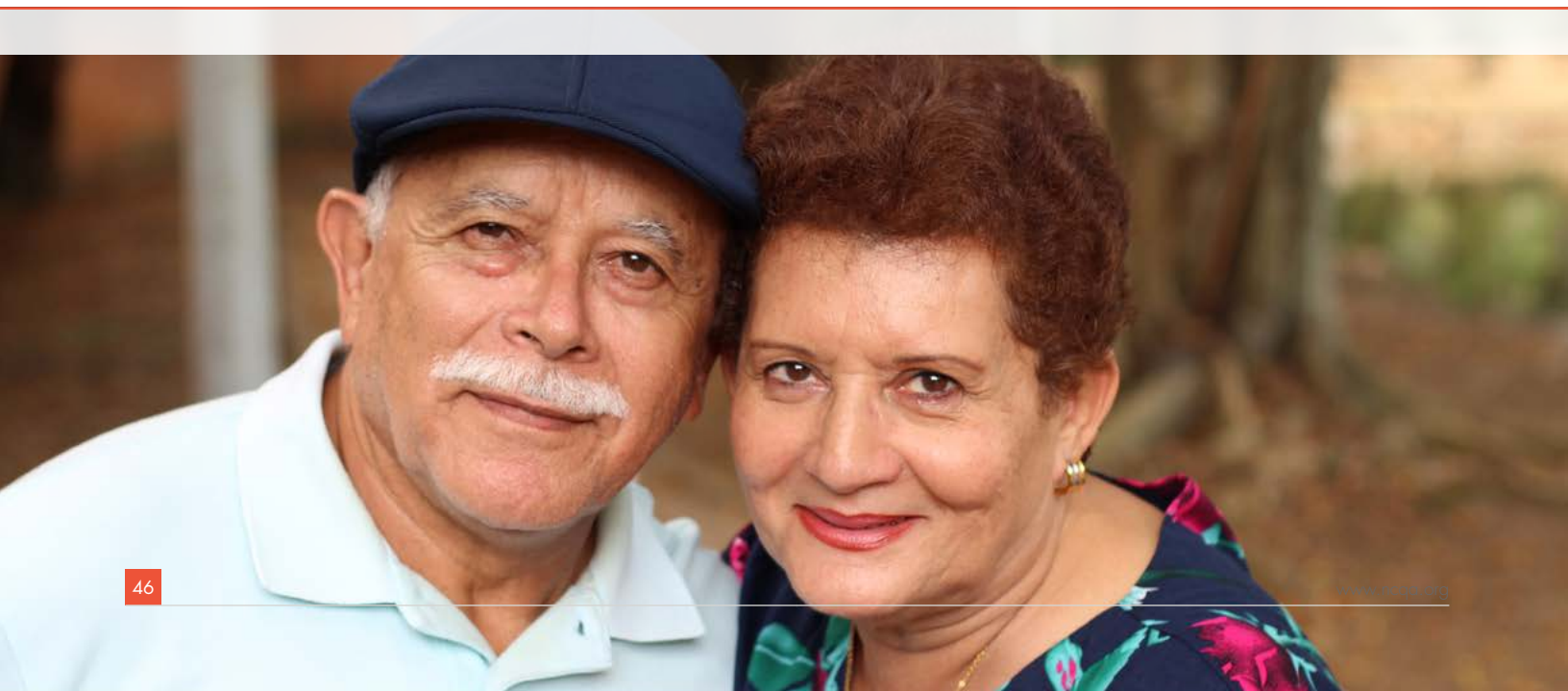
The movement of members between care settings (e.g., from hospital to rehabilitation facility after surgery) as condition or care needs change over the course of a chronic or acute illness. Some transitions are planned, such as for elective surgery, and some are unplanned, such as a sudden hospitalization. Individuals can be particularly vulnerable to fragmented or poorly coordinated care during care transitions.

What Are ACEs?

Adverse childhood experiences—potentially traumatic events that occur from 0–17 years of age, such as violence, abuse, neglect, witnessing violence in the home or community, an aspect of the child's environment that undermines safety, stability and bonding such as substance misuse, behavioral health problems of a guardian or parental separation due to incarceration or another reason. [80] ACEs are linked to behavioral and physical health problems, including substance misuse in adulthood, and can impact education and job opportunities. [80] They can be prevented through better economic support to families, promotion of social norms that protect against violence and adversity, teaching appropriate skills and intervening to lessen harms. [80]

What Is Health Equity?

As defined by the Robert Wood Johnson Foundation, “Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.” [81]



IN-THE-FIELD EXAMPLE

Organization: Pear Therapeutics, Inc.

Case Study: reSET-O™: The Inner Champion (Ashland Integrative Medicine, Ashland, KY)

Problem: Unemployment and poverty fuel drug addiction in a state already hit hard by the opioid epidemic. In 2017, Boyd County, where Ashland is located, had the third-highest rate of overdose deaths in Kentucky.

Response: To combat the opioid epidemic, in early 2019 Ashland Integrative Medicine's physicians began prescribing reSET-O® to help its patients with opioid use disorder, most of whom are on Medicaid, and offered assistance of a peer support specialist who was a person in recovery and championed reSET-O at Ashland.

Product Use Results: As of February 2021, Ashland clinicians had prescribed reSET-O to 394 patients.

- 93% of patients are managed on the Pear.MD Clinician Dashboard.
- 93% of patients use the app during non-clinic hours (one or more interactions with the app).
- On average, patients completed 33 modules and spent 456 minutes using the therapeutic.
- 74% of active patients completed the recommended four lessons across the 12-week prescription.
- 53% of patients completed all 31 core lessons throughout the 12-week prescription.

Outcomes:

- Retention in treatment rate of 85.7% (patients still using the therapeutic) during the last 4 weeks of the recommended 12-week prescription.
- Responder rate ($\geq 80\%$ for urine drug screens or self-report negative) = 66.3%.

VIEWS FROM THE TOP

New care pathways such as digital health, particularly through asynchronous mobile applications, are finding ways to fit into the care delivery system. Digital health leaders described how.



- **"Care is human."** Digital health solutions cannot completely replace personal treatment and should be used as a complement or wrap-around service to other therapeutic interventions. The best engagement occurs when a practitioner helps an individual understand where the solution fits into their care journey.
- **Integration.** Digital health solutions can be integrated into workflows for everyday use by practices, managed care organizations and payers.
- **How much digital is too much?** There must be more collaboration among stakeholders and developers to help the industry understand the right balance and appropriate amount of "face-to-face" and digital health use. Many individuals use digital health tools after hours and on weekends when they cannot get in-office appointments or in-person care.
- **Increased choice.** Most individuals have strong preferences about the modality of care; more user-centric options and choice means reaching more people.
- **Digital health tools can be used as prevention, something that has often been overlooked in behavioral healthcare.**
 - Leveraging consumer-facing digital health solutions is a way to intervene upstream and create health routines that inspire people to look after their mental health on their own terms.
 - People are already trying to cope and manage their mental health; giving them the tools to do that can prevent worsening conditions.

COVID CONSIDERATIONS

Innovative solutions increased access to remote care: Although there are many challenges to managing behavioral health conditions during a pandemic, organizations were able to find innovative solutions to improve remote care.

- **Free or discounted digital health services.** Some digital behavioral health organizations offered their self-management mobile apps for free or at a discount for specific populations such as health care workers or teachers. These tools helped individuals manage their symptoms and reduce stress related to the impact of the pandemic.
- **New workflows and protocols.** Practices quickly implemented new workflows and protocols for “digital handoffs” to maintain connections to behavioral health practitioners; for example, by video-conferencing a practitioner into an appointment or helping individuals download and troubleshoot mobile apps in the office.
- **Meet people where they are.** Behavioral health practitioners leveraged appointment times to discuss other issues (e.g., struggling with rent or food due to loss of employment) that must be addressed before treatment can take place.
- **Digital townhalls.** One practice held weekly digital townhalls through social media to answer questions about the pandemic, offer behavioral health management advice and provide a forum for the community to connect.
- **Digital health portals in the practice.** Some practices created digital or telehealth spaces in treatment rooms or other areas where individuals could access tablets or computers to video conference with behavioral health practitioners. These portals improved access to services for individuals who lacked appropriate technology or internet connectivity and prevented the spread of COVID-19 by limiting in-person contact.
- **Proactive outreach.** Some practices proactively contacted at-risk individuals or those with chronic conditions to find out what they needed to manage their condition while in-person services were suspended.

IN-THE-FIELD EXAMPLE

Organization: North Carolina Department of Health and Human Services & McLeod Addictive Disease Center

Problem: There are over 80 Opioid Treatment Programs (OTP) in North Carolina. Before the COVID-19 pandemic, reimbursement only supported in-person services. When statewide stay-at-home orders were implemented, traditional service delivery was no longer tenable. McLeod Addictive Disease Center, a Charlotte-based non-profit behavioral health service provider serving 2,700 OTP patients across 8 locations, is a clear example of how COVID-19 prompted policy flexibilities enacted by Federal and State Opioid Treatment Authorities enabled providers to maintain vital behavioral health services.

Process/Solution: Recognizing that the regulatory requirements for in-person service delivery were not consistent with public health guidance, SAMHSA and the North Carolina Department of Health and Human Services allowed provision of services via telehealth/telephone, and relaxed restrictions on take-home medication. At the same time, NC Medicaid and state-funded services temporarily added coverage to pay for these services. These changes enabled providers to implement widespread teleworking. In March, 77% of McLeod’s employees began working from home. This resulted in a revised intake process with 50% of the assessment process provided via telehealth. Changes were coupled with a shift from a walk-in system to scheduled appointments.

Results: New flexibility in service delivery allowed billable telehealth visits, resulting in minimal disruptions to care. McLeod increased telehealth/telephone visits from none in January to 35% telehealth and 21% telephone visits in July. The number of OTP patients increased from 2,693 in May to 2,701 in July.

Telehealth removes barriers to treatment and enables a flexible work arrangement for staff, making it easier to recruit staff for positions and locations that were traditionally difficult to fill.

Decreases in no-show rates are striking: Of 2,701 individuals, only 35 did not show for their scheduled July appointment. Normalization of treatment, relaxing long-standing regulations and allowing individuals to choose how to engage in services have positively affected their experience. Removing inequity in Medicaid coverage for medication and allowing billable telehealth services allowed McLeod to remain financially viable.



Component 4: Measurement and Impact

The best way for an organization to evaluate the impact of its PHM strategy is to measure, improve and repeat. By tracking metrics over time, the organization can determine which interventions are working—at both the individual and population levels—and where to invest resources. Measuring the impact of interventions starts with picking relevant measures. Comparing results to previously specified benchmarks and goals lets the organization track progress over time.

Measures of experience, cost/utilization and clinical quality should be examined comprehensively to determine a strategy's impact. If measures are examined by themselves—independently of each other—the organization might not see how a strategy meets (or does not meet) its goals for population health.

After analyzing and interpreting results, the organization can identify and act on opportunities for improvement, which may change as new analyses are conducted.

This component describes the unique challenges of measuring behavioral health and the different types of measures and methods of quality improvement, including:



Types of performance measures.



Behavioral health-specific performance measures.



Tools to evaluate the impact of a PHM strategy.

Note: This guide does not replace the PHM category of standards in NCQA Health Plan Accreditation, MBHO Accreditation, PHP Accreditation, PCMH-Behavioral Health Distinction or any other NCQA Accreditation, Certification or Recognition, or dictate additional requirements that must be met for an NCQA survey or integrated care.

➔ TYPES OF PERFORMANCE MEASURES

Performance measurement is standardized assessment of outcomes and results to generate reliable data on the effectiveness and efficiency of programs. [82] In health care, performance measurement is subject to the disparate nature and variable perspectives of many stakeholders, including practitioners, individuals and payers.

Measure Types

Measures should be based on an organization's goals and should align with contract requirements. There are different types of measures and measure sets:

- **Process measures.** Assess clinical performance based on objective clinical criteria defined by practice guidelines or other clinical specifications.
- **Outcome measures.** Assess incidence or prevalence rates for desirable/undesirable health status outcomes.
- **Utilization measures.** Capture frequency and rates of services and procedures through a range of care settings and provide information about how, and how efficiently, an organization manages and expends resources (e.g., total cost of care, all-cause readmission).
- **Experience measures.** [83] Evaluate interactions between individuals and the health care system, including practitioners and facilities. Positive experience is associated with patient adherence, better outcomes, improved patient safety practices and lower utilization of unnecessary health care services.
- **Patient-reported outcome measures (PROM).** [84] Capture a patient's perception of their health. These are often self-completed questionnaires that measure a variety of global, disease- and person-specific outcomes. They are the gold standard when quantifying post-treatment patient experience.
 - The screening and assessment tools described in Component 1 are PROMs. They can be used before, during and after treatment to assess individuals' progress and adjust care plans.

IN-THE-FIELD EXAMPLE

Organization: Headspace Inc., Santa Monica, CA

Problem: After divesting operations in Alaska in August 2019, BP—the oil and gas company—needed evidence-based digital mental health tools to support employees through a period of significant change.

Solution: BP sought to run a pilot with Headspace for Work, a mental health solution offering science-backed meditation and mindfulness tools, to help employees in all BP locations manage stress and sleep quality during the period of change. To determine the effectiveness of Headspace, two key outcomes were measured:

1. Engagement and satisfaction. Would employees use, enjoy and/or recommend Headspace?
2. Health outcomes. Would Headspace help employees manage stress and get better sleep?

The Headspace Science Team designed a 3-month study incorporating validated self-report measures (PSS-4 and PROMIS Sleep Disturbance Scale) and employee feedback to gather quantitative and qualitative data; 275 employees participated.

Headspace was effective in improving health and well-being. Levels of perceived stress declined and employees showed significant improvement in sleep and stress resilience, with a 34% decrease in poor sleep quality and a 25% decrease in trouble sleeping. There were 30%–50% monthly active users with Headspace over the course of 3 months (compared with an average of 3%–5% with EAP, as reported by the Society for Human Resource Management) and overwhelmingly positive feedback about the experience.

The results of the field study are consistent with outcomes reported in peer-reviewed publications investigating the effect of Headspace use across a variety of populations and settings. Use consistently decreased perceived stress, symptoms of depression and anxiety, job strain and burnout [143] [148] [146] [147] and increased positivity and well-being. [144] [145] [148] Taken together, results suggest that brief, guided mindfulness training delivered via smartphone can improve a range of outcomes related to work stress and well-being, with potentially lasting effects.

Process/Structure, Outcome and Utilization Measures: HEDIS

HEDIS is a group of standardized process, outcome and utilization measures designed to ensure that policymakers, payers and the public have the information they need to compare performance of health care organizations. HEDIS measures cover the following domains of care:

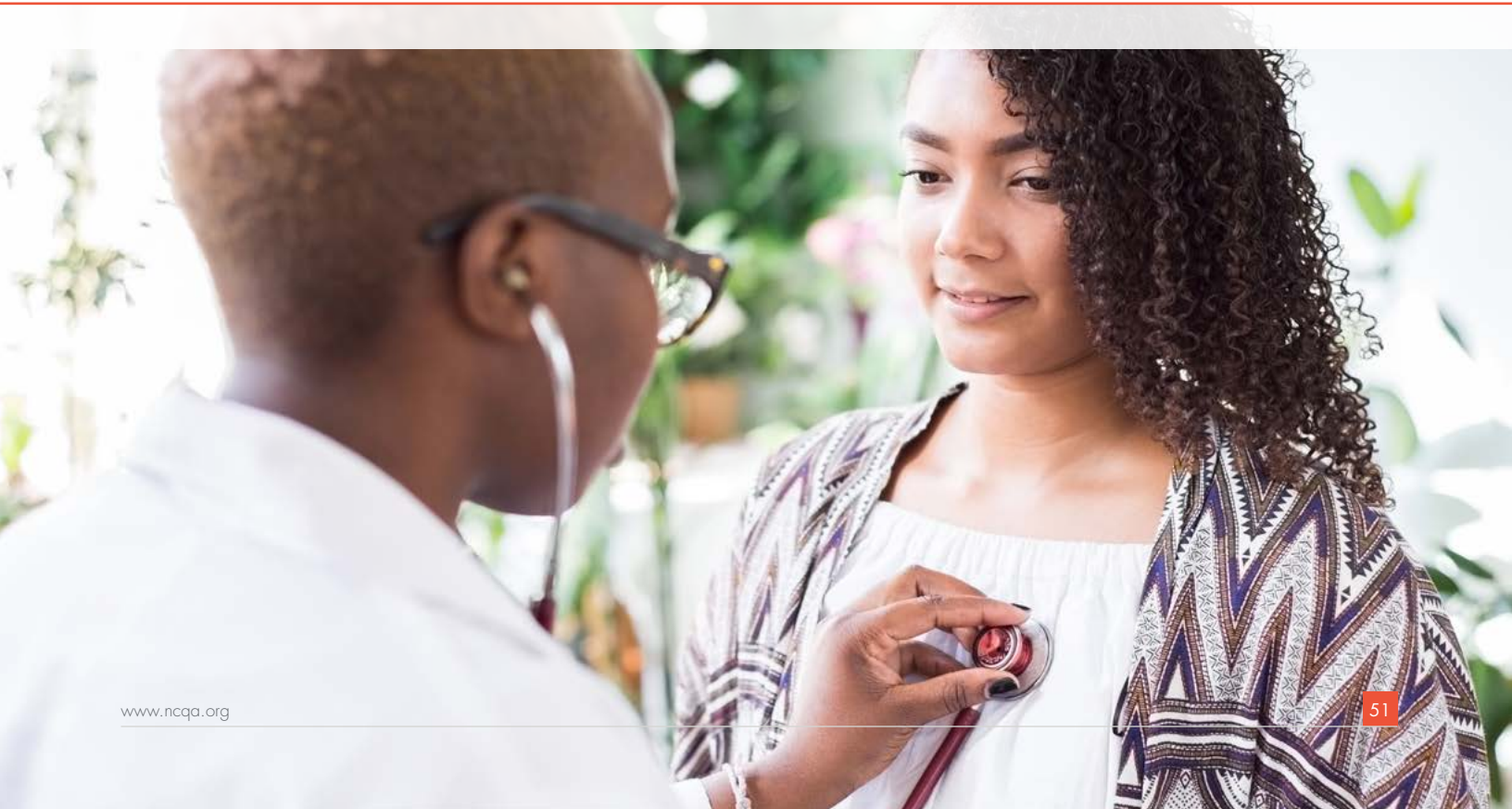
- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Collected Using Electronic Clinical Data Systems (ECDS; refer to Common Q&As).

HEDIS measures and specifications are developed and owned by NCQA. [85] Performance on HEDIS measures is often the basis of value-based payment contracts. Meeting a HEDIS benchmark may determine the loss, bonus or incentive awarded in the contract.

Experience Measures

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys evaluate patients' experience with health care. Practitioners use CAHPS measures during PCMH transformation to track quality improvement initiatives, promote and maintain a focus on patient experience, monitor changes and trends and monitor and coach practitioners. [86] Tracking and evaluating CAHPS results can help practitioners and care delivery organizations understand their patients and create quality initiatives. [87]

The ECHO™ (Experience of Care and Health Outcomes) Survey is used by practitioners, MBHOs, health plans, states and federal agencies to evaluate behavioral health treatment. Its format is consistent with CAHPS surveys. ECHO can be used to improve quality of behavioral, mental and substance use services, to evaluate an organization's quality and to hold practitioners accountable for quality of care. [88]



Behavioral Health-Specific Performance Measures

These measures are primarily targeted at health plans or MBHOs. They can help organizations determine the effectiveness and efficiency of their PHM strategy because they often show the population-focused impact of behavioral health management. NCQA's measures cover these specific behavioral health topics and areas: [89] [90]

TOPIC	MEASURE	MEASURE DETAILS
Screening	Depression Screening & Follow-Up for Adolescents and Adults	Assesses members 12 years of age and older who were screened for clinical depression using a standardized instrument and, if screened positive, received follow-up care. [91]
	Prenatal Depression Screening and Follow-Up	Assesses the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care. [92]
	Postpartum Depression Screening and Follow-Up	Assesses the percentage of deliveries in which members were screened for clinical depression during the postpartum period and, if screened positive, received follow-up care. [93]
Symptom Monitoring	Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	Assesses members 12 years of age and older with a diagnosis of major depression or dysthymia who had an outpatient encounter with a PHQ-9 score present in their record in the same assessment period as the encounter. [94]
Medication Adherence	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Assesses adults 19–64 years of age who have schizophrenia and were dispensed and remained on an antipsychotic medication for at least 80% of the treatment period. [95]
	Antidepressant Medication Management	Assesses adults 18 years of age and older with a diagnosis of major depression who were newly treated with and remained on antidepressant medications.
Medication Management	Follow-Up Care for Children Prescribed ADHD Medication	Assesses follow-up care for children prescribed an ADHD medication included in the Initiation Phase and Continuation and Maintenance. [96]
Access to Care	Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment	Assesses adults and adolescents 13 years of age and older with a new episode of AOD dependence who received: <ul style="list-style-type: none"> Initiation of AOD Treatment: Adolescents and adults who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth or medication-assisted treatment (MAT) within 14 days of diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and had two or more additional AOD services or MAT within 34 days of the initiation visit. [97]
	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	Assesses whether children/adolescents without an indication for antipsychotic medication use had documentation of psychosocial care as first-line treatment before being prescribed an antipsychotic medication. [98]

TOPIC	MEASURE	MEASURE DETAILS
Coordination	Follow-Up After Hospitalization for Mental Illness	Assesses emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness who received a follow-up visit for mental illness. [99]
	Follow-Up After ED Visit for AOD	Assesses ED visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug abuse or dependence who had a follow up visit for AOD. [100]
	Follow-Up After ED Visit for Mental Illness	Assesses ED visits for adults and children 6 years of age and older with a diagnosis of mental illness who received a follow-up visit for mental illness. [101]
Overuse	Use of Opioids at High Dosage	Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older who received prescription opioids for ≥ 15 days during the measurement year at a high dosage (average milligram morphine equivalent [MME] > 120 mg). [102]
	Use of Opioids from Multiple Providers	Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older who received prescription opioids for ≥ 15 days during the measurement year from multiple providers. [103]
Integration of Medical Needs	Diabetes Screening for People With Schizophrenia or Bipolar disorder Who Are Using Antipsychotic Medications	Assesses adults 18–64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year. [104]
	Diabetes Monitoring for People With Diabetes and Schizophrenia	Assesses adults 18–64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year. [104]
	Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia	Assesses adults 18–64 years of age with schizophrenia and cardiovascular disease who had an LDL-C test during the measurement year. [104]
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Assesses the percentage of children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year. [105]
	Unhealthy Alcohol Use Screening and Follow-Up	Assesses members 18 years or older who were screened for unhealthy alcohol use using a standardized tool and, if screened positive, received appropriate care. [106]
Utilization	Identification of Alcohol and Other Drug Services	Summarizes the number and percentage of members who had a service for AOD abuse or dependence (i.e., a claim with both a diagnosis of AOD abuse or dependence and a specific AOD-related service) during the measurement year. [107]
	Mental Health Utilization	Summarizes the number and percentage of members receiving mental health services, including inpatient; intensive outpatient or partial hospitalization; outpatient; ED; telehealth; or any other service. [108]
Outcomes	Depression Remission or Response for Adolescents and Adults	Assesses members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4–8 months of the elevated score. [109]

➔ TOOLS TO EVALUATE IMPACT

It is important for an organization to continually evaluate its PHM strategy and its ability to meet goals. Common evaluation tools include the Plan-Do-Study-Act (PDSA) cycle and root cause analysis. Component 1 discussed how organizations can develop a strategy and set goals.

PDSA Cycle [110]

- Develop a plan to test the change (Plan).
 - ➔ What question is being answered? What is the predicted outcome? What data must be collected?
- Carry out the test (Do).
 - ➔ Carry out the test on a small scale, documenting problems and unexpected observations.
- Observe and learn from the consequences (Study).
 - ➔ Analyze results and compare to predictions.
- Determine if modifications should be made to the test (Act).
 - ➔ Make a plan for next steps based on results.

The PDSA cycle can be used through many iterations. An iterative cycle can identify value-added techniques and activities that help achieve PHM strategy goals. [111] In some cases, an action may require several cycles as new information is learned during implementation. An organization can create a new PDSA cycle based on modifications and reevaluate progress in the same way.

Root Cause Analysis

A “root cause” is a factor that increases the likelihood of error. The goal of root cause analysis is to find out what happened, why it happened and how to prevent it from happening again. It typically begins with data collection and review of an event.

The following steps are important to a comprehensive root cause analysis: [112]

- Appoint a team to conduct the analysis.
 - ➔ The team should be interdisciplinary and knowledgeable of the processes involved in the event, and should include: [113]
 - A subject matter expert on the event (nurse, case manager).
 - Individuals not familiar with the event.
 - A leader versed in root cause analysis (administrator).
 - A member representative.
- Analyze the event.
 - ➔ Describe the initial sequence of events, identify information gaps and information needed, find additional information, identify root-cause and contributing factors.
- Act.
 - ➔ Identify actions implemented in similar past events, develop an action plan, provide feedback.

There might be more than one root cause—a constellation of events can result in one adverse event. An effective action plan considers all causes of an adverse event.



➡ USING A POPULATION HEALTH MANAGEMENT APPROACH FOR BEHAVIORAL HEALTH

A common industry refrain is, “You can’t improve what you don’t measure.” An organization cannot fully execute population health management without collecting and evaluating performance measures. Measurement completes the PHM Conceptual Model because it helps organizations determine the impact of their PHM strategy.

Existing behavioral health performance measures are primarily used by health plans and MBHOs. Other organizations and practitioners should use patient-reported outcome measures to evaluate progress with a program or treatment plan. Aggregated patient-specific measures can paint a full picture of how well a PHM strategy is serving patients with behavioral health conditions.



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