HITPC Quality Measures Working Group

Questions for Quality Measurement in Behavioral Health Settings

National Council for Behavioral Health

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The National Council for Behavioral Health (National Council) is the unifying voice of America’s community mental health and addictions treatment organizations. Together with our 2,100 member organizations who employ over 750,000 individuals, we serve our nation’s most vulnerable citizens — the more than 8 million adults and children living with mental illnesses and addiction disorders. The National Council pioneered Mental Health First Aid in the U.S. and has trained more than 100,000 individuals to connect youth and adults in need to mental health and addictions care in their communities.

Our mission is to advance our members’ ability to deliver integrated healthcare. We advocate for policies that ensure that people who have mental health and substance use problems can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement consulting and resources to ensure services are efficient and effective.

Our members provide a wide range of services and a full continuum of care including outpatient mental health and substance abuse treatment, emergency room diversion programs, crisis intervention and stabilization services, intensive outpatient and partial hospitalization programs, community outreach and services to the homeless, and care/case management services, residential services and services to the cognitively disabled.

Many of our members either provide integrated behavioral health and physical health care directly or work with a medical partner such as a federally qualified health center (FQHC) to coordinate these services for this very vulnerable population. Seriously and persistently mentally ill patients require coordinated care. Some studies have indicated that this population has a life expectancy 25 years less than the general population. They are not dying from behavioral health illnesses but from untreated chronic diseases.

Fundamentally we believe and advocate strongly that behavioral health providers need and should be incorporated into the health care system on par with their medical counterparts. We continue to advocate for behavioral health providers being included in HITECH as eligible professionals and have access to Meaningful Use Incentives. There are several bills in Congress that also support this concept including the Behavioral Health Information Technology Act of 2013 (S.1517) proposed by Senator Whitehouse of Rhode Island and the Behavioral Health IT Act (HR 2957) proposed by Representative Murphy of Pennsylvania. We encourage the support for passage of these bills.

The need to focus on the Triple Aims of better health, better healthcare and lower costs is never more apparent than when working with people with behavioral health disorders. A focus on quality and coordinated care supported by new payment methodologies can support our members in providing the best outcomes for their clients.

Questions

1. What programs require quality measure reporting in behavioral health settings?

Behavioral health providers and organizations provide a wide variety of services and a full continuum of care including but not limited to:

* Assertive Community Treatment
* Assessment and Referral
* Case/Care Management/Services Coordination
* Community Housing
* Community Integration
* Crisis and Information Call Centers
* Crisis Intervention
* Crisis Stabilization
* Day Treatment
* Detoxification
* Drug Court Treatment
* Emergency Room Diversion
* Employee Assistance
* Homeless Services
* Inpatient Treatment
* Integrated Behavioral Health/Primary Care
* Intensive Family-Based Services
* Intensive Outpatient Treatment for MH and SU
* Out-of-Home Treatment
* Outpatient MH/SU Treatment
* Partial Hospitalization
* Prevention/Diversion
* Residential Treatment
* Services to the cognitively disabled
* Supported Living
* Therapeutic Communities
* Opioid Treatment Programs
* Criminal Justice
* Juvenile Justice
* Home and Community Services

Many behavioral health programs are also FQHCs or are in process of applying to become FQHCs.

As these programs are regulated by their state, Medicare and/or Medicaid and may also be accredited by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities, (CARF) they require quality measure reporting across a broad spectrum of care.

1. Are quality measures used in behavioral health settings mapped to standardized vocabularies (e.g., SNOMED CT, LOINC)?

We are not experts in the areas of SNOMED CT and LOINC, however, from a review of several current behavioral health measures they are linked to SNOMED CT, however, we did not determine that they were linked to LOINC. We would recommend that a representative from the National Quality Forum be consulted to provide more expert information in this area.

1. There are currently 14 clinical quality measures in meaningful use Stage 2 that relate to behavioral health. Are these measures useful for your setting and across diverse behavioral health settings? What other additional measures might be of relevance (e.g., care coordination, for certain clinical conditions like diabetes)?

The current behavioral health clinical quality measures are useful in many but not all behavioral health settings. It should be noted that an additional 17 measures that were recently approved by NQF, however, these are not yet incorporated into Meaningful Use.

Many of the current measures only address a specific segment of the population such as those in a hospital setting or do not address adolescents and adults. E.g. NQF 1661, 1663 and 1664 address screening for alcohol and/or drug abuse in a hospital setting but only for patients who are 18 years and older. NQF 0518 addresses screening for depression at the beginning or resumption of home care but there is no corresponding measure for screening for substance use.

We agree with Dr. Pincus’ recommendation in his previous testimony that measures should be developed that require coordination between medical and behavioral health providers. E.g. Screening for depression for all patients with a chronic disease (diabetes, asthma, cardiovascular disease, cancer etc., and if positive a referral is made and percentage of patients who actually engaged in treatment would be such a measure. Further collaboration needs to occur between medical and behavioral health providers to develop and present these measures.

1. ONC’s EHR certification program could be leveraged to support quality measurement in behavioral health settings. Currently, ONC’s certification program supports capture and export, import and calculate, and electronic submission using the QRDA standard[[1]](#footnote-1).
   1. Would you support certification to these functions for the behavioral health setting (capture and export, import and calculate, electronic submission)?

No. Not at this time. Having the capabilities identified requires the provider to have a Meaningful Use Certified product that can provide these functions. Without the resources, financial, workforce and otherwise, behavioral health providers are not in a position to purchase and implement technologies with these capabilities.

The current NPRM, Voluntary 2015 Edition Electronic Health Record (EHR) Certification Criteria, is requesting comment on a Non MU Certification for Behavioral Health. As part of the ONC HITPC Behavioral Health LTPC Workgroup it is my understanding that this certification, if implemented, would not incorporate capture and export and import and calculate functionality.

Electronic submission according to QRDA standards only works for the providers we represent i.e. those providing services to the nations seriously and persistently mentally ill and substance using clients, if all Medicaid programs across the country use this standard. Our providers’ major payment source is Medicaid not Medicare or private insurance. At this time each state Department of Mental Health or Substance Use and/or Medicaid agency has a different transport method and requiring certification for a transport method that would not be utilized universally would be a burden for providers and we think for vendors as well.

* 1. What other functions to support quality measurement would you recommend certification for?

It is not so much a matter of function but rather a matter of just what measures should be collected and having some agreement among federal partners and the states as to a basic set of measures to use. If we can harmonize the measures then providers across all states would be able to report to states and federal partners using one mechanism. The data could then be analyzed and we may have a chance at utilizing the data as part of a leaning health system and continue to improve the care for people receiving mental health and substance use services across the nation.

1. What additional gaps or barriers need to be addressed to support electronic quality measure construction and reporting in behavioral health settings?

We recognize the need and support he effort to obtain and analyze clinical quality measures, however, there needs to be continued recognition that without resources similar to those provided to medical providers under HITECH we are asking behavioral health providers to do things that their medical partners never would have done without the resources they were provided. We encourage support for the Behavioral Health IT Act which would help a large number of behavioral health organizations move forward and be able to implement the systems that will allow for continued quality measurement for people with behavioral health disorders, improvement in their health, health care and lower costs overall.

42 CFR Part 2, the federal regulation for sharing substance use records will also prevent the sharing of patient level quality data. Unlike HIPAA which allows for sharing data for Treatment, Payment or Operations, Part 2 requires that the client indicate the purpose for sharing records. Not all clients may allow sharing the data for quality measurement and currently EHRs and HIEs do not have a mechanism to segment the data to manage these requests. There are recommendations for HHS to provide sub regulatory guidance which would allow the acceleration of health information exchange and still maintain the protections afforded to substance use clients and we recommend that HHS continue to seek ways to resolve this problem. Data segmentation may be the answer, however, that is still a number of years away and we cannot afford to allow behavioral health clients to receive sub standard care until if and when data segmentation is implemented in all systems across the nation.

1. What clinical questions related to behavioral health would you like the answers to – what would a related performance measure look like?

In general we believe that clinical questions related to the Triple Aims of providing improved health and better outcomes at lower costs for people with behavioral health disorders are the right questions. We would like measures that assist us to arrive at these answers and believe that this can only occur if behavioral health is seen as a true partner in the care continuum. We seek answers around which treatments work for which patients. Determine the appropriate level or package of services that are required from behavioral health, medical providers, and ancillary services will help us as a system to provide higher quality care to the people that we serve.

Thank you for the opportunity to present to the WMWG. If you have questions I can be contacted at [MikeL@thenationalcouncil.org](mailto:MikeL@thenationalcouncil.org).

1. Quality Reporting Document Architecture (QRDA) documents. QRDA is a document format that provides a standard structure with which to report quality measure data to organizations that will analyze and interpret the data. [↑](#footnote-ref-1)