Integrus Health Group

Integrating Primary and Behavioral Health Care

Aligning Outcomes with Funding to Enhance Prescriber Capacity in Jackson County, Missouri: Brief Report

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Project Overview: Aligning funding to enhance prescriber capacity to serve uninsured persons in Jackson County, Missouri and improve outcomes for participants in care are the main goals of this project. Understanding the true demand for services allows the mental health fund to make investments in programing that will produce the desired results. Phase I of a three-part pilot initiative included a qualitative assessment of access measures within the Community Mental Health Fund (Levy) contracting processes. Phase II and III included training on rapid-cycle improvement process and testing improvement methods aligned with data collection. Outcomes from this demonstration will inform initial steps toward value-based payment systems.

Information Sources: Qualitative information was gathered from six different mental health agencies on: measurement and tracking of referrals; timeliness to evaluation and prescribing; utilization management; and current IT systems. Agencies included in the pilot assessment are three Community Mental Health Centers(CMHC) and three special population (niche) providers.

Demonstration Agencies	
Prescribing (CMHC)	**Niche Providers**
Comprehensive	Mattie Rhodes
Swope Health	Hope House
TMC-BH	ReStart

Phase I Prescribing Agency Findings:

- ☐ Standards of care, the amount of oversight, and other factors in quality assurance varied widely among facilities.
- ☐ Prescriber capacity was reduced when periodic updates on patients' treatment plans and services were not given.
- ☐ Staff were open to learning about skills and procedures that support potential improvement.

Phase I Niche Provider Findings:

- ☐ It is unclear what process improvements can be put into place to assure successful referrals to presriber services.
- ☐ The changes in procedures at the CMHCs inadvertently reduce contact with referring agencies. A mutual lack of clarity and accountability in referrals places smaller providers at a disadvantage.
- ☐ Prescriber resources are often not efficiently managed. For example, a prescriber handling a complex participants with little support from internal therapists or referring staff.

Recommendations from Phase I

Incentives for On-demand Assessment would guarantee an assessment that includes appropriate prescribing within 1-5 days in exchange for a higher rate of payment. This idea resonated with both prescribing agencies and the niche providers. Measurement could be done with little effort by agencies willing to be accountable to outcome variables of their own, such as a higher rate of completion of treatment goals.

Contracting agencies should use utilization management techniques to assure the Levy and the public that funds are being used in an efficient manner. This should be integrated into the Levy's

contractual process, with support training and assistance available to agencies lacking the skills or resources.

Prioritize High-Turnover Populations in settings such as Hope House and ReStart. Augmenting prescriber sessions with a therapist or care coordinator would improve adherence and follow-up.

Use Rapid Cycle Improvement to ensure that pilot processes can be quickly adjusted by engaging all those involved. This would include:

- ☐ Train/coach participants in basic data collection, analysis of diagnostic causes and systematic adjustment of processes.
- ☐ With introduction of pay-for-value experiments, involve Integrus to provide feedback.
- ☐ Involve referring agencies in tracking and decisions about incentives.

Continue to evaluate information systems able to capture the kinds of data needed for value-based payment arrangements. First Call is the Levy's current IT developer/ provider. There is interest in adapting the current system to a value-based funding structure.

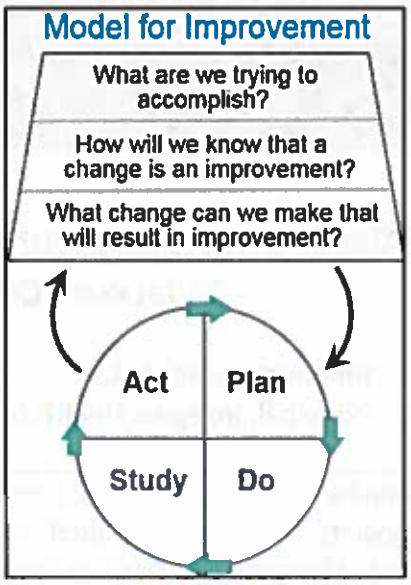
Developing Common Standards between the Levy and its provider agencies is best accomplished through a collaborative effort between the Levy and CMHC leadership. Such an undertaking would be best left until other processes are in place.

Phase II and III Summary

Phase II and III focused on clarifying the demand for resources through training on rapid-cycle improvement process and data collection, creating common definitions around urgent referrals and applying and testing these new processes improvement methods. During the initial training sessions it was discovered as in many instances, there is a range of management interventions that can and should be taken to address system inefficiencies.

Training sessions were provided to all demonstrations agencies through group and individual on-line sessions. Each agency had the opportunity to work through an internal area of process improvement using the rapid-cycle method. The next step was to apply the method to address the commonly defined prescriber access and utilization concerns.

Rapid Cycle Improvement Model



Defining and prioritizing urgent referrals between the CMHC's and Niche providers was another focus area. While the new "open-intake" process was intended to improve access to care, the unintended consequence is the reduction in detailed information about the level of urgency in people presenting for intakes and significant challenges in tracking of urgent referrals.

Significant time was spent on data collection between both the CMHCs and Niche providers to best define the demand and process for making referrals between agencies. Emphasis was on the critical nature of defining an "urgent referral" for the nice provider, agreeing on the definition with the CMHC. The generation of appropriate data to identify, monitor and track such urgent referrals was developed.

Intregrus provided both formal training and hands-on consultation with all agencies concentrating on measures associated with prescriber capacity including wait lists and length of time between intake and evaluation appointment. This intense work also contributed to developing a mind set as well as a skill base that applies to all areas of provider operations and regulatory oversight.

Phase II and III Results include several significant changes.

Moving from anecdotal to greater certainty of information through actual measurement is itself a major step forward. The Fund continues to hear about problems with accessing care, yet there is little to no measurement data available by which to set baselines or track improvements.

Demonstration participants have developed common definitions and agreed upon processes for making and tracking referrals. In some cases, EHR "fields" had to be modified to get to an appropriate measure. Work continues in this area.

Bringing attention to elements of workflow is resulting in a deeper level of engagement around proper collection and use of information to address perceived resource shortages.

With continued modest changes in this process, the 30% inefficiency widely cited in health and social services fields can be significantly improved. Simultaneously, brining attention to the continuous improvement process creates a more dynamic and vibrant organization.

Below is an example of the process improvements made at a demonstration site.

Agency Improvement: Mattie Rhodes
Prior to Demonstration
☐ Isolated 3-hour per week psychiatrist
☐ Psychiatrist managing wait-list with 6-8 week wait time for new evaluations resulting in no new referrals
☐ Psychiatrist managing prescription assistance process.
☐ High no-show rate without data to determine why
Post Rapid Cycle Improvement Process
☐ CEO, Senior Management and Psychiatrist created a flow-chart highlighting steps in prescribing process. Psychiatrist was no longer working in isolation
☐ Collectively created metrics to measure process flow using the Rapid Cycle approach, resulting in a quicker response time to understanding issues and developing interventions.
☐ Developed a deeper engagement around the use of information and problem solving based on actual data.
☐ Without these improvements, access issues would of continued for months and likely resulted in a request for additional funding for psychiatrist time.

Ongoing Challenges include staffing shortages and leadership changes at agencies. A couple of the demonstration participants are slow to implement the use of Rapid Cycle methods due to leadership turn-over and significant staff shortages. These challenges are putting more service delivery demands on their time and taking away from the management time needed to adequately define the metrics and consistently collect and measure data. A positive result is agencies understanding the importance of a continuous improvement process rather than a one-time a year quality assessment. Agencies are also looking into their electronic management systems for areas of improvement.

Recommendations from Phase II and III

- ☐ Continue to define "access to care" and develop common measures with MH Fund Staff and Board. Access to care has been defined as a Community Goal by the Fund.
- ☐ Expand the use of Rapid-Cycle methods to other identified agencies through training and consultation.
- ☐ Mental Health Fund Infrastructure development to include enhanced data collection methods to pilot value-based funding structures to providers.

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COMMUNITY MENTAL HEALTH FUND