



Quality and Performance Measures: The Role of Clinical Mental Health Counselors (CMHCs) in Improving Mental Health Services

Introduction

The quality of behavioral health care can be measured, monitored, and improved over time using performance measures.

Under the changing health care landscape, clinical mental health counselors (CMHCs) and other mental health providers now have the opportunity to integrate behavioral health metrics into measurement systems across payers. This is especially true as purchasers and payers are implementing integrated care delivery systems and payment reform strategies, especially efforts emanating from the Affordable Care Act such as accountable care organizations (ACOs).

The concept of performance measurement is well established in the medical sector where most purchasers, clinicians and policymakers, and increasingly some consumers now take for granted and indeed expect that performance measures for medical conditions will be calculated, published, and scrutinized.

The development of performance measures in behavioral health has a more recent history; although performance measures for mental and addictive disorders are now receiving greater attention than ever before.

The fact that this attention is warranted was highlighted by a national study showing that persons with depression received effective care only 57.7 percent of the time and that persons with alcohol dependence received effective care only 10.5 percent of the time, the lowest of any of the conditions examined.

CMHC efforts to develop targeted measurements and policies to improve the quality of behavioral health care should complement larger statewide goals and joint health policy agendas.

While health care reform has accelerated the development and use of performance indicators, the behavioral health field needs to become more fully engaged in the development of performance measures.

Many current measures do not adequately account for variations in patient panels. These measures do not necessarily account for more severely mentally ill patients or patients with multiple physical and behavioral co-morbidities.

Current accreditation and certification programs do not adequately include CMHC input. This has resulted in mental health and substance use measures being entirely excluded, as well as inadequate measures of coordination with physical and behavioral co-morbidities.

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In this paper, we first focus on describing the basics and vision of quality measurement, and the measurement challenges to the development of performance measures in behavioral health -- and the need for a new commitment to developing and using quality measures. Then we discuss new initiatives and programs. Finally, we propose the roles that CMHCs can play in the development and use of performance measures.

Quality Measurement Components

A broad vision for quality measurement and reporting in the Medicare program and the private sector exists.

Components of this vision include: 1) Quality Measure Development; 2) Quality Measurement (including payment incentives); and 3) Public Reporting. The changing health care landscape greatly expands existing efforts noted above while introducing new tools for the Medicare program to identify, measure and pay for quality care.

Quality Measure Development

A quality measure is a “standard for assessing the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.”

CMS is required to identify gaps where no quality measures exist and to identify existing quality measures that need improvement, updating or expansion for use in federal health care programs (including Medicare, Medicaid, and CHIP).

Under the changing landscape, identified gaps must be reported on a publicly available website and the HHS Secretary must make awards to develop, update or expand quality measures. In developing new measures, priorities must include measures that assess outcomes, functional status, coordination of care across episodes, shared decision-making, use of health information technology, efficiency, safety, timeliness, equity, and patient experience.

Outcomes measures will be developed for acute and chronic diseases and primary and preventative care for hospitals and physicians.

Updated provider-level outcome measures for hospitals and physicians will be developed as well as for other providers. The measures should address the five most prevalent and resource-intensive acute and chronic medical and mental health conditions and care for distinct patient populations such as healthy children, chronically ill adults or infirm elderly individuals.

A new entity selected by the Secretary will develop quality measures (currently the National Quality Forum [NQF]) and convene multi-stakeholder groups to provide input on the selection of quality measures and national priorities through an open and transparent process.

Selected measures will be used for existing and new Medicare (as well as Medicaid and CHIP) quality reporting and payment programs described below.

The HHS Secretary will provide feedback to eligible professionals on their performance on reported quality measures and to develop a plan to integrate reporting on quality measures with reporting on the meaningful use of EHRs.

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Existing and newly developed quality measures will be used to determine whether participating providers are “meaningfully using” EHRs to improve the quality of care delivered and qualify for incentive payments.

Quality Measurement

The Physician Quality Reporting Program will institute a penalty for failure to report beginning in 2015 (maximum two percent). An additional incentive payment (one-half percent) is available for eligible professionals who satisfactorily submit data on quality measures through a Maintenance of Certification Program (such as a qualified American Board of Specialties Maintenance of Certification Program).

Under the changing health care landscape, CMS will provide feedback to eligible professionals on their performance on reported quality measures and to develop a plan to integrate reporting on quality measures with reporting on the meaningful use of EHRs.

A Quality Reporting for Psychiatric Hospitals is a new quality measurement and reporting program. Once operational, if a facility does not report selected quality measures, the facility’s annual update will be reduced by two percentage points

Under the changing landscape, “Value-based Purchasing Programs” link payment rates to performance on specific quality measures and/or improvements in performance.

Implementation of value-based purchasing programs for hospitals (other than psychiatric hospitals, rehabilitation hospitals, children’s hospitals, long-term care hospitals and certain cancer treatment and research facilities) and for physicians (through the use of a payment modifier) will be in place. CMS will develop plans to implement value-based purchasing programs for ambulatory surgery centers, skilled nursing facilities and home health services.

Existing and newly developed quality measures also will be used to determine whether participating providers are “meaningfully using” EHRs to improve the quality of care delivered and qualify for incentive payments.

Public Reporting

CMS has established a “Physician Compare” website that will publicly report information on physicians and other eligible professionals who participate in the Physician Quality Reporting Program. Information reported must include the quality measures collected under SAMHSA will award grants to centers of excellence in the treatment of depressive disorders.

The work from these centers of excellence could help with the development of evidence-based depression treatment guidelines. The Physician Quality Reporting System as well as assessments of patient health outcomes, risk-adjusted resource use, efficiency, patient experience, and other relevant information deemed appropriate by the HHS Secretary.

Caregivers must have a reasonable opportunity to review their results before the information is made public. A newly authorized quality reporting programs for psychiatric hospitals, long-term care hospitals, inpatient rehabilitation hospitals, hospice programs, and non-PPS cancer hospitals will require the Secretary to make reported quality information available to the public after the providers have had an opportunity to review.

A “Patient-Centered Outcomes Research Institute”, or PCORI, as a nonprofit corporation that is not an agency or establishment of the U.S. Government will be created. The institute’s purpose is “to assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and

appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of medical treatments, services, and items.”

The PCORI must ensure that subpopulations are appropriately accounted for in research designs, so this would cover individuals with behavioral health conditions, and they (and their families and careers) should also be represented in the patient and consumer representatives on the advisory panels.

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The development of a National Strategy to Improve Health Care Quality to improve the delivery of health care services, patient health outcomes and population health will be critically important to the behavioral healthcare community and SBHAs

A New Commitment Needed

Challenges have arisen in the development of performance measures for mental health and substance abuse because of the structure of the treatment system, the quality and availability of data, and many complex computational issues. Measuring the quality of mental health and substance abuse services is particularly challenging for a variety of reasons.

A key to improving the quality of mental health services lies in the ability of CMHCs and other providers in the field, to renew their efforts to publicly emphasize the importance and value of effective mental health services.

In mental health, no confirmatory laboratory or radiological test exists for diagnosis; clinical diagnosis is frequently imprecise; important care processes often are not captured in data systems; clinical outcomes are not captured in a standard format; and performance is likely to be highly related to case mix. The situation is similar for substance use disorders; however biological tests are common for detecting

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While potentially discouraging, such results also point to the critical need to disseminate more effectively the existing knowledge about the value and quality of mental health services and the potential that such services have for positively transforming the lives of individuals with mental illness.

It appears that the limited progress in improving the quality of mental health services is attributable less to a lack of good ideas than the capacity, determination, and resources to take good ideas to scale. We are replete with examples of how individuals and organizations have successfully improved services and/or achieved targeted outcomes. However, what largely remains a mystery is how to best translate, adapt, or otherwise transfer disparate efforts so that similar success can be achieved across broad populations and service settings. Moreover, such efforts could lead to continued reductions in the stigma often associated with receiving mental health services, as well as a greater sense of optimism and hope for recovery among future service recipients.

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New Initiatives in Quality Measurement and Improvement in Health Care

Recent initiatives will help guide local, state, and national efforts to improve healthcare quality through three major aims:

- **Better Care:** Improve the overall quality, by making healthcare more patient-centered, reliable, accessible, and safe.
- **Healthy People/Healthy Communities:** Improve the health of the U.S. population by supporting proven interventions to address behavioral, social and environmental determinants of health in addition to delivering higher-quality care.
- **Affordable Care:** Reduce the cost of quality healthcare for individuals, families, employers and government.

National Quality Strategy

As the National Quality Strategy is implemented, the United States Department of Health and Human Services (HHS) will work with stakeholders to create specific quantitative goals and measures for each of these priorities:

- Making care safer by reducing harm caused in the delivery of care;
- Ensuring that each person and family are engaged as partners in their care;
- Promoting effective communication and coordination of care;
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease;
- Working with communities to promote wide use of best practices to enable healthy living; and
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new healthcare delivery models.

National Framework for Quality Improvement in Behavioral Health Care

SAMHSA has developed a National Framework for Quality Improvement in Behavioral Health Care which identifies national priorities—and goals and opportunities—for improving the delivery of behavioral health services, achieving better behavioral health outcomes and improving the behavioral health of the U.S. population, especially those struggling with or at risk for mental illnesses and substance abuse.

SMASHA has developed a National Framework for Quality Improvement in Behavioral Health Care which identifies the following goals (paraphrased):

- Prevent and reduce the harm caused by mental illness and addictions.
- Emphasizing the use of client preferences and desired outcomes into the design and delivery of mental health treatment.
- Create an integrated behavioral health system that improves coordination across treatment providers and specialties.
- Increase the availability and quality of behavioral health services in all U.S. communities.
- Eliminate adverse behavioral healthcare induced by treatment providers (i.e., medication errors, abuse, etc.)
- Reduce costs while improving quality

Efforts to implement quality measures successfully will require an understanding of the current behavioral health status and needs of both populations and delivery systems, as well as the ability to

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anticipate the data and informational requirements necessary to assess adequately and monitor changes in the health care environment on these same populations and delivery systems over time.

According to SAMHSA, the creation of a National Behavioral Health Quality Framework represents an important step in achieving the overarching purpose of SAMHSA's Strategic Initiative for Data, Outcomes, and Quality—namely, “realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact and lead to improved quality of services and outcomes for individuals, families, and communities.”

As improving the quality of behavioral healthcare is a primary aim of the Strategy, CMHCs could help develop state-specific quality strategies to help meet the priorities of the National Quality Strategy. Quality measurements developed and implemented by providers should be synchronized with the goals and priorities of the National Quality Strategy. CMHCs working with other providers should consider organizing the many behavioral health metrics into a single streamlined measure set.

CMHC Actions – Be At the Quality Improvement Table!

CMHCs and providers need to make inroads in demonstrating the value of behavioral health's role in emerging systems and identifying then leading what type of delivery model a state is moving toward.

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To have a viable seat at the table on providing value and robust quality of care the following conditions should be in place in behavioral health organizations:

- CMHCs should work with Medicaid, Medicare and other private payers to analyze information collected from quality data measurement systems to improve behavioral health quality.
- Accessibility to treatment;
- Identify your practice or agency's costs and demonstrate how well they are understood – both in terms of cost effectiveness and efficiency;
- The ability to provide episodic care under bundled rates, rather than a more open-ended approach. The term “treat to target” is being used to describe a scenario in which agencies and providers can, for example, document a client's concrete improvement in 6 to 12 months, rather than simply renew a client's static treatment plan over and over again;
- Health information technology capacity to allow full communication with primary care; and
- The ability to produce “Outcomes to our Outcomes” where it can be shown, for example, that a community provider's effective services, directly reduce the need for higher-cost, more disruptive treatments for behavioral health consumers.

CMHCs should consider developing partnerships, or join existing partnerships, with Medicaid, private insurers, providers and other critical stakeholders, to collaborate on developing a comprehensive quality strategy for the state that includes metrics to assess the quality of behavioral health services.

CMHCs should work with Medicaid, Medicare and private payers to analyze information collected from quality data measurement systems to improve behavioral health quality.

The Agency for Healthcare Research and Quality through the issuance of grants, must identify areas in which gaps exist in quality measurement reporting, including behavioral health measures, across episodes of care and care transitions for patients across the continuum of providers, healthcare settings and health plans, equity of health services and health disparities.

CMHCs should consider collaborating with behavioral health providers to apply for AHRQ grants to develop new innovative behavioral health quality metrics measures.

To optimize individualized care, a modern behavioral health system should include a structure in which all holistic outcomes, measures and indicators of health are collected, stored and shared with the individual and alof the providers who are associated with care of the individual. CMHCs should support and participate in the development of interoperable, integrated electronic health records that will be necessary, as will community-wide indicators of mental health and substance use disorders.

The Profession Must Lead on Quality Improvement

The Clinical Mental Health Counseling Profession must lead on quality metrics for mental health care and their consistent adoption across payers and other regulatory entities. This can be accomplished by identifying a few priority areas for improvement, as well as establishing a series of goals covering various areas of practice:

- Undertake a systematic review and analysis of quality and performance measures that are used to accredit and/or certify alternative care-delivery models. This will be beneficial for improving quality and cost of care and establishing adapted payment structures.
- Broaden the range of quality measures to include outcomes and integrated care measures for individuals with multiple physical and behavioral co-morbidities.
- Continue research activities on quality and effective mental health practices.

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The Advancement for Clinical Practice Committee of the American Mental Health Counselors Association (AMHCA) is responsible for developing, coordinating, and producing the white papers, which give a brief orientation to clinical mental health counselors about topics relevant to current practice. Existing AMHCA white papers include technology in counseling, trauma-informed practices, and responding to suicide risk. The Committee has a protocol for interested authors and contributors; please contact the chair of the Committee.

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Appendix

Behavioral Health Clinical Quality Measures

Technical Expert Panel (TEP) Project Overview

The Office of the National Coordinator for Health Information Technology (ONC) and the Substance Abuse and Mental Health Services Administration (SAMHSA) supported a federal cross-agency initiative regarding Behavioral Health Clinical Quality Measures (BH CQMs). The project, which concluded on September 30, 2012, facilitated the development of a portfolio of BH CQMs for potential inclusion in the Centers for Medicare & Medicaid (CMS) Electronic Health Record (EHR) Incentive Program for Stage 2 and/or Stage 3 of Meaningful Use and developed recommendations for future CQM development across six behavioral health domains (depression, suicide, drug use, alcohol use, trauma, and autism).

The first phase involved e-specification of 10 clinical quality measures related to behavioral health (see table 1). Measures included both National Quality Forum (NQF) endorsed measures and measures that have been submitted for endorsement for which e-specifications were needed for use in EHRs.

Table 1. Final Prioritized eSpecified List of Behavioral Health Clinical Quality Measures

Measure Concept	Subgroup	Recommended Priority	Setting	NQF#	Steward
Bipolar Disorder (BD and Major Depression (MD): Appraisal for alcohol or chemical substance use	Alcohol	1	EP	0110	CQAIMH
BBD and MD: Assessment for Manic or hypomanic behaviors	Depression	1	EP	0109	CQAIMH
BD: Suicide Risk Assessment Suicide	Suicide	1	EP	0110	CQAIMH
Maternal Depression Screening	Depression	2	EP	1401	NCQA
Follow-up after Hospitalization for Mental Illness	Depression	1	EP	0576	NCQA
Risky behavior assessment or counseling by age 13 – Alcohol, Tobacco, Substance Abuse, Sexual Activity	Substance Use Disorder (SUD)	1	EP	1406	NCQA

Measure Concept	Subgroup	Recommended Priority	Setting	NQF#	Steward
Risky behavior assessment or counseling by age 18– Alcohol, Tobacco, Substance Abuse, Sexual Activity	SUD	1	EP	1507	NCQA
Alcohol Screening	Alcohol	1	EH	1661	TJC
Alcohol Brief Intervention	Alcohol	1	EH	1663	TJC
Bipolar antimanic agent	Depression	2	EP	0580	RHI

**0110 and 1401 were included in the Final Rule of Stage 2 MU*

NQF Behavioral Health Measures

The National Quality Forum (NQF) Board of Directors has endorsed 10 quality measures focused on behavioral health, addressing issues such as alcohol and tobacco abuse, antipsychotic medication adherence, and post care follow-up after hospitalization for mental illness.

The measures include those that have been endorsed for at least three years and are now undergoing NQF endorsement maintenance. The ongoing evaluation and updating of endorsed measures ensures they are current, “best in class,” address gaps in existing measures, are synchronistic with national priorities, and enhance NQF’s behavioral health portfolio. In all, 22 measures were submitted for evaluation against NQF’s endorsement criteria. Eleven measures were withdrawn from consideration or deferred; 10 measures – including six new submissions – were endorsed.

Endorsed Measures

- 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NCQA)
- 0027: Medical Assistance With Smoking and Tobacco Use Cessation (NCQA)
- 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (AMA-PCPI)
- 1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia (CMS)
- 1932: Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD) (NCQA)
- 1927: Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (NCQA)
- 1933: Cardiovascular health monitoring for people with cardiovascular disease and schizophrenia (SMC) (NCQA)
- 1934: Diabetes monitoring for people with diabetes and schizophrenia (NCQA)
- 1937: Follow-Up After Hospitalization for Schizophrenia (7- and 30-day) (NCQA)
- 0576: Follow-Up After Hospitalization for Mental Illness (NCQA)