

# Measurement-Based Care Approaches & Incentivization for Alternative Payment Models

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# Agenda

- ❑ Introductions and Acknowledgements
- ❑ EBT Performance-Based Incentives Model
- ❑ Measurement-Based Care (MBC) Solutions
  - Why Mirah Inc.?
  - Case example with Data
- ❑ *Systems Application*: Community Health Center, Inc. (CHC) & Child Guidance Center (CGC) of Southern CT
- ❑ Mirah Pilot at CHR and Clifford Beers
- ❑ MBC's Role in APMs/Q & A discussion



# EBT Performance-Based Incentives Managed by CHDI & DCF

## **Performance-Based Metrics**

(80% - 90% of funds and per child caps)

1. **Engagement**
2. **Measures collected and entered**
3. **Improved Outcomes**

## **Training, Coaching, & Workforce Development**

(10 - 15% of funds)

1. **New, booster, and advanced EBT trainings**
2. **Time to implement post-training**

## **Best Practice Standard (EBT dependent)**

(<5% of funds)

1. **Trauma screening**



# Measurement-Based Care (MBC) Solutions

## Evolution of MBC and MBC-platforms

- Platforms developed in response to pressure from payers and The Joint Commission
- TJC standard made numerous demands but provided no funding for achieving this mandate
- Real suggestions included paper and pencil measures and a full time employee whose job was to aggregate this data and share it with clinicians

## Why Mirah Inc.?

- Proprietary measures (CAMS and PTPB) vs measurement batteries
- Pricing
- Dedicated MBC platform
- Flexible measurement planning
- Valuable analytics making success easier

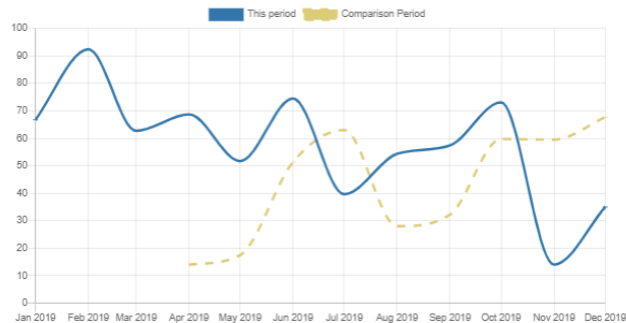


# Outcomes Over Time

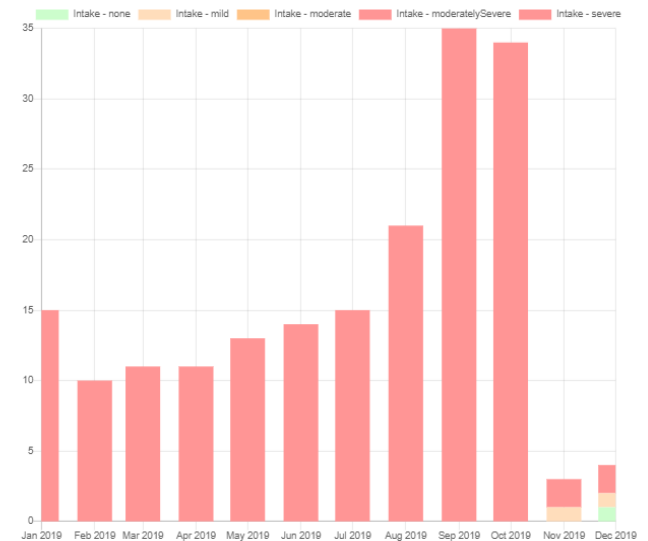
Avg LOS (days)

76.9

↑ +0%



### Intake Severity Breakdown



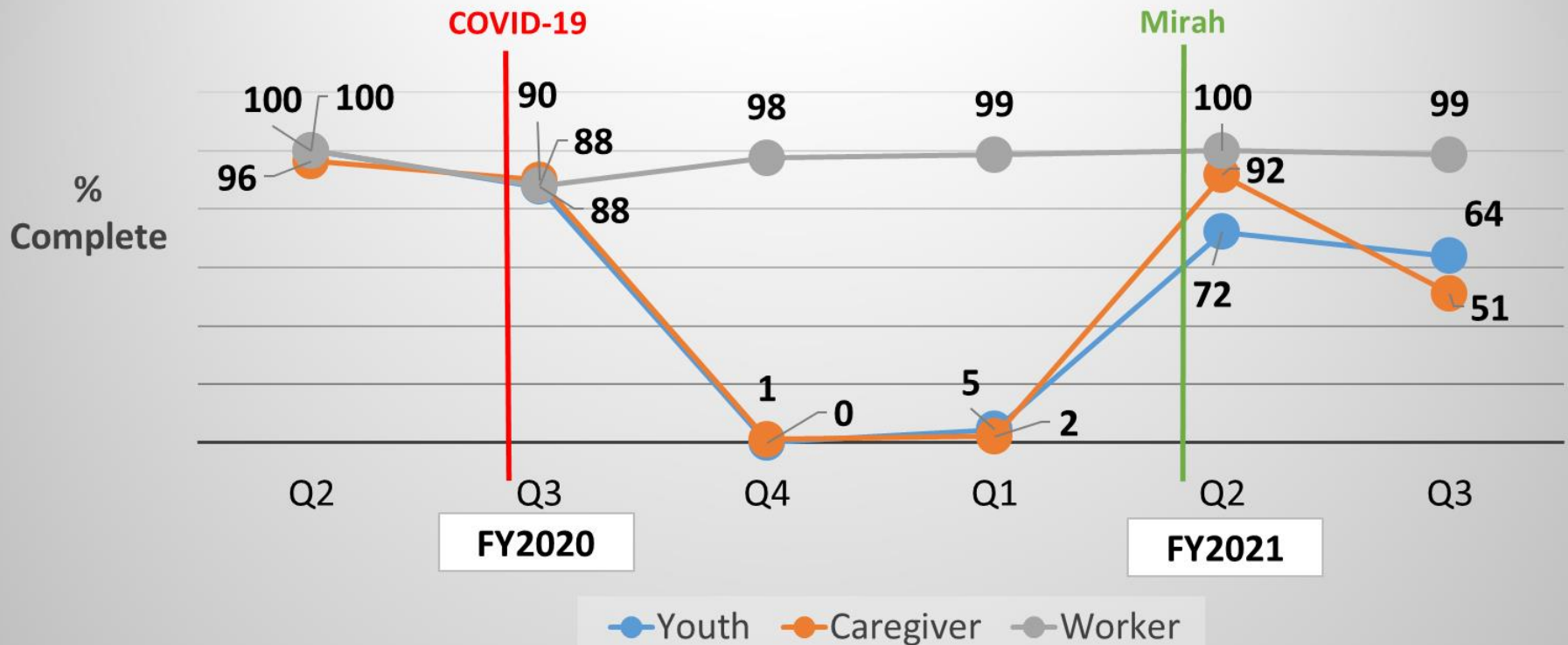
Comparing to 01/01/2018-12/31/2018

	Total Treatments ⚖	Avg Intake Score ⬆	Avg # Sessions ⚖	Avg LOS (days) ⚖	Avg End Score ⚖	Avg Δ from Intake ⚖	Intake Severity Breakdown	Current Severity Breakdown
🏠 Demo Clinic	73 (vs 24) ⬆ +204%	21.7 (vs 22.2) ⬇ -1%	5.5 (vs 4.9) ⬆ +13%	76.9 (vs 76.7)	12.3 (vs 13.6) ⬇ -9%	-9.4 (vs -8.4) ⬇ -12%		
🏢 Units								
👨 Providers								
👨 Greg House	18 (vs 2) ⬆ +800%	20.2 (vs 22.2) ⬇ -8%	4.9 (vs 6.5) ⬇ -24%	57.8 (vs 49)	12.6 (vs 14.5) ⬇ -13%	-7.6 (vs -7.5) ⬇ -1%		
👩 Dr Deanna Troi	7 (vs 4) ⬆ +75%	21.9 (vs 22.5) ⬇ -3%	6.6 (vs 4.5) ⬆ +46%	64 (vs 71.8)	9.3 (vs 12.8) ⬇ -27%	-12.6 (vs -9.4) ⬇ -29%		
👨 Dr Henry Jekyll	9 (vs 0) ⬆ N/A	21.9	5.2 (vs 0) ⬆ N/A	39.7	15.4	-6.4		
👩 Dr Dana Scully	11 (vs 5) ⬆ +120%	21.9 (vs 21.4) ⬆ +2%	6.1 (vs 4.8) ⬆ +27%	88.5 (vs 95.2)	11.4 (vs 10.6) ⬆ +7%	-10.5 (vs -10.8) ⬆ +2%		
👩 Dr Meredith Grey	13 (vs 8) ⬆ +63%	22.5 (vs 21.8) ⬆ +3%	4.3 (vs 4.8) ⬇ -12%	97.5 (vs 81.4)	14.2 (vs 15) ⬇ -6%	-8.3 (vs -6.8) ⬇ -23%		
👨 Dr John Zoidberg	15 (vs 5) ⬆ +200%	22.5 (vs 22.4) ⬆ +0%	6.5 (vs 4.8) ⬆ +36%	101.7 (vs 65.8)	10.5 (vs 14.6) ⬇ -28%	-11.9 (vs -7.8) ⬇ -53%		
🏠 Patients								
🏠 Care Episodes								



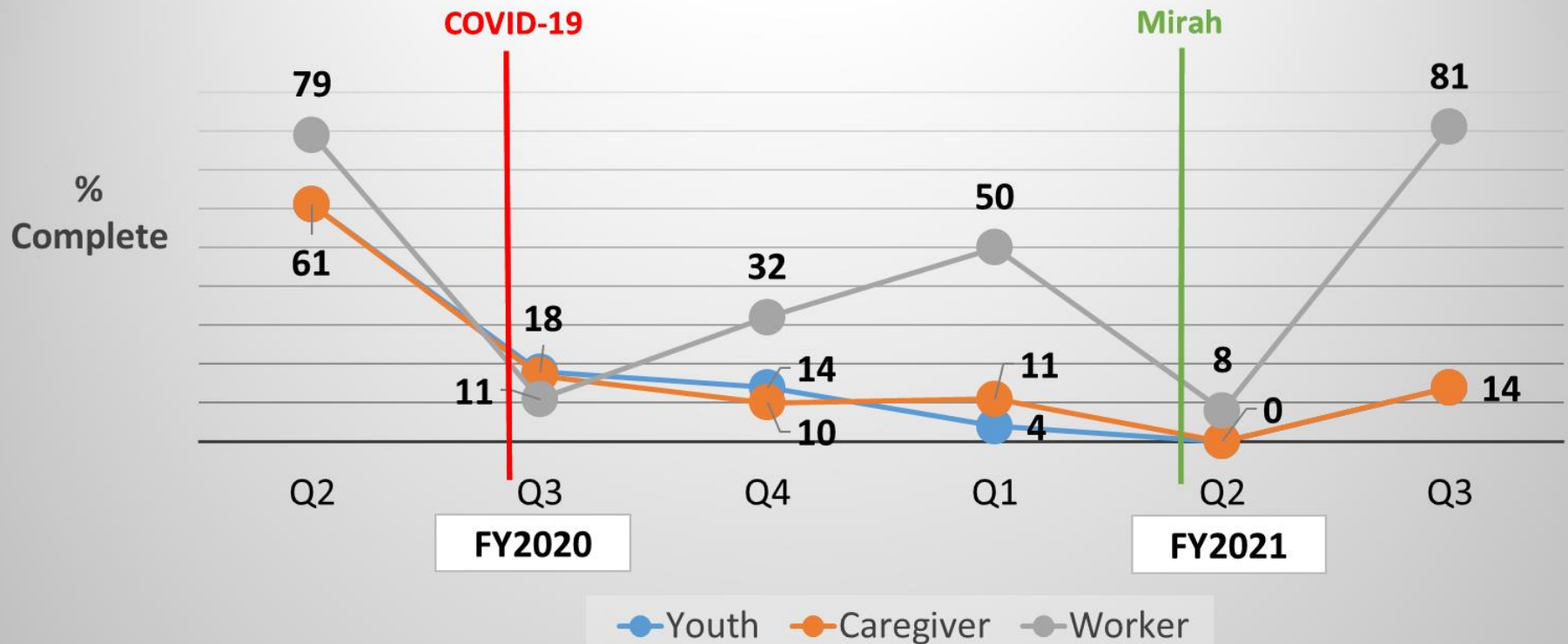
# CGC Southern Early Implementation amid COVID-19

## Intake Ohio Scale Data Collection Rates



# CGC Southern Early Implementation amid COVID-19

## Discharge Ohio Outcome Data Collection Rates





# CHC/CGC Southern of CT

**Time Commitment & Effort:** 6 clinicians part of a 3 month pilot

- Weekly 1 hour meetings
  - Pilot team + QI directors + Clinical Director
- 3-4 clients per clinician as part of pilot
- Learning curve without formalized training initially
- Development of MIRAHA play book
  - (1-2 hours per week for 2 months) (QI director and Intake Director)
- *Train the trainer model*
  - 8 weeks 1 hour sessions
  - Same time commitment as clinician training
- IT/Clinical collaboration of new MIRAHA questions into clinical charting



# Time Commitment & Effort: ROLL OUT

- Two, 1-hour presentations on MIRA to all clinical staff (18 staff members)
  - Review of playbook
  - Rollout of manual set up to 2-3 cases per clinician
- *Train the Trainer Model*- Full roll out
  - Split into 2 groups with 2-3 trainers per group
  - Automatic scheduling turned on, all clients receive measures
- Weekly 1 hour, weekly meetings (trouble shooting, feedback, using analytics for monitoring compliance/development)
- BI report outside of MIRA for clinician compliance and tracking reasons not completed, batching of required data (OHIO) into outside PIE system



# Longitudinal Benefits

Built in reporting provides insight in usage, outcomes, engagement, and predictive analytics.

## RESULTS

### Observed Results with Mirah

- 120% | Improvement in adult depression remission
- 20% | Decrease in no-show rate
- 40% | Faster reduction in child symptom severity



# CHC/CGC Southern of CT – Next Steps

## EBT (TF-CBT and MATCH) investment

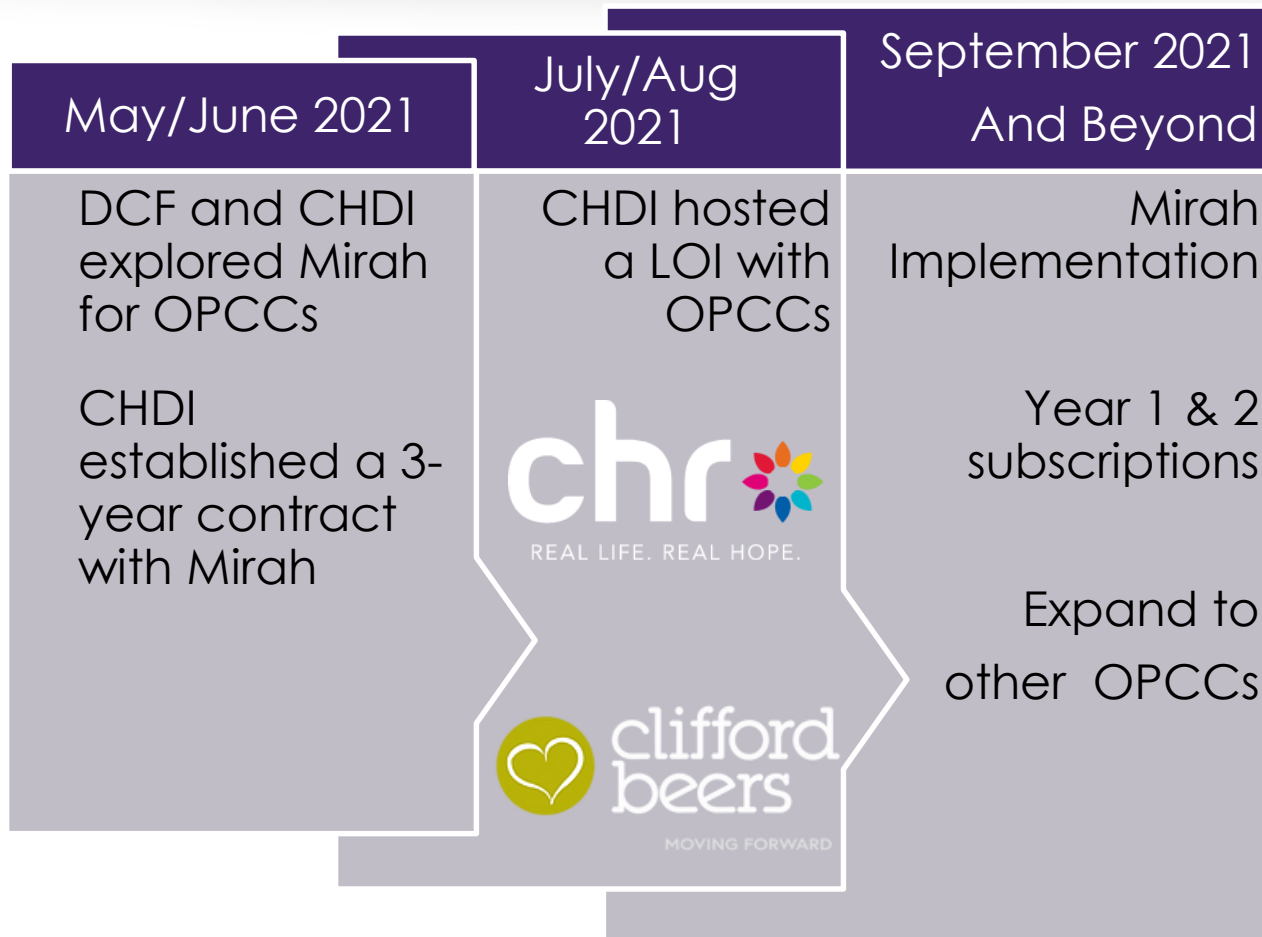
- Build out of TF-CBT measures in MIRAH (complete)
- Pilot clinician to test (pilot stage)
- Batching from MIRAH into EBP (pilot stage)
- Future roll out to TF-CBT team to save clinician data entry time, and get clinicians into one fewer system
- Future hope: Expand MIRAH to ARC

## Research

- Large scale data collection of this kind presents significant opportunities for research
- Nearly limitless opportunities for monitoring interventions



# DCF OPCC Pilot of Mirah Services



# MBC's Role in Alternative Payment Models (APMs)

## MBC

- “Evidenced-based practice”
- Real-time, accurate data collection
- High quality feedback loop for families and youth
- System measurement and reporting
- Feedback for workforce development and performance improvements

## MBC & APMs

- Responsive input
- Accurate activity captures to improve timely reimbursement
- Emerging “Best Practice”
- System-level enhancement





## Q & A Discussion