**Alternative Payment Methodology & Measurement-Based Care**
**September 22, 2021**
**2:00 pm – 3:00 pm**
**Co-Chairs: Eric Schwartz, Tim Marshall, Jeff Vanderploeg**

1. **Welcome & Introductions (:03)**

Tim Marshall opened and welcomed the participants to the 4th meeting of the APM workgroup. Eric Schwartz & Jeff Vanderploeg were out due to other commitments.

2. **Overview of Workgroup Goals, Anticipated Deliverables, and Timeline (:02)**

Tim Marshall reviewed the workgroup goals. He noted plans for future meetings to include presentations of other states' APM efforts. He noted that there would be presenters for the InCK meetings as well and the information would be shared across workgroups. Marshall noted that additional meetings may need to be scheduled in between the monthly meetings to accommodate more presentations and to work toward having recommendations hopefully completed at the November meeting.

3. **Presentation on Mirah, Performance-Based Sustainability Payments, and Measurement-Based Care Approaches (:45)**

Presenters: Jack Lu (CHDI), Daniel Bryant (CHC Middletown), and Shari Fanelli (CGC of Southern CT).

Jack Lu began the presentation on Measurement Based Care Approaches & Incentivization for Alternative Payment Models. Lu noted that over many years CHDI and DCF have worked toward use of performance-based incentives for EBTs including Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Modular Approach to Therapy for Children (MATCH), Cognitive Behavioral Intervention for Trauma in Schools (CBITS) and Bounce Back. They have incorporated quality indicators and measures of performance such as engagement, data collection and improved outcomes. He explained that a portion of incentive funds are reserved for training, coaching and workforce development for clinicians. An additional portion are designated for incentivizing activities specific to the EBT model. Lu emphasized that this type of incentive funding cannot sustain implementation, and is additional to the volume-based reimbursement of services.

Daniel Bryant provided some historical background on the selection of metrics, stating that when reviewing performance improvement goals, physical health programs such as diabetes and weight consultation had real biometrics, but behavioral health focused on productivity goals. Bryant explained that as a Behavioral health provider, he wanted to be able to demonstrate performance improvement comparable to physical health providers through data. In 2018, the Joint Commission announced it would begin requiring MBC. It was required that programs use validated tools to assess outcomes over time, collect and analyze data, and use data to inform practice and supervision. Bryant noted, however, that the requirement was not accompanied by funding, and another participant noted that there was also no guidance provided on implementation.

Bryant explained that in evaluating potential MBCs, Mirah's MBC was a good solution that worked well for the patients. It allowed for assessment of both pediatric and adult clients and only took approximately 7 minutes to complete the assessment. Pricing was competitive and system data entry and supplied analytics were user-friendly and helpful. The reports provided beneficial information, allowing users to see where patients are coming in on average, how well clinicians are

doing, and how sites are doing overall. A participant asked if all of the information was coming from paid claims. Bryant responded no, the information is coming from the web-based Mirah system with the data entered by providers.

Lu introduced an example of Mirah implementation using CGC Southern, one of the OPCC agencies that offers more than one EBT. Following use of Mirah, Lu reported that the agency's collection rates of Ohios increased. CGC Southern had continued to expand and troubleshoot using Mirah as a piece of the puzzle for improvement.

Shari Fanelli reported directly on CGC Southern's experience piloting use of Mirah (3 month pilot). She reported that they started with six clinicians, a clinical director, and Bryant. Each clinician in the pilot had 3-4 clients entered in Mirah. Fanelli explained how the group met weekly and worked on integrating use of Mirah with their EHR and DCF's PIE system. CGC Southern used a train-the-trainer model over an 8-week period and then rolled out Mirah to the full staff. A participant asked if Fanelli could tell anything about client engagement, the extent to which they viewed the information, and how they used it. Bryant responded that they get about 70% of total patients filling out the assessment with 68% fully completing it. Links are sent before every visit. About 75% of clinicians are using Mirah. It's a big cultural shift for many clinicians to begin using this type of real-time data collection method, but it can be very beneficial for clinicians when the system catches something that would be missed otherwise (either a risk or a progress indicator).

A participant asked if patients can review their own data. Bryant answered that patients do not have direct access to their own data, and the therapist would be the one to share and discuss/debrief any data with the patient. Bryant reported that a common complaint from clinicians is that they do not have time. Bryant added, however, that the reports are very user-friendly for clinicians and are easy to hone in on feedback that can be used in sessions to inform care. Results in Mirah can also be shared with clients by the clinicians which can be helpful to demonstrate trends in improvement, etc. Fanelli added that client-identified goals can be added into the system.

Marshall asked if the presenters could share their experience with adolescent substance use and using telehealth. He noted that there have been reports that telehealth is challenging for engaging youth with substance use disorder. Fanelli has noticed that youth are more honest when entering information in Mirah and noted an example where a youth disclosed using substances in the system when the clinician did not otherwise know, and the system flagged it as a risk automatically.

A participant asked if the clients had to log into different software, etc. and if it was bi-directional with the agency's EHR. Bryant explained that there is no software needed, that it is accessed through an online link sent via email or text and is easy to use. He added that unfortunately the EHR his agency uses does not work well with Mirah at this point.

A participant asked if the system allows for conditional questions (e.g., if the response is "yes", another set of questions are triggered for response). Bryant responded that yes Mirah does this, and it is possible to build out measures as needed as well.

Robert Plant from Beacon noted his excitement for the presentation and also referenced the work Beacon is doing on measurement based care.

Lu returned to the presentation and showed a sample dashboard as it would appear if a clinician were sharing the data results with the patient. Fanelli reviewed the components of the dashboard and addressed how it could be used with a client as well as with their parent to discuss changes from session to session and trends over time on given assessments. Bryant discussed its use also as an effective reminder for clients and also the use of the system for predicting no-shows.

Fanelli reviewed the next steps for CGC Southern, which include building out TF-CBT required measures. She is also hoping ARC can be integrated with Mirah in the future as well. Bryant added the potential benefit of using data collected through Mirah for research purposes.

Lu reviewed the timeline of the Mirah OPCC pilot. Following a letter of intent process, CHR and Clifford Beers will join the pilot this fall.

Lu concluded the presentation with a discussion of the relationship between MBC and APM. MBC is not an APM, but can support APM by incorporating high quality and real-time feedback at system and client levels.

Marshall then thanked the presenters and opened the discussion for a few questions. A participant asked how this kind of data collection can shed light on early childhood traumas to potentially prevent more complex needs later. Bryant responded that while these are complex issues that have greater systemic context that would need to be addressed, it's possible to build in questions that could identify trauma, needs, etc. that could help the clinician support the child and family toward better outcomes.

A participant asked about the connection between the measurements presented and an APM. Lu answered that collecting the data can demonstrate outcomes over time. The outcomes can be utilized for reimbursement. Marshall noted that ultimately the question for this group is what would CT like to do in relation to an APM and what components of APM would be good for CT. At this point there is no recommendation on any particular platform or measures.

4. **Wrap-Up, Final Thoughts, Future Directions, Adjournment (:10)**

Marshall stated the next meeting is on October 27th followed by a meeting in November, and adjourned the meeting at 3pm.

5. **CHAT BOX:**

All Chat Box questions were addressed during the discussion and are reflected in the minutes above.