Getting to the ‘big picture’

Development of composite scoring systems for mental health and substance use programs

Shannon M. Campbell, MPP
Senior Research & Evaluation Analyst
Mental Health & Addiction Services, Multnomah County Health Department
Portland, Oregon

Contact information: shannon.campbell@multco.us
Background

- Health plans and providers already track multiple metrics
  - Federally- or state-mandated, HEDIS, grant-mandated, internal quality, etc.

- How do we:
  - See the “big picture” for how an agency is doing currently?
  - Reward strong performance?
Background

- Composite scoring
  - Used in multiple sectors to bring together different measures into one score, from the very simple to the very complex

- Examples: CMS’ HQI (for hospitals) and MIPS (for medical providers)
Preparation & process

- Identify areas of interest: what contributes to quality care (processes), what are signs of quality care having occurred (outcomes)?
  - Concepts like easy access or reduced hospitalizations
- Specific metrics gathered from what we already collect, what literature or national agencies suggest (HEDIS, CMS, ASAM, SAMHSA, etc.)--operationalizing those areas of interest into something we can measure with the data we have
- Collaboration with providers throughout all of the above
Metrics & benchmarks: mental health case rates

- **Access**
  - Appointment offered within 14 days (85%)
  - DHS youth receiving assessments within 60 days of referral (80%)

- **Initiation and retention**
  - Clients with second appointment within 30 days of their first (85%)
  - Clients reaching minimum number of sessions within 6 months (minimum varies by level of care) (75%)
M & B: mental health case rates

- Case management
  - Adult clients with schizophrenia with 1+ case management encounter every 90 days of active services (90%)
- Acute care
  - Discharges receiving follow-up within 7 days (90%)
  - Rate of subacute and psychiatric hospitalization bed days (benchmark is expected utilization, based on case mix)
- ACORN implementation and results (pending)
M & B: substance use detox

- Care transitions
  - Approved SUD residential, outpatient, or MAT encounter during detox or within 14 days after (50%)
  - Opioid use disorder clients not previously on MAT who induct during detox or within 14 days after (25%)

- Readmissions
  - Readmissions to detox within 30 days (<10%)
M & B: substance use residential

- Coordination of care
  - Approved SUD outpatient or MAT encounter, during tx. or within 7 days after (50%)
  - 1+ primary care encounters, during tx. or within 30 days after (75%)
  - OUD clients with 1+ MAT encounters during tx. or within 7 days after (50%)

- Engagement and retention
  - Clients who leave in <7 days (and do not return or transfer to another facility within 3 days) (<10%)
  - 21+ consecutive days in treatment (70%)
M & B: substance use residential

- Acute care
  - Clients encountering emergency services for substance overdose/poisoning during tx. or within 90 days after (<2.5%)
  - Clients experiencing behavioral health-based ED/inpatient hospitalizations during tx. or within 90 days after (<5%)
M & B: substance use outpatient

- Coordination of care
  - 1+ primary care encounters, during tx. or within 30 days after (65%)
  - OUD clients with 1+ MAT encounters during tx. or within 7 days after (30%)

- Engagement and retention
  - Clients with 3+ encounters in first 30 days (65%)
  - New clients with at least 90 days in tx., averaging 4 encounters per month (not counting UAs) (55%)
M & B: substance use outpatient

- Acute care
  - Clients encountering emergency services for substance overdose/poisoning during tx. or within 90 days after (<2.5%)
  - Clients experiencing behavioral health-based ED/inpatient hospitalizations during tx. or within 90 days after (<2.5%)

- Other
  - Clients averaging 1+ UA every 30 days in services (75%)

**OTP-specific metrics TBD; want to make sure we are aligned with Wheelhouse and HSO MAT data workgroup**
Bringing it all together

- Opportunity scoring
  - Flexible and dynamic: measures weighted according to their relevance to each agency
    - E.g., if a measure applies only to a few clients, any impact (positive or negative) is small
    - Can still make small adjustments for weighting purposes (e.g., if a single measure tends to dominate due to a large denominator)
  - Agencies measured on benchmarks, not on perfection
    - E.g., if the goal is 85% access, your subscore is whatever percentage you achieved divided by 85, not by 100; “extra credit” can be earned to help with shortfalls on other measures
Application

- Mental health
  - Agency’s score totaled, compared to their total benchmarks (what would the “perfect agency” with this case mix, this number of clients, score?); grades of A+, A, B, C, D, F assigned
  - First round of incentive dollars are being distributed to the highest performing agencies this spring, according to their grade and proportionate to the number of clients they serve

- Substance use
  - Scoring process and grading will be similar; implementation and application TBD--still in draft stage, finalizing measures and benchmarks
Questions?