They Say PROVE IT!

You have the DLA-20!!!

Presented by:

Michael Flora, MBA, M.A.Ed.

Senior operations and Management Consultant

MTM Services

E-mail: michael.flora@mtmservices.org

Web Site: mtmservices.org

Presented by:

Willa Presmanes, M.Ed., M.A.

Medical Necessity/UM Consultant, Co-Author of the DLA-20

Email: Willa.Presmanes@MTMServices.org

Web Site: mtmservices.org

- How does your provider organization demonstrate value through attainment of measurement-based goals and clinical outcomes? This session will focus on the strategies through the use of the DLA-20 to incorporate the "Golden Thread" and report clinical improvement for those we serve to the Board of Directors, community stakeholders and payers

Learning Objectives:

- List proven strategies to show value and cost through Level of Care and outcome measurement

- Describe proven strategies in the use of the DLA-20 to demonstrate improvement and goal attainment

- Review sample dashboards and clinical reporting for Key stakeholders, payers and board members

MCO and Provider Network "Values" Needed

Under a MCO Management Model the **Value** of Behavioral Health Service providers will depend upon our ability to:

1. Be Accessible (Fast Access to all Needed Services)
2. Be Efficient (Provide High quality Services at Lowest Possible Cost)
3. Ability to focus on mergers and acquisition in an Integrated Healthcare environment – Establishing a business case that supports valued partner status
4. Electronic Health Record capacity to connect with other providers in the BH/IDD arena and quickly with physical health providers MCOs.
5. Focus on Episodic Care Needs and Treat to Target Models
6. Ability/Willingness to participate in Bundled/Case Rate Shared Risk Payment Models
7. Produce Outcomes!
   - Engaged Clients using Natural Support Networks
   - Help Clients Self Manage Their Health, Wellness and Recovery
   - Reduce Need for Emergent/ High Cost Services

Healthcare Reform Shared Risk/Shared Savings Payment Models

- Full Risk Capitation/Sub-Capitation Rates (Per Member per Month) – MCO/BHO Risk
- Partial Risk Outpatient Only Capitation/Sub-Capitation Rates – Provider Network Risk
- Bundled Rates/Episodes of Care Rates – Shared Risk
- Stratified Case Rates – Shared Risk
- Case Rates – Shared Risk
- Prospective Payment System (PPS) – Shared Risk
- Global Payments – Shared Risk (Payment based on a zero-based budgeting exercise that integrates complexity and severity of population served which will determine how many and what types of clinicians are needed to support a team based health and wellness approach.)
- Capped Grant Funding – Shared Risk
- Performance Based Fee for Service – Shared Risk
- Fee for Service – High Payer Risk

Shift in Payment Model…

1. As Value Based Payment Models are implemented, new models of "shared risk "funding are being introduced.

2. A shift by payers such as Medicaid, Medicare and Third Party Insurance from "**paying for volume"** to "**paying for value**" provides a significant challenge for CBHOs.

3. A large majority of CBHOs do not have an ongoing awareness of their authorization requirements, UM/UR criteria under episode of care, write offs due to not meeting payer specific requirements and cost of services or cost of processes involved in the delivery of services (i.e., "What is your cost and time to treatment?")

Provider "Business Case" Core Elements

1. Incorporate as much objective data as possible to support awareness of service delivery capacity being delivered by association members

2. Provide demographic, diagnostic and population groups served information.

3. Provide service locations/clinics by county/region with a companion service array table to support awareness of services/programs available

4. Identify qualitative outcomes that provide a shift from "providing services" to focus on "VALUE of Care"

5. Identify the cost of services delivered and outcomes achieved to objectively measure "Value"

6. Identify "unique factors" that association members can provide (i.e., historical community based case management/ coordination of care experience, etc.)

"Value-Based Purchasing" Model

1. Payment Reform is moving from *"paying for volume to paying for value/quality"*

2. VBP requires integration of our clinical, quality and financial information and the ability to track and analyze costs by consumer, provider, team, program, and payor and can operate effectively under fee for service, case rate, and sub-capitation payment models in order to succeed under a variety of Pay for Performance (P4) bonus arrangements.

3. Ability of all staff to develop a dynamic tension between "quality" and "cost" as if they are on a pendulum

Value of Care Components

"Value" of Care Equation

1. **Services provided** – Timely access to clinical and medical services, service array, duration and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs

2. **Cost of services** provided based on current service delivery processes by CPT/HCPCS code and staff type

3. **Outcomes achieved** (i.e., how do we demonstrate that people are getting "better" such as with the DLA-20 Activities of Daily Living)

4. **Value is determined** based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.

"Value" of Care Equation

Outcomes achieved (i.e., how do we demonstrate that people are getting "better"

Medical Necessity Defined

- **Medical necessity** starts with a practitioner evaluating a client or patient and authorizing or rendering services that fall within the scope of their license.

- Medically necessary services are those that prevent the client from getting worse (either deteriorating or prolonging the illness) or developing new problems.

- The definition also **asserts the role of medically necessary services in dealing not just with the symptoms or signs of an illness but the impact of the illness on the ability of the individual to function**. This speaks directly to rehabilitation services, which are primarily focused on maintaining or raising the functional level of the client.

Sources: **Ohio SOQIC Standardized Documentation Training Manual**, 2004;
http://www.balancingincentiveprogram.org/resources/example-core-standardized-assessment-instruments-level-ii, 2013

The outcome focus in 2018 is on

- **Measurement-Based Care (MBC)** is routine practice throughout the medical and surgical fields – from blood pressure cuffs to A1c tests for diabetes. Yet today, only 18% of psychiatrists and 11% of psychologists routinely administer simple measurement tools, such as symptom and functional rating scales, to monitor their patients' progress. As a result, millions of patients seeking help for their behavioral health disorders are missing important opportunities to have their treatments adjusted in a timely manner, possibly leading to worsening symptoms that may be going altogether undetected by their providers.

- **Measurable outcomes** are required by JCAHO, CARF, CMS Medicaid/Medicare/other payers and for compliance in parity law.

- **PROVE that clients are getting better!**

What is MBC*?

Measurement Based Care

1. Use objective standardized outcome measure

2. Use standardized measure in a standardized process

3. Use to measure impact & drive client change

▶ The Kennedy Forum has made available a paper on this subject and a list of tools.

- https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf

* The Joint Commission (JCAHO, January 2018) requirements

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▶ **Standard CTS.03.01.09** — The organization assesses the outcomes of care, treatment, or services provided to the individual served.

   — **EP 1** — The organization uses a standardized tool or instrument to monitor the individual's progress in achieving his or her care, treatment, or service goals.

▶ **EP 2** — The organization gathers and analyzes the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual's plan for care, treatment, or services as needed.

▶ **EP 3** — The organization evaluates the outcomes of care, treatment, or services provided to the population(s) it serves by aggregating and analyzing the data gathered through the standardized monitoring effort.

Source: The Joint Commission, January 2018 Revised Standards
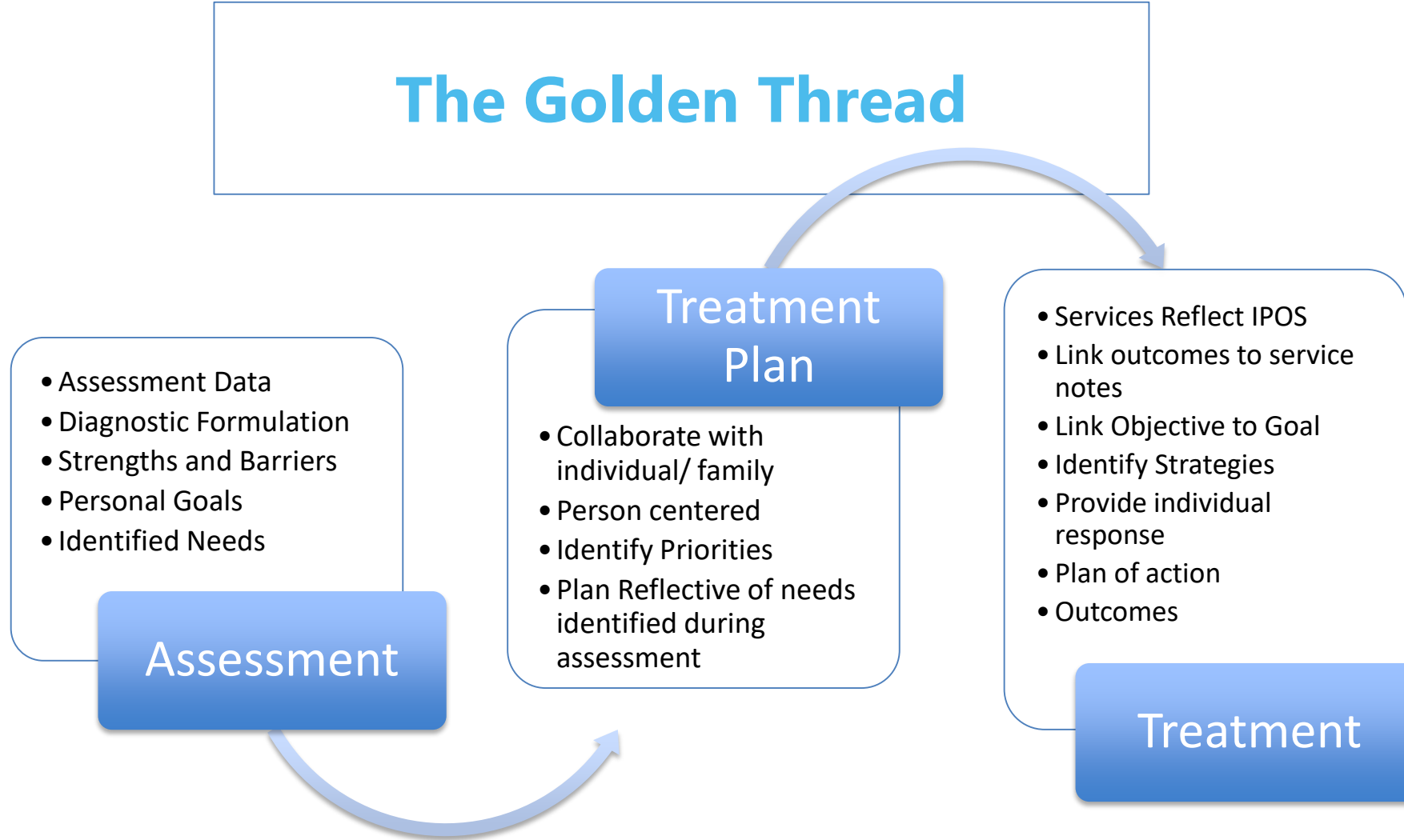
The DLA-20© (Daily Living Activities – 20) is standardized!

We have definitions and qualifiers with well-established reliability and validity as a repeated measure of change in Severity of Illness (ICD-10 4th digit & ICF), Level of Care (LOC) & DSM-5 counts of serious disturbances.

- **Consistent**
  - Different people rate the same client similarly over same period

- **Sensitive**
  - Not all patients with the same illness will be rated similarly

- **Relevant**
  - Ratings guide treatment focus

- **Service-driven**
  - Ratings determine amount of appropriate services/levels of care

- **Outcome-driven**
  - Document true improvements over time with repeated measures

The DLA-20 has qualifiers or anchors for each of 20 defined variables scored on a 7 point rating scale

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| DAILY LIVING ACTIVITIES SCALE (DLA) ANCHORS	1- Extremely severe functional impairment, needs pervasive level of continuous paid supports	2- Very severe functional impairment, needs extensive level of continuous paid supports	3- Severe functional impairment, needs moderate level of continuous paid supports	4- Moderate functional impairments, needs low level of continuous paid supports	5- Mild functional impairment, needs moderate level of intermittent paid supports	6- Very mild functional impairment, needs low level of intermittent paid supports	7- No significant functional impairment, no need for paid supports.
Health Practices: Rate independent self-care for physical and mental health, including treatment plan compliance and medication compliance (if applicable).	No self-care and approaching health endangering threat, relies on pervasive assistance (example: multiple and lengthy stays in protective environment)	Marked limitations in self-care and compliance, relies on extensive assistance (e.g. in and out of protective environment).	Limited self-care and compliance, often relies on the continuous assistance of helping persons for health care.	Marginal self-care and compliance, relies on the regular assistance of helping persons.	Moderately sufficient self-care and compliance, relies on the routine assistance (e.g. home visits by helping persons), in private or self-help residences.	Adequate self-care and compliance with minimal support (e.g. some assistance from neighbors, friends, other helping persons).	Optimal self-care and compliance, with no assistance from others.
Housing Maintenance: Rate self-sufficiency for maintenance of adequate housing, management of household	Not self-sufficient, approaching health endangering threat, relies on pervasive supervision in protective environment, does not participate in household maintenance.	Marked limitations in self-sufficiency, relies on constant supervision and extensive assistance in protective environment, participates in household maintenance a little bit of the time.	Limited self-sufficiency, relies on continuous assistance, in private or self-help environment, occasional participation in household maintenance.	Marginal self-sufficiency, often relies on regular assistance in private or self-help environment, participates in household maintenance some of the time.	Moderate self-sufficiency, relies on routine assistance in private or self-help residences (e.g. home visits by helping persons), participates a good bit of the time in household maintenance.	Adequate self-sufficiency with minimal assistance (e.g. some support from neighbors, friends, other helping persons).	Optimal self-sufficiency with no significant assistance.
Communication: Rate continual, effective communication	Not effective in communicating with others, extremely dependent on assistance.	Very limited effectiveness in communicating with others, very dependent on assistance.	Limited effectiveness in communicating with others, dependent on assistance.	Marginal effectiveness in communicating with others, uses regular assistance.	Moderately effective in communicating with others, uses routine assistance	Adequately effective in communicating with others, minimal need for assistance	Optimal effectiveness in communicating with others, no significant assistance needed.
Safety: Rate maintenance of personal safety	No self-protection approaching health endangering threat, relies on pervasive level of continuous supervision.	Marked limitations in self-protection relies on extensive level of continuous supervision.	Limited self-protection, relies on moderate level of continuous supervision.	Marginal self-protection, relies on regular assistance and monitoring.	Moderate self-protection, relies on routine assistance or minitoring (e.g. home visits by helping persons).	Adequate self-protection with minimal assistance needed (e.g. some support from neighbors, friends, other.	Optimal self-protection with no significant assistance from others.

MTM Behavioral Health Benefit Package Design – Level of Care Criteria
Adult Services
Integrates Recovery, Outcomes, Systems Finance, Compliance, and Advocacy
Initiatives

Level of Care # 4	Service	Amount	Add-Ons	Average Cost
Indicators of Level: • Primary DSM-V of: Schizophrenia; Major Depressive Disorders; Bipolar Disorders; Other Psychotic Disorders; or Schizoaffective Disorder. <u>And</u> • DLA20 >2.1 and < 4.0 or mGAF 21 – 40 • ICD10 4th digit severity modifier = 3 **OR** • DSMV Diagnosis of Moderate to severe Substance Use Disorder (>=4 symptoms) ASAM PPC-2R Level I OR • Co-Occurring DSM-V Diagnoses (Mental illness & Substance abuse/dependence) • ASAM PPC-2R Level I	**Recommended Length of Services: 2 to 5 years**			
	1. Diagnosis/Assessment	☐ Maximum of 4 contacts per episode of need	☐ Mental Health Education & Referral	
	2. Crisis Interventions	☐ As needed, no maximum	☐ Hotline Services	
	3. Counseling/Psychotherapy:	• Up to 12 Individual Sessions per episode of need • Up to 12 group sessions per episode of need	☐ AA/NA Support Groups	
	4. Medication/Somatic Services	• Psychiatric Evaluation within 2 weeks of admission. • Minimum of 1 contact a month with Medical Staff, until stable on meds	☐	
Additional/Optional Service Eligibility: • Severe Levels in at least 7 of the 20 Daily Living Activities (DLA20®) OR 3 of the 10 Multnomah Community Assessment Scale categories OR ___ of Colorado CCAR or - __ Fla. FFARS or ____ for LOCUS • Client willingness to participate in services as documented on Tx Plan	**5. Comprehensive Community Support Services (CCSS):**	• Staff must offer an average of three face-to-face contacts per week per consumer and one contact per week to consumer's supports • The frequency of contacts with an individual consumer at any one time will depend on the needs and preferences of the individual consumer.	☐ Peer support ☐ Supported Employment - at least 1 visit per month ☐ Supported Housing - at least 4 visits per month ☐ Respite or close family supervision	
	6. Psychosocial Rehabilitation Services (PSR)	• Integrated Model Program • Individual Classes	☐ Drop-in Program	

IMAGINE ILLNESS:
Challenging symptoms;
Housing or money stressors;
Unsatisfactory communication
    around wants and needs;
Unsafe practices, decisions;
Poor sleep, no regular routine;
Irregular appetite or
    regular stomach distress;
Stressed relationships;
Dependent on alcohol or
    drugs, opiates or cigarettes;
Risks to sexual health
Unhealthy oral hygiene
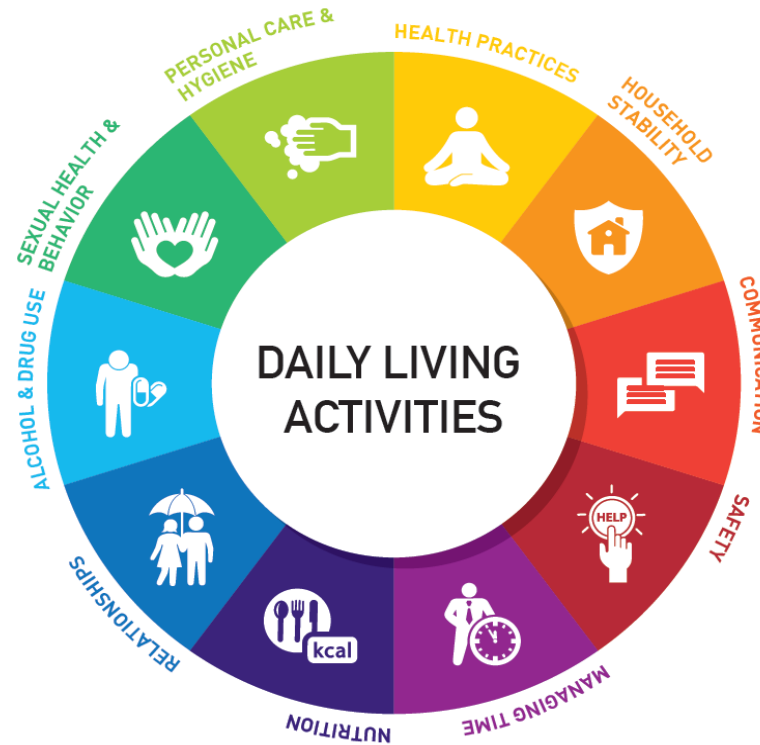
IMAGINE WELLNESS, OUTCOMES:
Manage fewer symptoms;
Stable residence, bills;
Clearer communication &
    satisfied needs;
Safe decisions, coping;
Improved sleep and
    time management;
Good nutrition, less
    stomach distress;
Supportive relationships;
No dependence on
    alcohol/drugs;
Sexual health;
Healthy oral hygiene;

SOON

DAILY LIVING ACTIVITIES

PERSONAL CARE & HYGIENE · HEALTH PRACTICES · HOUSEHOLD STABILITY · COMMUNICATION · SAFETY · MANAGING TIME · NUTRITION · RELATIONSHIPS · ALCOHOL & DRUG USE · SEXUAL HEALTH & BEHAVIOR

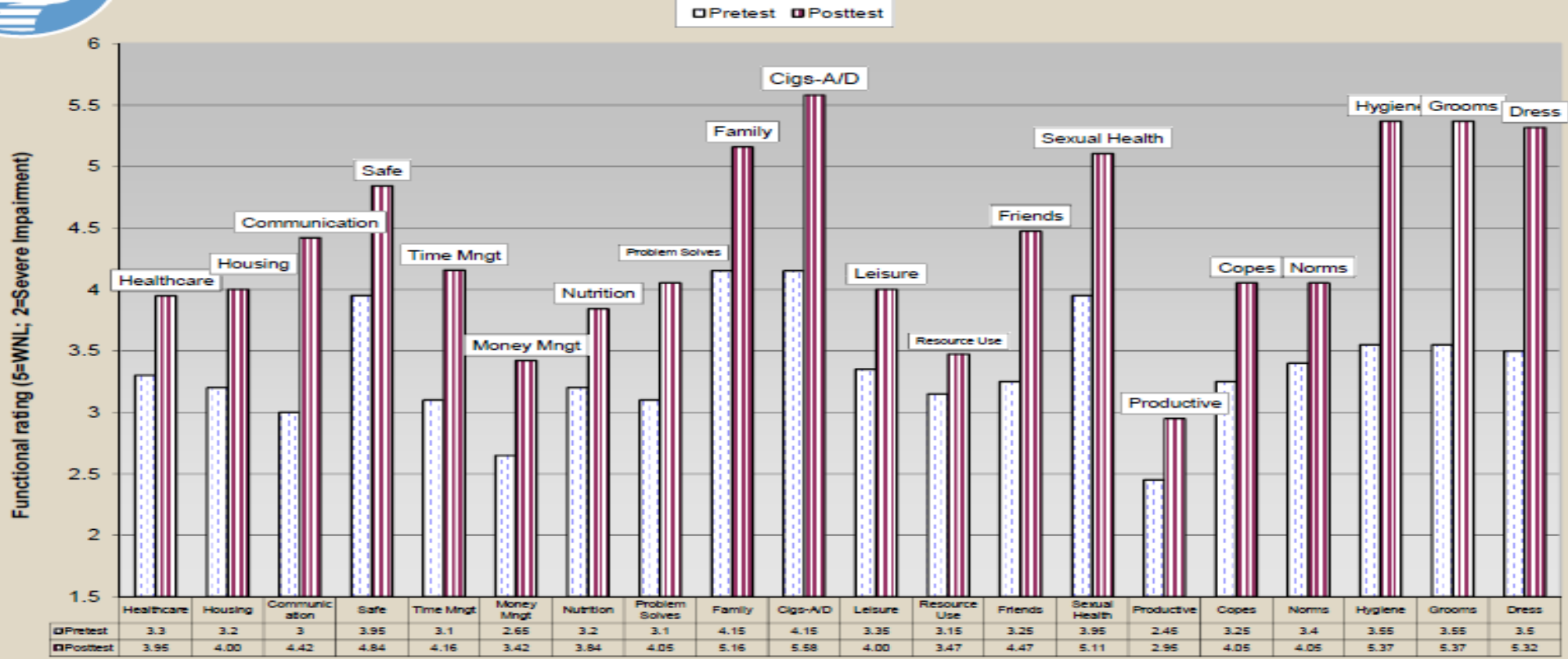JCAHO EP1: Standardize IMPACT OF SYMPTOMS TO DRIVE CLIENT CARE, OUTCOMES

HOW DO STANDARDIZED TOOLS HELP YOU PROVE VALUE, THAT CLIENTS GETTING BETTER?

www.TheNationalCouncil.org

Sample Agency Results

□Pretest ■Posttest

	Healthcare	Housing	Communication	Safe	Time Mngt	Money Mngt	Nutrition	Problem Solves	Family	Cigs-A/D	Leisure	Resource Use	Friends	Sexual Health	Productive	Copes	Norms	Hygiene	Grooms	Dress
Pretest	3.3	3.2	3	3.95	3.1	2.65	3.2	3.1	4.15	4.15	3.35	3.15	3.25	3.95	2.45	3.25	3.4	3.55	3.55	3.5
Posttest	3.95	4.00	4.42	4.84	4.16	3.42	3.84	4.05	5.16	5.58	4.00	3.47	4.47	5.11	2.95	4.05	4.05	5.37	5.37	5.32

DLA

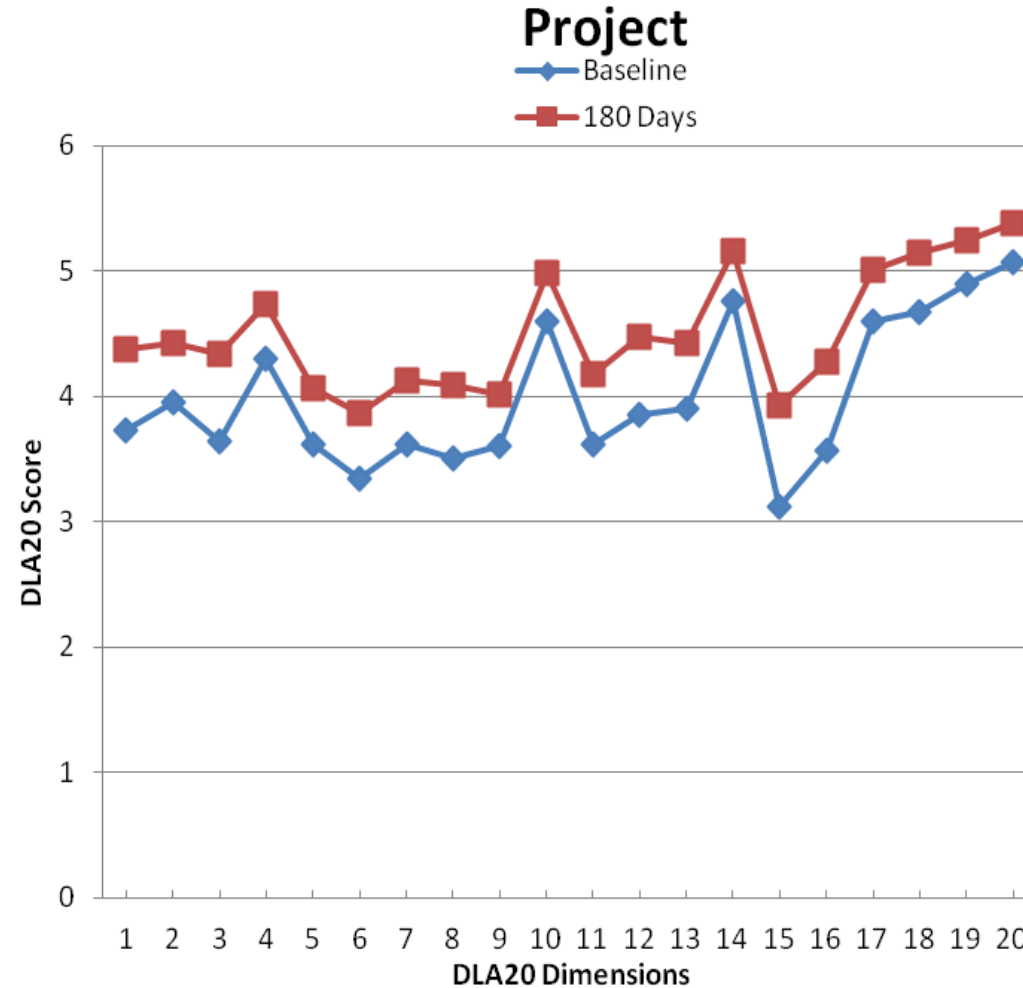Highlighted Areas improved by >/= .3 points

Overall Improvement In 20 Activities of Daily Living (ADLs) Measured in the DLA-20

Average Baseline and Final DLA20 Scores Overall Project

JCAHO EP 2, 3, 2018: What is standardized process?

Standardization is the process of developing and implementing criteria or anchors based on the consensus of different parties that include users (providers), interest groups (payers), programs and governments. Standardization can help to maximize compatibility, interoperability, safety, repeatability AND QUALITY.

1) Data are routinely collected at multiple points in time.
2) Progress (i.e., toward the desired outcome) is monitored and evaluated. They are analyzed and delivered to the service provider as objective feedback. Analysis can be used to inform goals and objectives, monitor individual progress, and inform decisions related to changes in individual plans for care, treatment, or services.

DLA-20 Average Composite Scores standardizes Severity of Illness (4th digit modifier) for ICD-10

- *Adequate Independence (DLA-20 >=6)*: No difficulty means the person has **no problem**
- *Mild difficulty (DLA-20 = 5.1 -6)* means problem is present less than 25 percent of the time with intensity a person can tolerate and happened rarely over the last 30 days
- *Moderate difficulty (DLA-20 = 4.1 - 5)* means problem is present less than 50 percent of the time with moderate intensity that is interfering in the persons' day-to-day life and happened occasionally over the last 30 days
- *Serious difficulty (DLA-20 =3.1 -4)* means problem is present more than 50 percent of the time with severe intensity that is partially disrupting the persons' day-to-day life and happened frequently over the last 30 days.
- *Severe difficulty (DLA-20 = 2.1 -3)* means problem is present more than 75 percent of the time with severe intensity disrupting the persons' day-to-day life and happened frequently over the last 30 days.
- *Extremely severe (DLA-20 <=2)* indicates complete difficulty, a problem that is present more than 95 percent of the time with intensity that is totally disrupting the persons' day-to-day life and happened every day over the last 30 days.

Source: (www.who.int/classifications/icf/icfchecklist.pdf (12/5/2014)

Example of Standardization Process:
MEDICAL DECISION MAKING for TREATMENT PLANING, DISCHARGE: Lambert and colleagues generate four categories of outcomes to report to providers.

- White Message—The Client is functioning in the normal range. Consider Termination or lowest levels of care.

- **Green Message—The rate of change the client is making is in the adequate range. Consider revising treatment plan to meet new need or continue the treatment plan as recommended.**

- Yellow Message—The rate of change the client is making is less than adequate. Recommendations: consider altering the treatment plan by intensifying treatment, shifting intervention strategies, and monitoring progress especially carefully. This client may end up with no significant benefit from therapy.

- **Red Message—The client is not making the expected level of progress. Steps should be taken to carefully review this case and decide upon a new course of action such as referral for medication or intensification of treatment. The treatment plan should be reconsidered.**

What does MBC look like when we put objective, standardized numbers to the health issues?
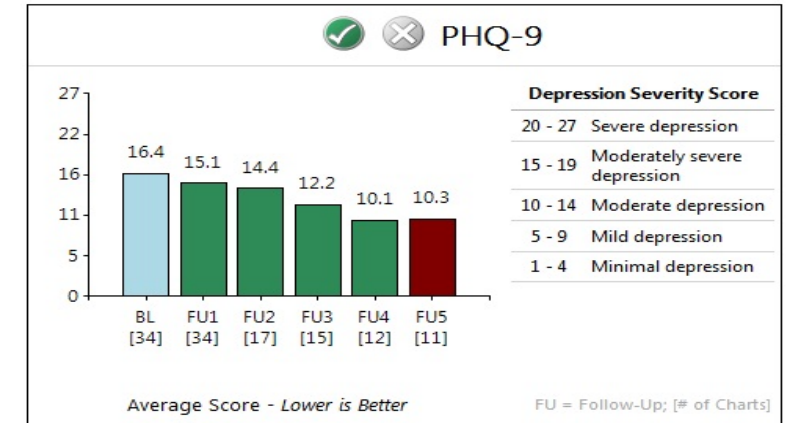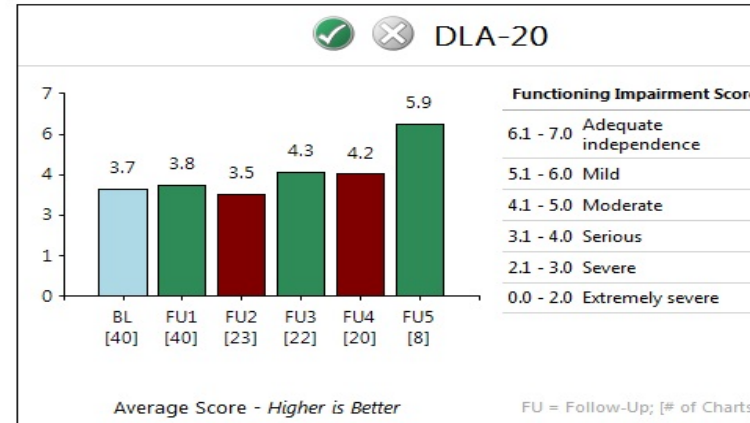
You can see and track initial challenges, then change in behavioral health, hopefully improved scores over time:
1) Less symptoms so reduced PHQ9 scores

AND
2) Better functioning in ADLs so higher DLA-20 functional assessment scores

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Admit Date - Start: 08/01/2009
Admit Date - End: 03/24/2016
Programs: [All Programs]

Trending DLA-20 and PHQ-9 Results

DLA-20

Functioning Impairment Score	
6.1 - 7.0	Adequate independence
5.1 - 6.0	Mild
4.1 - 5.0	Moderate
3.1 - 4.0	Serious
2.1 - 3.0	Severe
0.0 - 2.0	Extremely severe

BL [40]: 3.7, FU1 [40]: 3.8, FU2 [23]: 3.5, FU3 [22]: 4.3, FU4 [20]: 4.2, FU5 [8]: 5.9

Average Score - Higher is Better   FU = Follow-Up; [# of Charts]

PHQ-9

Depression Severity Score	
20 - 27	Severe depression
15 - 19	Moderately severe depression
10 - 14	Moderate depression
5 - 9	Mild depression
1 - 4	Minimal depression

BL [34]: 16.4, FU1 [34]: 15.1, FU2 [17]: 14.4, FU3 [15]: 12.2, FU4 [12]: 10.1, FU5 [11]: 10.3

Average Score - Lower is Better   FU = Follow-Up; [# of Charts]

Patient Improvement Matrix

	PHQ-9 Not Improved	PHQ-9 Did Improve	
	1 (3.3%)	22 (73.3%)	DLA-20 Did Improve
	3 (10.0%)	4 (13.3%)	DLA-20 Not Improved

# of Patients w/at Least 2 Completed DLA-20 & PHQ-9

Trending Comparison

— DLA-20 Avg   — PHQ-9 Avg
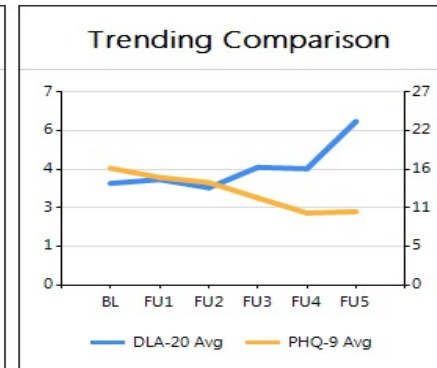
Form Summary Data

Instance	DLA-20				PHQ-9	
	Charts	Avg	mGAF	SOI	Charts	Avg
Baseline	40	3.7	36.9	2.0	34	16.4
Follow-Up 1	40	3.8	38.3	1.8	34	15.1
Follow-Up 2	23	3.5	35.3	1.9	17	14.4
Follow-Up 3	22	4.3	42.7	1.3	15	12.2
Follow-Up 4	20	4.2	42.2	1.3	12	10.1
Follow-Up 5	8	5.9	59.4	0.0	11	10.3

Data comes from Patients who have at least 2 signed versions of the PHQ-9 and the DLA-20 forms and were admitted within the filter date range.
The PHQ-9 form contains 9 questions with answers ranging from 0 to 3 with 0 being best.
The DLA-20 form contains 20 questions with answers ranging from 1 to 7 with 7 being best. 5, 6, and 7 are considered "Within Normal Limits".
For each Form, the Baseline is the form with the first signed date. Each Follow-Up # is in the sequence of signature dates. Only the first 5 Follow-Up Forms are recognized in this report.

Trending DLA-20 and PHQ-9 Results - v3.0.0   Page 1 of 1   Run on 2/24/2016 9:57:57 AM
(deployed 2/23/2016)

So, can you prove your value? If you've got DLA-20 – yes!
If NO, choose tools that will measure VALUE - Are your clients getting "Better"?

- What **standardized** outcome measurement tool is your center using and, alternatively, which standardized tool is being used by all CBHCs statewide?

- Is the measure symptom focused or functionality focused?

- Is there good inter-rater reliability?

- Do the direct care staff that are using the measure consider it "helpful" to support initial and updated treatment planning needs?

- Can the outcome measurement be directly linked to the level of severity for DSM 5 and the fourth digit modifier for ICD-10 (Severity of Impairment)?

- Do you have data measurement and reporting capacity to graphically share with staff and clients the progress being achieved tied to the cost of services being provided?

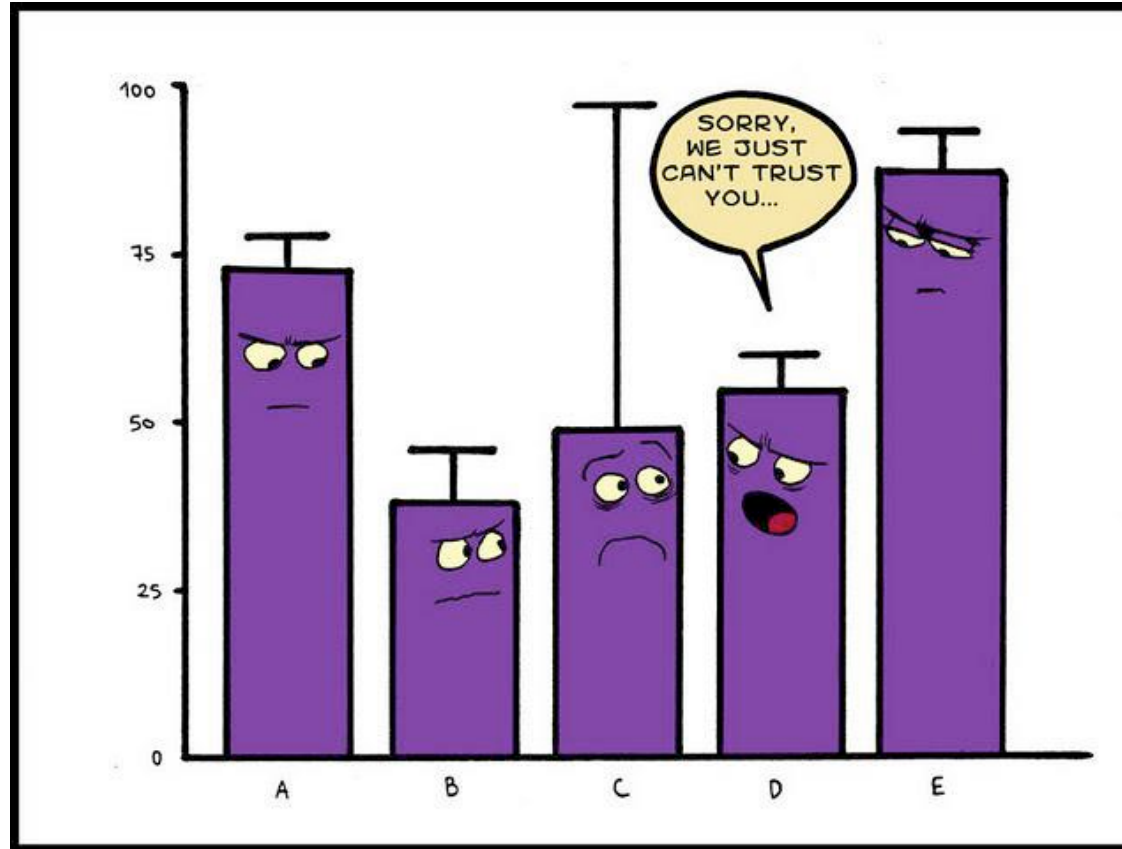# States Adopting Statewide Standardized DLA-20 Functionality Outcome Measure

- Kansas
- Maryland
- Mississippi
- Missouri
- North Dakota
- Rhode Island
- South Carolina
- Utah
- Wyoming

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What does your data tell you?

Questions?