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# Quality Indicators for Physical and Behavioral Health Care Integration

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## Earlier this year

Secretary Sylvia Burwell of the US Department of Health and Human Services announced measurable goals and a timeline to move the US health care system "toward paying providers based on the quality, rather than the quantity of care they give patients."[1] In April, Congress passed the Medicare Access and CHIP Reauthorization Act of 2015 (HR 2) to repeal the sustainable growth rate formula and develop options for alternative, value-based payment models for Medicare.[2] These initiatives are in pursuit of the "triple aim" of better health care quality, improved population health, and more affordable health care. Achieving these goals will require a robust set of quality metrics that are especially focused on high-need/high-cost patient populations. The interface of behavioral (including mental health and substance use conditions) and general health care is an especially promising area for leveraging change of the status quo.

## The Interface of Behavioral Health and General Health Care

The World Health Organization has stated "the magnitude, suffering, and burden in terms of disability and costs for individuals, families, and societies are staggering" and documented that 4 of the 6 leading causes of years lived with disability are due to psychiatric disorders (depression, alcohol-use disorders, schizophrenia, and bipolar disorder).[3] Behavioral health issues are also associated with high utilization and medical spending, particularly in instances where there is comorbidity with other physical health conditions. A report from the Center for Health Care Strategies found that "Mental illness is nearly universal among

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the highest-cost, most frequently hospitalized [Medicaid] beneficiaries….”[4] Moreover, a recent report by the Agency for Healthcare Research and Quality showed that 4 mental health or substance use disorders were among the top 10 conditions resulting in the most all-cause, 30-day readmissions for Medicaid patients during 2011.[5]

Individuals with behavioral health issues often have many comorbid general medical conditions (eg, cardiovascular diseases, high blood pressure, diabetes, arthritis, digestive disorders, and asthma), and many have a shorter life expectancy of more than 2 decades compared with the general population.[6] At the same time, chronic general medical illnesses are often accompanied by behavioral health issues, which increase the risk for serious complications and premature death. For example, a 35-year-old man with schizophrenia, diabetes, and tobacco dependence can expect an up to 25-year shortened life span and increased medical costs. A 60-year-old woman diagnosed with diabetes, congestive heart failure, and depression is at risk of frequent hospitalizations, poor self-management, treatment nonadherence, and being an early candidate for long-term care. A 25-year-old woman with human immunodeficiency virus infection and posttraumatic stress disorder who uses intravenous drugs may experience frequent visits to emergency departments and may have nonadherence to medication and increased medical costs.

Effective integrated care models exist, but have not yet been widely implemented. Promising new programs for integration of mental health care in primary care settings offer important opportunities for innovation in how care is delivered. Leading models, such as the collaborative care model, have demonstrated significant cost savings in low-income, high-risk populations with medical comorbidity compared with traditional care models.[7] Nevertheless, there have been few incentives (and some disincentives) to improve linkages between general and behavioral health care practitioners or to apply effective integrated care models on a large scale. Although multiple initiatives for integrating behavioral and general medical services have demonstrated improved patient outcomes and potential savings, actual implementation and “scaling up” of effective strategies have been limited. An important barrier has been the failure to develop and apply incentive, payment, and improvement strategies that reinforce best practices and outcomes for integrated care for patients.

## Gaps in Quality Measurement and Opportunities for Improvement

The key to implementation of these integration strategies is the development of meaningful and valid quality measures. Until recently, the field has largely responded with measures that address narrow condition-specific targets that focus on limited care processes. Of the 611 measures endorsed by the National Quality Forum, only 31 are mental health or substance use measures, 4 of which are at the interface of behavioral and general medical care.[8] Moreover, only 1 of 33 quality measures for the Centers for Medicare & Medicaid Services accountable care organization program is targeting behavioral health: screening for clinical depression and providing a follow-up plan.

There is an opportunity for quality care measurement strategies to meet the needs of organizations focused on population-based care, such as accountable care organizations and related models of bundled care payment. Almost a decade ago, the Institute of Medicine

issued a report on adapting *Crossing the Quality Chasm* for mental health and substance abuse care. The Institute of Medicine Committee noted that the quality measurement infrastructure and capacity to develop and effectively apply quality measurement and improvement strategies in this area are significantly underdeveloped, especially linkages among the silos of mental health, substance use, and general health care.[9] Although the committee also issued recommendations to build this infrastructure and overcome measurement barriers, relatively few of the recommendations have been implemented in a robust manner.

## Toward Improved Measurement of the Value of Integrated Care

In addition to broad insurance reform, the Affordable Care Act mandates parity of insurance benefits between behavioral and general health care as well as the establishment of health homes for individuals with complex chronic conditions. These initiatives have been bolstered by further programs such as the Primary and Behavioral Health Care Integration grants from the Substance Abuse and Mental Health Services Administration and newly legislated programs like Section 223 of the Protecting Access to Medicare Act to establish certified community behavioral health centers. Now value-based care has been further prioritized with the passing of the Medicare Access and CHIP Reauthorization Act of 2015. These innovations and incentives provide a potential platform on which to redesign care at the interface of behavioral and general health.

Developing and validating a set of robust quality measures that targets this high-cost/high-need patient population and is tied to new payment mechanisms can play a powerful role to encourage more cost-effective care. If designed and implemented correctly, measures associated with best practices and outcomes for integrated care can increase accountability across health care settings, diminish disincentives to serve and treat these complex patients, broaden dissemination of research-proven models that improve patient outcomes, and enhance the efficiency of the health care system as a whole.

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