Shifting from “Volume of Services” to “Value of Care” Service Delivery using the DLA-20

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Focus on Functioning

- New focus, new ACA law 1/2014:
  - State and federal funding agencies have changed laws and standards that affect funding for services you provide

How can you comply with state/federal regulations when billing Medicaid, Medicare, or any 3rd party payer?

- Establish **medical necessity**
- Make **rehabilitation** your treatment goal and your outcomes measureable.

Both requirements can be addressed if you <u>focus on assessed needs:</u>

- Having the right tools makes it easier.
  - Measure Impact of Symptom Severity on ADLs : Mild, Moderate, Serious, Severe, Extremely Severe
  - Tie assessed needs to objectives!

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Medical Necessity

- 3 essential components to establish **medical necessity**:
  1. Diagnosis of a mental, behavioral, or emotional disorder
     - Serious mental illness (SMI), severe & persistent mental illness (SPMI), serious emotional disturbance (SED), or alcohol/drug dependence
       See American Psychiatric Association (APA) DSM-5 for diagnostic criteria
  2. Disorder has been diagnosed in the past year
  3. Disorder results in functional impairment which substantially interferes with or limits one or more daily life activities

- This means that functional impairment in daily living activities must be present in clinical documentation in order to establish **medical necessity**

Is the DLA-20 compatible with the APA DSM 5?

- Among the assessment measures for the DSM 5 is a Level 1 cross-cutting self/informant rated measure that serves as a review of **symptoms across** mental disorders (and cultures). A clinician-rated severity scale for symptoms of schizophrenia *and* other psychotic disorders is also provided (note: symptom based!).

- Severity measures are disorder (symptom) specific. Level II severity is measured in 26 different functional areas, 26 tools.
  - ➔http://www.psychiatry.org/practice/dsm/dsm5/online-assessment-measures#Level2

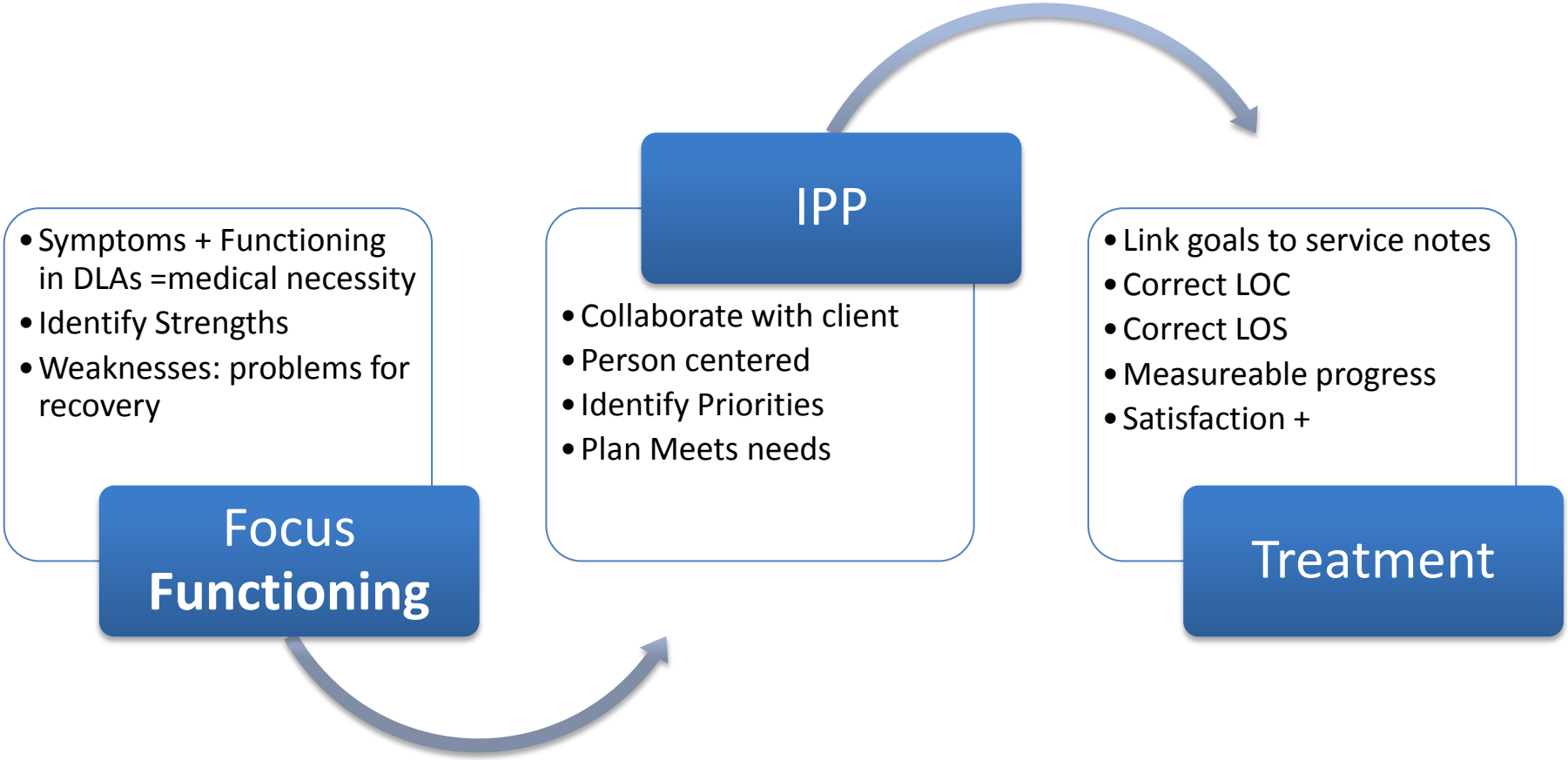
Is the DLA-20 compatible with the APA DSM 5?

- APA kept the requirement to count symptoms and to “specify severity” of the disorder, omitting, of course, the Axis system and the 100-point severity rating scale on the GAF. The DSM-5 replaced the GAF with an equally subjective method of measuring severity.
- In the same general terms, mild, moderate and severe, and again with no definitions or anchors.
- They are not driven by functional impairments. They compliment the definition of medical necessity but do not complete the definition.

Is the DLA-20 compatible with the APA DSM 5?

- **PQRS# CMS# GPRO# NQF# Reporting Method National Quality Strategy Domain Measure Title: Description**
- 134 CMS2v4 0418 Claims, Registry, EHR, GPRO Web Interface, Measures Group (Prev Care, HIV/AIDS) Community/ Population Health **Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.
- **182 N/A Claims, Registry Communication and Care Coordination Functional Outcome Assessment: Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.**
- 226 CMS138v3 0028 Claims, Registry, EHR, GPRO Web Interface, Measures Group (Prev Care, HF, CAD, COPD, IBD, Asthma, Oncology, CKD, Cataracts, Diabetes, General Surgery, Hepatitis C, HIV/AIDS, Sinusitis, Sleep Apnea, Total Knee Replacement, AOE) Community/ Population Health **Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Demonstrating medical necessity in our documentation



Is the DLA-20 compatible with the APA DSM 5?

- **Providers & clients collaborate on 20 ADLs in one tool and cross cut symptoms/diagnoses with anchors, to demonstrate functional impairments in daily living.**
- **Able to summarize strengths, assessed needs, recommended levels of care, and possible outcomes.**
- **Self-report tools would be a bonus**

DLA-20 Activities

- Health Practices
- Housing Stability
- Communication
- Safety
- Managing Time
- Managing Money
- Nutrition
- Problem Solving
- Family Relationships
- Alcohol/Drug Use
- Leisure
- Community Resources
- Social Network
- Sexual Health and Sexuality
- Productivity
- Coping Skills
- Behavior Norms
- Personal Care, Hygiene
- Grooming
- Dress

DLA-20 Benchmarks

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.

DLA-20

- Since implementation of the Affordable Care Act (October, 2013), the DLA20 was “approved” for CMS, Category 3 measurement tools for Medicaid.
- In October 2015 CMS "approved" the DLA20 for measuring activities of daily living (ADLs) for functional assessments.
- CARF and JCAHO “accepted” the DLA20 as a functional assessment tool.
- The DLA is a reliable and valid measure for the purposes of needs assessment, level of care consideration, treatment planning, and demonstrating outcomes. The DLA is validated for assessing all disabilities, including dual diagnoses, and ages >=6.

- **What External forces or opportunities are coming into play that will both force and support a shift from “Volume of Services” model to the “Value of Care” Model?**


The New
Healthcare Paradigm
Optimizing performance through data
analytics and benchmarking
Midwest Region
BAKER TILLY

Baker Tilly Report Summary

INTRODUCTION

The new normal in healthcare has arrived. The implementation of the Patient Protection & Affordable Care Act has rapidly changed the economic landscape for both payers and providers. Reimbursement methods are rapidly changing. Both public and private payers are transitioning to new payment models that are increasingly focused on patient outcomes, population health, and patient satisfaction.

As indicated by the data observations in this report, succeeding in the new normal will require providers to focus on results rather than the delivery of discrete services. They will need to collaborate with other providers to create treatment plans that optimize patient outcomes and minimize total costs. Successful organizations will implement systems to effectively gather and analyze critical data that will drive strategies that improve results. Leading hospitals will use this information to better understand and manage the overall health of the population they are serving, including finding new ways to educate their patient population while improving the availability and efficiency of their care models.

This report observes and analyzes three critical areas that will drive sustainability and profitability of healthcare organizations in the future: population health, cost management, and patient outcomes. T

Shift in a Payment Model

1. As parity and national integrated healthcare provided under the Affordable Care Act (ACA) 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 cost of services or cost of processes involved in the delivery of services (i.e., “What is your cost and time to treatment?”)

States Shifting From 1915 (b), (c) Carve Out Medicaid Waivers

- One of the more significant changes that has been realized out of the passage of the ACA in 2010 is that over 40 states have moved from a 1915 (b) – Mental Health/SUD and 1915 (c) – I/DD Carve Out Medicaid waiver (meaning all BH/I-DD funding was set aside and managed separately from physical health Medicaid funding) that was based on providing skill training to support improved functionality have moved to amend their Medicaid Plans to shift to an inclusive 1115 General Integrated Medical Waiver (all Medicaid funding for both Primary Care and Behavioral Health/I-DD have been integrated into one funding pool and therefore is being managed by single MCOs.

- This shift to support integrated healthcare to support the total wellness needs of the clients (physical health and BH/I-DD) is also including dental health in states like Illinois. Therefore, the outcome tool that the BH/I-DD providers need to use has to have some relevance in the physical health world and needs to be information that can be meaningful to the treatment of the whole person and her/his total health care needs.

States Shifting to the 1115 Waiver

- The transition in Alaska and other states is going to be how to identify with the CBHCs that they can use an outcomes tool with sub-scale scores to identify for the physical health providers the functional status/improvement in ADLs that each client has which will affect their physical health needs as well as BH needs.

State Example of an Element Cross Walk for Outcome Tools

Clinical Elements to Measure	DLA-20	Basis 24	PhQ-9	ANSA	C-SSRS
Stable housing	ADL-2				
Reduction in Substance Use	ADL-10	Q 21 - 24			
Decrease in utilization of crisis services	ADL-2, 4, 8, 12, 17	Q2, Q8			Entire Tool
Increase in employment/productivity/education involvement	ADL-15	*Q33 - Q35*			
Recovery engagement – is there a way to measure?	ADL-5, 6, 8. 9, 11, 12, 13 and 16	Q2, Q8, Q9			
Individual's input into treatment goals	ADL-3			YES	
Improved functioning and symptoms	ADLs 1-20	Q1-Q20	Q 1 - 9		
Improved social connectedness	ADL-9 and 13	Q 4-8			
Enhanced wellness indicators	ADL - 1, 7 and 14	Q9			
Criminal justice system involvement	ADL-17				
Reduction in self-harm	ADL-1, 4, 16 and 17	Q2, Q11, Q20	Q9		Entire Tool
Structure to daily living activities	ADL - 5, 7, 17, 18, 19 and 20	Q1			

Value of Care

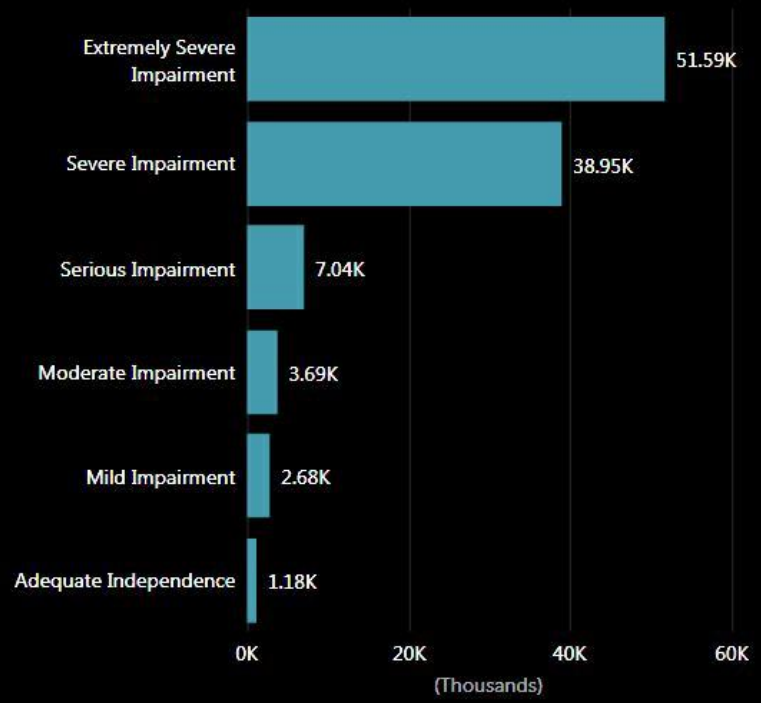
- **Services Provided**: Timely access to clinical and medical services, service array, duration and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs
- **Cost of services** provided based on current service delivery processes by CPT code and staff type
- **Outcomes achieved** (i.e., how do we demonstrate that people are getting "better"

Level of Care # 4	Service Options	Amount Per Authorization	Additional Services and Referral	Cost
Indicators of Level: • DSM-5 Diagnosis (V-codes excluded), And • DLA-20: 4.1-5.0 • mGAF: 41-50 with 1-3 serious areas of disturbance	Typical Length of Services: 1 to 3 Years (Reassessed every 90 days)			
	1. Diagnosis/Assessment	• Maximum of 4 contacts per year	• Prevention and wellness education or self-help resources	
	1. Crisis Interventions	• As needed, no maximum	• Hotline Services	
	1. Counseling/Psychotherapy:	• Individual: Up to 12 sessions per year and/or • Family Therapy: Up to 12 sessions and/or • Group: Up to 12 sessions	• Service Plan Development	
	1. Medication/Somatic Services	• Psychiatric Evaluation/Med follow-up as needed • Nursing Services		
Program-specific Criteria • Evaluation for SPMI • Evaluation for Psych Rehab (PR)	1. Targeted Case Management- SPMI:	• Up to 4-6 hours per week of eligible CSS services	• Peer Support • NAMI • Self-help resources	
	1. DLA-20 <=4.3: Rehabilitative Health Services	• Up to 4-6 hours per week of eligible CSS Services	• Peer Support • NAMI • Self-help resources	
Possible descriptors: • Prior history of hospitalizations - past 2 years • No imminent danger to self or others • Moderate structure and supports in his/her life • Everyday functioning is seriously impaired, meaning serious impairment in work, school, stable housing, relationships, law/legal – or – • Serious impairment in judgement, thinking, mood, anxiety, - or – • Serious impairment due to anxiety, other symptoms (hallucinations, delusions, severe obsessional rituals), passive suicidal ideation • Potential for compliance is fair to good • Acute stabilization may be needed	Transition/Discharge Criteria: • Stable on medications • Self-administers meds • Means of obtaining meds when discharged • Community integration • Community support • Medical needs addressed • Moderate symptoms • Moderate impairments in functioning • Client is goal directed • Employed or otherwise consistently engaged (volunteer, etc.) • Client has a good understanding of illness • Family or significant other(s) understand and support the client and the illness			

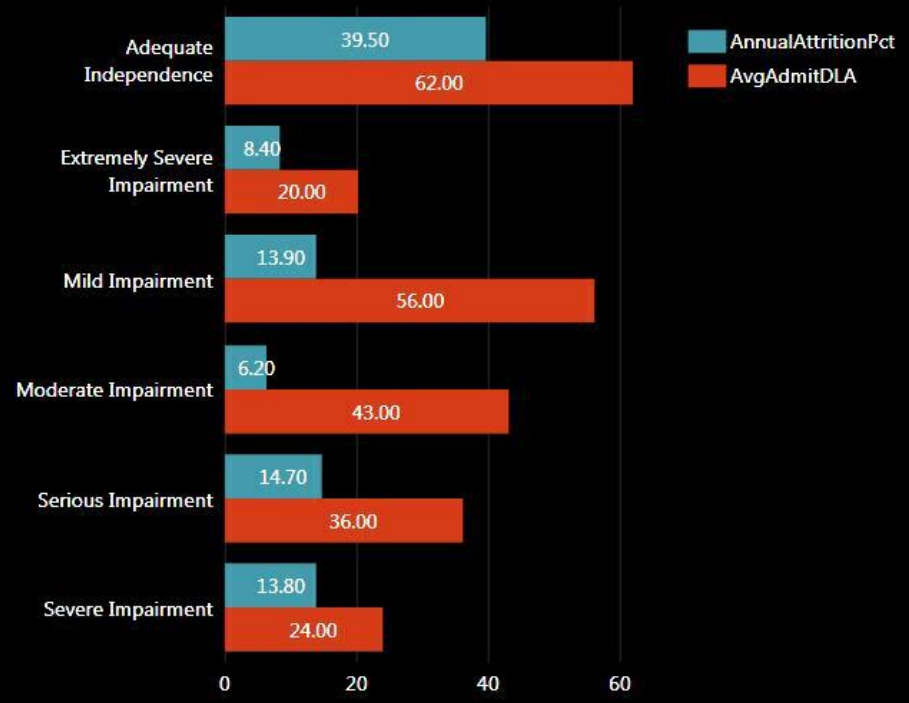
G1. DLA Risk Group Dashboard

InitialDLARiskGroup	AvgAdmitDLA ▲	AvgServiceMix	CohortPersonCount	SixMonthAvgChange	YearOneAvgChange	PopulationAvgAnnualCost	AnnualAttritionPct
Extremely Severe Impairment	20.00	5.80	169.00	27.00	36.00	$8,719,095.32	8.40
Severe Impairment	24.00	4.60	3,789.00	30.00	39.00	$147,568,402.20	13.80
Serious Impairment	36.00	4.40	7,478.00	38.00	47.00	$52,638,988.04	14.70
Moderate Impairment	43.00	3.70	17,284.00	47.00	51.00	$63,748,577.20	6.20
Mild Impairment	56.00	2.80	8,346.00	59.00	60.00	$22,400,997.84	13.90
Adequate Independence	62.00	1.90	349.00	68.00	71.00	$410,657.83	39.50
Total	**241.00**	**23.20**	**37,415.00**	**269.00**	**304.00**	**$295,486,718.43**	**96.50**

AvgAnnualMemberCost by InitialDLARiskGroup



AnnualAttritionPct, and AvgAdmitDLA by InitialDLARiskGroup



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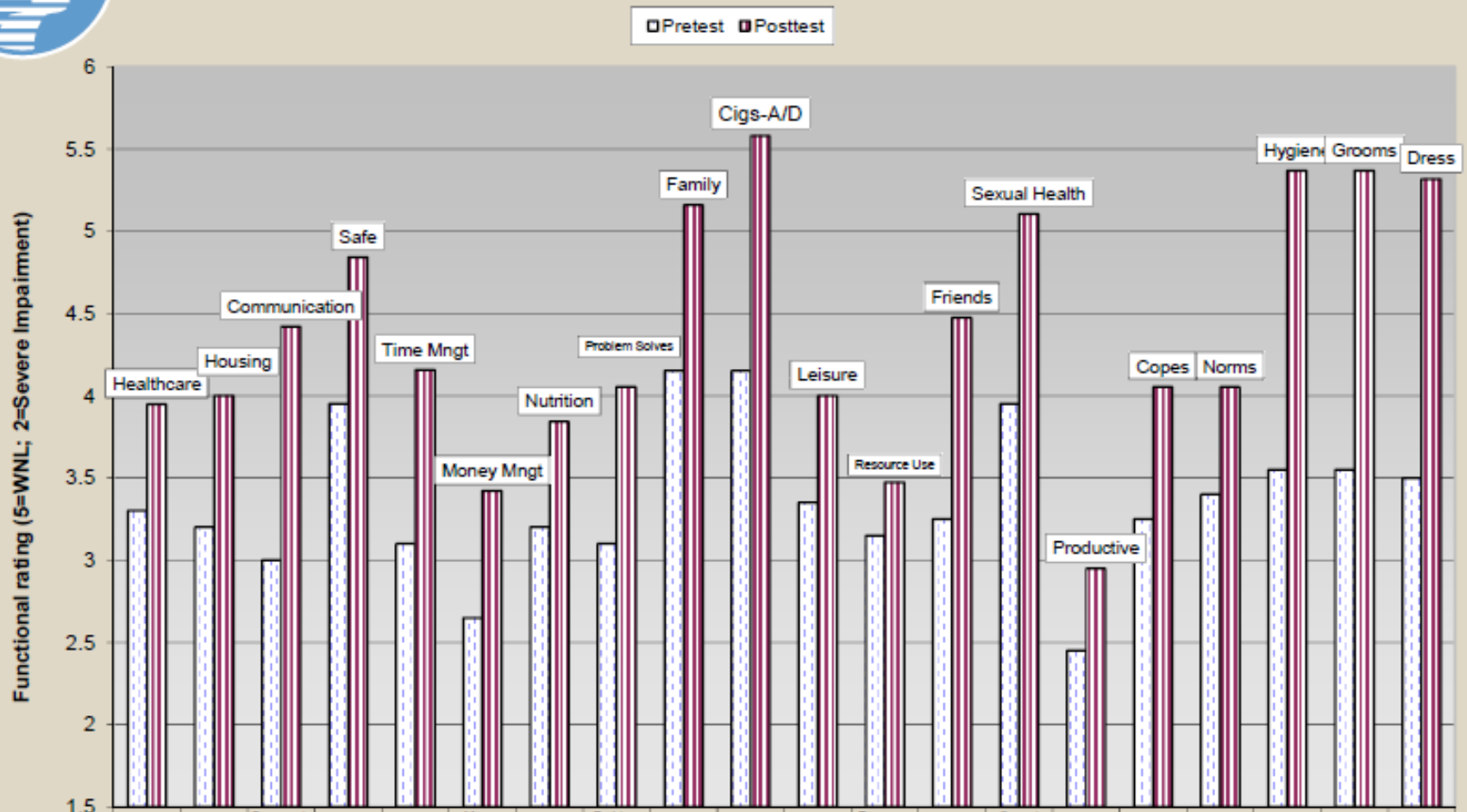
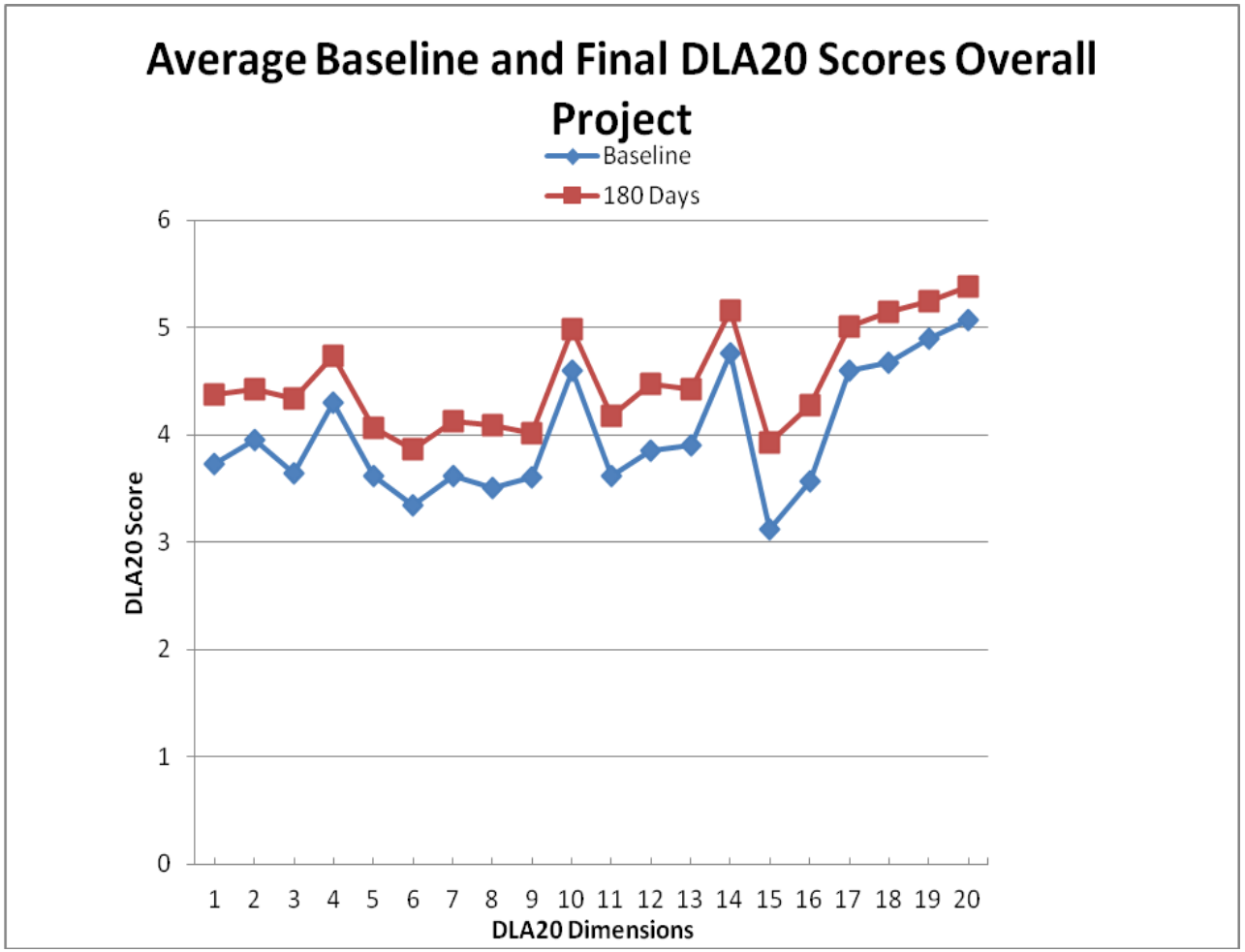
Cobb_Douglas Functional Results



	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

Highlighted Areas improved by >/= .3 points

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



Statistical Analysis of 20 ADLs:

As the table shows there were statistically significant improvements in all DLA20 areas of functioning as well as in the overall estimated GAF.

Scale	Mean DLA20 Score Baseline	60 Day	120 Day	180 Day	F	Significance
1. Health Practices	3.73	3.95	4.08	4.38	32.248	0.000
2. Housing Stability & Maintenance	3.96	4.06	4.20	4.42	14.321	0.000
3 Communication	3.64	3.81	4.07	4.34	36.768	0.000
4. Safety	4.30	4.34	4.48	4.74	14.233	0.000
5. Managing Time	3.61	3.76	3.95	4.07	15.059	0.000
6. Managing Money	3.34	3.47	3.60	3.87	20.755	0.000
7. Nutrition	3.61	3.78	3.94	4.13	20.508	0.000
8. Problem Solving	3.51	3.63	3.85	4.09	29.861	0.000
9. Family Relationships	3.61	3.64	3.82	4.01	12.668	0.000
10. Alcohol/ Drug Use	4.60	4.75	4.93	4.98	9.047	0.000
11. Leisure	3.62	3.75	3.96	4.18	27.023	0.000
12. Community Resources	3.85	4.06	4.23	4.47	26.289	0.000
13. Social Network	3.90	3.99	4.26	4.42	20.590	0.000
14. Sexuality	4.76	4.85	5.06	5.16	16.296	0.000
15. Productivity	3.12	3.30	3.61	3.92	46.358	0.000
16. Coping Skills	3.56	3.76	4.03	4.27	39.292	0.000
17. Behavior Norms	4.60	4.66	4.82	5.01	13.972	0.000
18. Personal Hygiene	4.67	4.79	4.90	5.15	21.217	0.000
19. Grooming	4.90	4.99	5.10	5.24	11.551	0.000
20. Dress	5.07	5.07	5.20	5.38	12.349	0.000
GAF	**39.98**	**41.21**	**43.04**	**45.12**	**87.787**	**0.000**

(Note: All statistical analyses were conducted by Brian Dates Director of Evaluation and Research, Southwest Counseling Solutions)

Value of Care Measurements Indicators

1. Average percentage change in DLA20 based functionality achieved from baseline level compared to levels at 90 days, 180 days, 270 days and 12 months
2. Total Annual Cost of Services provided per severity level
3. Number of clients in the cohort for each severity level
4. Total average annual cost of services per client
5. Equals the average cost per client per percentage point of improvement in functionality achieved

What Do We Need to Begin to Measure to Support Value of Care?

Need to Measure if Clients are 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 the DSM 5 and the fourth digit modifier for ICD-10?
- 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 with Statewide Standardize DLA-20 Functionality Outcome Measure

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

Thank you for your time

- Questions?
- Comments?
- Feedback?

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