Minnesota Substance Use Disorder Community of Practice:

February 26, 2025 Meeting Summary

Background

On February 26, 2025, participants attended the Minnesota (MN) Substance Use Disorder (SUD) Community of Practice (CoP). The CoP comprises people engaged in SUD treatment and prevention in any capacity. This includes individuals with lived experience, providers, family members, researchers, recovery peers, and advocates. The goal of the MN SUD CoP is to encourage the translation of knowledge into action and provide a framework for information sharing, competence development, rich discussion, and mentoring.

Boyd Brown of Health Management Associates (HMA) facilitated the MN SUD CoP meeting. During the meeting, participants discussed the strategies for developing a SUD data quality framework in Minnesota, led by subject matter expert Lauren Niles, DrPH, MPH, Principal at HMA. Objectives for the meeting included providing CoP members with a brief overview of quality concepts and components of a comprehensive quality strategy, discussing unique challenges of monitoring quality for SUD and mental health services and systems, providing CoP members with a brief overview of the intersection of quality monitoring and ability for systems to meaningfully participate in alternative payment or value-based models, and discussing opportunities and strategies for development of quality strategy and framework that meets needs of Minnesota system. An overview of the presentation, followed by the open participant discussion, is provided below.

Presentations and Discussion: Developing an SUD Quality Framework for Minnesota

Lauren Niles, DrPH, MPH, Principal (HMA)

Presentation

- Dr. Niles started the meeting with an open text poll of participants that allowed them to ask any questions they may have related to data quality at the start of the meeting. Two questions were received, which were answered later in the meeting (see Discussion section below).
- Following the poll, Dr. Niles shared a definition for quality as, "*The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*." She also shared several frameworks for

developing quality strategies. The domains of the first, developed by the Institute of Medicine (IOM), included:
    - Efficiency
    - Equity
    - Patient-Centeredness
    - Safety
    - Timeliness
    - Effectiveness
- Another useful quality framework, developed by the National Association for Healthcare Quality (NAHQ), outlines some of the key quality competencies which include:
    - Professional Engagement
    - Quality Leadership and Integration
    - Performance and Process Improvement
    - Population Health and Care Transitions
    - Health Data Analytics
    - Patient Safety
    - Regulatory and Accreditation
    - Quality Review and Accountability
- Finally, building off the triple aim for healthcare improvement, Dr. Niles shared the "Quintuple Aim" framework, which includes the following areas for improving population health outcomes and should be considered when developing quality frameworks:
    - Clinical Outcomes
    - Patient Experience
    - Provider Satisfaction
    - Financial Sustainability
    - Health Equity
- Dr. Niles also clarified two terms that are often misused, Quality Assurance (QA) and Quality Improvement (QI). QA is "*a systematic process aimed at ensuring that the care provided to patients meets established standards of quality*," whereas QI is "*…a continuous and ongoing effort to achieve measurable improvements in the efficiency, effectiveness, performance, accountability, outcomes, and other indicators of quality in services or processes which achieve equity and improve the health of the community*."[1]
    - Dr. Niles clarified several overarching themes that are foundational to both QI and QA: (a) improvement requires change, (b) improvement should be continuous and incremental, (c) goals must be clear and aligned, and (d) measurement is critical in establishing stability.
    - In contrast, themes that differ between QI and QA include:
        - Focus: QA measures compliance against predefined standards, while QI proactively identifies improvement opportunities. QA relies on predetermined measures selected by an external body, while QI uses data-driven analysis and feedback to drive improvements on measures and metrics selected by the team

[1] World Health Organization. (2020). Quality of care: A process for making strategic choices in health systems. World Health Organization. Retrieved from https://www.who.int/publications/i/item/9789241563246

Riley, W. J., Moran, J. W., Corso, L. C., Beitsch, L. M., Bialek, R., & Cofsky, A. (2010). Defining quality improvement in public health. Journal of Public Health Management and Practice, 16(1), 5-7.

- **Measurement:** QA typically happens yearly as part of reporting requirements, while QI is measured frequently as part of continuous quality improvement efforts.
- **Policy relationship:** QA is typically required by a regulatory body, which could be a state, federal government, or third-party quality program. QI is often a requirement for contracting relationships; it is often not specified how QI needs to be measured or what the goals of a QI effort should be - although some contracts do specify a particular focus area.
- **Payment relationship:** QA is often a requirement for participation in payment models or contracts. There are multiple ways it can be tied to payment, including payment for reporting, payment for improvement, etc. QI can also be tied to payment models, with a large potential for use in financial gain, especially given the more frequent monitoring

- Pulling together the above frameworks with the distinguishing factors of QI and QA, Dr. Niles shared that QA and QI need to be embedded within a broader quality strategy and design and should be integrated with other functions of the overall system design. Systems also have to coordinate with the larger goals of the organization, have well-defined values and goals, and have clear accountability. Once those are clear, quality processes like QI and QA can help drive towards the achievement of those goals with a strong foundation system that supports efforts, such as organizational leadership, buy-in from users, financial and human support, and an overall culture of quality. These efforts should **not** be happening in isolation.
- Dr. Niles noted that quality efforts can occur at three main levels, the micro level, the meso level, and the macro level. She also noted the importance of choosing quality measures that are appropriate for the level of the system in which the efforts are situated.
    - **Micro level**: The micro level includes insights to set priorities and direct resources through regulations and financial support and aims to demonstrate improvements in outcomes for populations (e.g., facilities or providers).
    - **Meso level**: The meso level includes insights to manage the delivery of evidence-based care and aims to select and incentivize high-quality care in the provider network and demonstrate effective management and outcomes for populations (e.g., managed care).
    - **Macro level**: The macro level includes insights to set priorities and direct resources through regulations and financial support and aims to demonstrate improvements in outcomes for populations (e.g., federal and state organizations).
- Participants were asked to answer a multiple-choice poll on whether a quality strategy exists within their organizations. The answers provided are summarized below.
    - 25% of respondents indicated, “Yes, I think we have one somewhere, but it is not used in routine efforts”
    - 33% of respondents indicated, “Yes, and it guides our routine quality efforts”
    - 16% of respondents indicated, “No, we do not have an existing quality strategy”
    - 16% of respondents indicated they were not sure
    - 8% of respondents indicated it did not apply to their role
- After the poll, Dr. Niles shared some of the unique challenges of monitoring quality for SUD and mental health services and systems. Some of the examples included:
    - Complexity of behavioral health conditions
    - Lack of consensus on the definition of recovery
    - Underutilization of standardized tools for monitoring symptoms or recovery
    - Fragmented payment for behavioral health, which challenges accountability
    - Privacy and data sharing challenges that limit care delivery and quality monitoring
    - Stigma, which leads to under-reporting and under-diagnosis, among other issues

    - Lack of "meaningful" industry-wide quality measures
    - Measures that focus on processes of care, rather than outcomes
- As an example, Dr. Niles shared insights from a white paper she published several years ago with a colleague, Serene Olin, entitled, "Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care." The study reviewed quality measure requirements from federal behavioral health funding mechanisms and programs and conducted interviews with providers, managed care entities, and state representatives in five state models to learn more about their specific challenges related to behavioral health quality measurement. The insights included:
    - Behavioral health care is supported through complex funding streams with disparate reporting requirements.
    - Measures are often seen as rudimentary and narrow, and therefore not useful for improving care delivery.
    - Reporting burden limits available resources to focus on measuring what matters.
    - Behavioral health integration is viewed as key to addressing access and stigma, but there is a lack of clarity on who is accountable and how to measure the quality of integration.
    - Widespread support for large-scale solutions and incentives needed to improve behavioral health data available for quality measurement.
- In a review of the 39 active federal reporting programs and over 1400 measurements and metrics, Dr. Niles found that:
    - Standardized quality measures used in federal programs are a mix of behavioral health and physical health measures.
    - Federal programs rely heavily on metrics and non-standardized quality measures, limiting use for benchmarking and value-based payment models.
    - Standardized behavioral health quality measures used in federal programs (n=35) focus on narrowly specified conditions or processes and are misaligned and used variably across programs.
    - Programs focused on behavioral health integration often do not have standard ways to capture key aspects of care (e.g., cost, care coordination, care experience, outcomes)
    - When asked about what measures were meaningful to different levels (micro, meso, macro), there were some differences and some agreement among providers, summarized in the table below.

Measurement Category	State	Managed Care	Facility
BH symptoms and functioning improvement (e.g., measurement-based care)	X	X	X
Patient goal attainment		X	X
Patient experience		X	X
Social outcomes (e.g., kindergarten readiness, crime rate, employment rate)	X		
BH integration- outcomes and effectiveness	X	X	
Cost	X	X	
Equity in BH outcomes	X	X	X
Social service coordination (e.g., linkage to social service agency)		X	X
Healthcare coordination/referral success		X	X
Evidence-based treatment (e.g., Fidelity to Cognitive Processing Therapy model)	X		X
Patient goal setting	X	X	X
BH integration processes (e.g., data sharing, warm handoffs)		X	X

- Dr. Niles briefly spoke about measurement-based care, the systematic administration of repeated and validated measures to track symptoms and outcomes, monitor progress, and inform clinical decision-making over time. Measurement-based care improves therapeutic alliance, and mutual understanding of patient engagement, and, for quality measurement, allows you to start quantifying improvements and set quantifiable goals on the behavioral health side.
    - Participants were then asked to answer a multiple-choice (select multiple) poll on how their organization currently uses measurement-based care. The top response was that it is used for Quality Improvement Efforts, followed by Patient Centered Care Delivery and Measurable Quality Outcomes, and then Organizational Learning or Practice Improvement and Value-Based Care.
- At the close of her presentation, Dr. Niles shared that behavioral health (including SUD) is a significant driver of health care costs, yet fewer than one of every five dollars spent on behavioral health care is tied to value-based payment (VBP) to control health care costs while maintaining quality. Innovative reimbursement and payment arrangements are still needed in the behavioral health field, given the complexity of many arrangements for care delivery. Process measures can be used in alternative payment models (APMs), and 95% of APMs do use them, incentivizing outcomes is the gold standard.
    - As the demand for value continues to grow, proactive positioning to meet evolving expectations will contribute significantly to shaping the future of healthcare delivery. Strategies for proactive positioning include:
        - Anticipate Evolving Expectations: Proactively position to meet the growing demand for value in health care, shaping the future of delivery.
        - Strategic Approach to VBP Success: Navigate Value-Based Care with a strategic and informed approach, understanding the changing dynamics.
        - Tailor Support to Provider Readiness: Assess the readiness of provider organizations and tailor support based on their unique state of readiness, ensuring effective arrangements for a seamless transition.
    - Dr. Niles shared HMA's Value-Based Payment Readiness Assessment Tool which can assist in gauging your organization's preparedness across six pivotal domains of core functions necessary for successful participation in payment reform models. These domains encompass measuring outcomes, evaluating board and leadership readiness, assessing technological capabilities for capturing and sharing data, gauging partnerships, payer engagement strategies, and financial alignment.
- To begin efforts in developing and improving behavioral health quality framework efforts, Dr. Niles presented the following roadmap for consideration.
    - Identify Population Goals and Priority Populations: Set population-level goals and identify priority populations relevant to population goals.
    - Choose the Right Tools and Strategies: Identify key drivers of quality and levers for change, use behavioral health Quality Framework to develop bundles of evidence-based quality measures and metrics to align efforts across the delivery system towards population goals, and publicly report performance data for measures/metrics at each level of the delivery system.
    - Align Policies and Payment to Support and Sustain Improvements to Behavioral Health Financing (i.e., coverage and reimbursement, value-based or alternative payment models): Investment in behavioral data infrastructure, improvements and investments in communication and collaboration across the system, investment in workforce development and cultural sensitivity, and relevant supportive policies.
        - As you set quality aims and quality measures, consider: (a) What level of the system is your change or intervention immediately working in? (b) What are the

impacts that you would like to see on the larger system? (c) How will you know what success looks like? and (d) What is currently being measured?

Discussion

- Question: How can you adopt strategies for different contexts and populations?
- Response: See strategies listed in the Presentation section above. It is important to start by setting high-level quality goals and objectives specific to your population of interest, as well as the context in which that population resides and operates. From there, you can begin to develop a strategy that takes into consideration the specific gaps and opportunities that exist and set a multi-faceted plan to address and monitor efforts.
- Question: How can we find data for programs that we benchmark against and improve?
- Response: It depends on what kind of data you are interested in. For example, some high-level benchmarks (e.g., Medicaid data, Medicare Stars program, etc.) are available for free online through publicly available reports. If you wanted to drill down to particular managed care organizations or other lower levels, you may have to purchase and/or make agreements to obtain that particular data, such as through NCQA's Quality Compass.
- Question: Do you use the macro/meso/micro levels conceptually within organizations or programs for QI/QA?
    - Response: I typically use other conceptual frameworks when I'm thinking about quality improvement work because I like to think of the political, financial, leadership, and other organizational aspects that get more granular, however, in general, the macro/meso/micro framework could be applied within organizations.
- Question: In the white paper referenced above, were any of the quality measures specific to the delivery of tobacco treatment?
    - Response: The table on page 11 of the Behavioral Health Quality Framework: A Roadmap for Using Measurement to Promote Joint Accountability and Whole-Person Care shows how one of the most frequently used behavioral health quality measures across federal reporting programs is "Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention." We have seen that this measure is used by CMS, Medicaid, and more at the time of this paper.
- Question: Culturally competent care with person-centered care is probably the most important indicator for [our organization], along with quality care and creating equitable access and outcomes. How are you currently measuring culturally competent care?
- Response: The answer does depend on where you sit in the system (macro, meso, micro). Some people are looking at culturally competent care within their provider network which has included work on training their workforce on how to deliver culturally competent care or ensuring their workforce is representative of the underlying demographics within their catchment areas. On the patient side, some organizations are using patient surveys to understand if patients or clients perceive or believe that their care was delivered per best practices for culturally competent care delivery or feel that their values were respected, for example. Fortunately, a lot of standardized instruments exist that are starting to monitor and measure this. These questions and measurement tools will vary at different levels of the system.
- Question: For our organization, benchmarking is key. Not only how do we know we are doing well, but how do we know we are doing well against other similar practices?
- Response: Using standardized quality measures and using those measures to monitor the population that they were validated for use in is key. With regard to monitoring MBC, organizations are, often, using different validated (or non-validated) instruments to meet their needs. This creates a challenge for benchmarking and monitoring across sites or organizations. It

becomes important to continue to cite where information comes from and how you are measuring it. Continue to have conversations and be mindful of these challenges.

- Comment: A consistent problem I see in SUD, particularly Intensive Outpatient, is that the client experience feedback is typically obtained at the end, rather than consistently throughout the process. We should be asking more frequently (from all partners involved), “How's this working for you?” If we do not check in in a non-critical way, how do we know how we are doing with the results?
- Response: This is a great point. Consistent monitoring of client experience, satisfaction, and symptoms over time is certainly a best practice. There is a lot of room to improve in this area, across organizations and entities operating at all levels of systems.

The MN SUD CoP will reconvene in May 2025.

To obtain the slides presented during the February 2025 MN SUD CoP, please email mnsudcop@healthmanagement.com.