RESEARCH BRIEF

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# Measuring the Performance of Behavioral Health Services in the Age of Value-Based Payment

## WHY WE DID THIS STUDY

In pursuit of the "Quadruple Aim," New York State has implemented an ambitious value-based payment (VBP) roadmap. VBP uses alternative payment arrangements to incentivize high-quality and effective care, contain costs, and promote worker well-being. Performance measurement is a central feature of VBP. In principle, performance measures address the full spectrum of care and capture population health processes and outcomes. In practice, certain sectors of the healthcare system have more developed performance measures than others. Behavioral health (BH) is an area in which performance measurement remains underdeveloped. To date, BH measures rely heavily on Healthcare Effectiveness Data and Information Set (HEDIS) outcomes and, to a lesser extent, on social determinants of health (SDH). These measures miss important facets of the spectrum of care, such as recovery-based and therapeutic alliance outcomes, which are empirically associated with quality and effectiveness. Moreover, the frameworks they presume may not align with the goals of BH workers. If unaddressed, these gaps between BH measures and the features and objectives of BH services may undermine the ability of VBP to advance the Quadruple Aim.

## KEY FINDINGS

- Behavioral health workers rate recovery- and therapeutic alliance-based outcomes less difficult to measure than SDH and HEDIS.
- These workers prefer their performance to be measured by recovery- and therapeutic alliance-based outcomes over SDH and HEDIS.
- They report that recovery- and therapeutic alliance-based outcomes have the greatest impact on client well-being and are most squarely in their control.

The goal of this brief is to bring BH workers' perspectives to the attention of third-party payors and state policymakers in order to inform a reconsideration of VBP performance measures. We used surveys and focus groups to investigate how BH workers perceived a range of possible BH outcome measures, asking them how important these measures are to clients' progress toward their treatment goals, how difficult they are to measure, and which outcomes they would choose as performance measures.

## HOW WE DID THIS STUDY

For this study, we recruited managers of BH services and direct service providers from an Independent Practice Association (IPA) in rural Upstate New York. This IPA is comprised of 15 nonhospital, community-based BH organizations and delivers the vast majority of BH services in the region. Twelve organizations agreed to participate in the study. Their staff size ranged from 8 to 181. Three-quarters had fewer than 35 staff. Survey data were collected from September 2020 through January 2021. The overall response rate was 69% and ranged from 50% to 100% across participating organizations. More than a quarter of respondents were managers of services, and 74% were direct service providers. The results in this brief are based on surveys with complete data on performance measurement questions (n = 230). The survey included 18 items that are known correlates of positive BH outcomes. Based on a comprehensive review of

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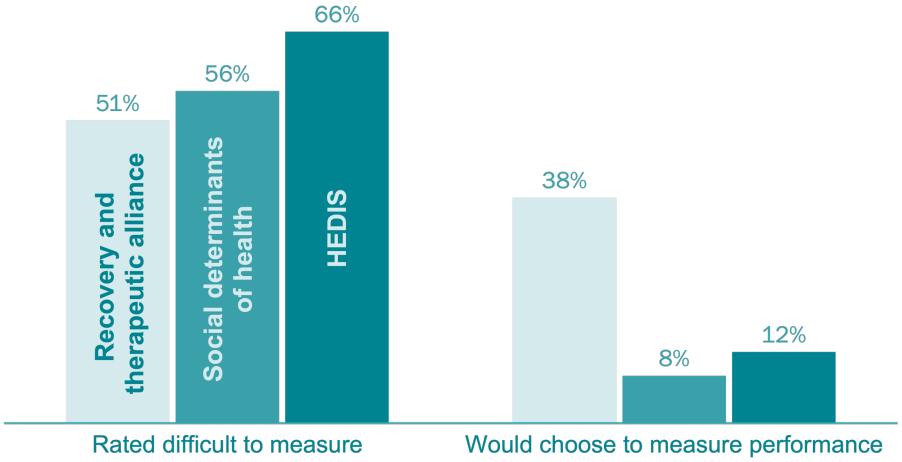
**Figure 1. Percentage of responses rating a given category "difficult to measure"; percentage of responses reflecting choice of performance measurement.**




the BH literature, we identified 6 items that measure aspects of recovery-based services and therapeutic alliance: clients' endorsement of treatment goals, engagement with treatment, therapeutic bond with service providers, connections to others who support their recovery, belief in their ability to make positive change, and recognition of their strengths. Eight items measure SDH, such as employment, housing, criminal justice involvement, and access to transportation. Four items are common HEDIS measures: clients' ability to remain out of the hospital whenever possible, adherence to medications, connection to care in the community following hospitalization, and management of chronic physical illness(es). We asked respondents to rate how *important* each item is (not, somewhat, very, extremely) to clients' progress toward their treatment goals, how *difficult* it is (not, somewhat, very, extremely) to gauge the degree to which clients achieve it, and to select up to four items they would *choose* as performance measures. We administered surveys using Qualtrics and analyzed the data using STATA.

To center BH workers' perspectives in our findings, we followed the survey with focus groups, conducted via Zoom in June 2021. We conducted two focus groups with a total of seven managers and three focus groups with a total of 14 direct service providers. We presented focus group participants with a list of the 18 survey items organized into three respective categories: recovery and therapeutic alliance, SDH, and HEDIS. We asked participants to describe in their own words what they perceived each category to represent. Next, we showed them the bar graph presented in Figure 1, but instead of naming the bars, we labeled them with numbers 1, 2, and 3. We invited participants to consider why survey respondents may have rated items in a given category as less difficult to measure than those in another or may have preferred a certain category over others. This approach minimized bias and ensured that when participants discussed categories, they were working from their local understandings rather than ours. Focus groups were audio recorded, transcribed, and coded using NVivo qualitative software.

## WHAT WE FOUND

**Importance:** BH workers strongly endorsed all 18 items as important for clients' progress toward their treatment goals. Between 92% and 100% of survey respondents rated each item as somewhat or very important. These results indicate that respondents perceived the categories of recovery and therapeutic alliance, SDH, and HEDIS as equally consequential for clients.

**Difficulty:** BH workers indicated that recovery and therapeutic alliance measures are less difficult to gauge than SDH and HEDIS measures. Half (51%) of respondents rated recovery and therapeutic alliance measures as somewhat or very difficult to measure. A significantly greater proportion rated SDH (55%) and HEDIS (66%) items as somewhat or very difficult to measure ($p<.01$).

**Preference:** A significantly greater percentage of BH workers indicated that they would choose to measure their performance with recovery and therapeutic alliance items over HEDIS and SDH items ($p<.01$). 38% of respondents indicated that they would choose to have their performance measured by at least one of the recovery and therapeutic alliance items, whereas 12% would choose HEDIS and 8% SDH measures.

**Recovery and therapeutic alliance:** Focus group participants associated the recovery and therapeutic

alliance category with "engagement" and "client-centered" care. They accounted for survey respondents rating it least difficult to measure by noting that its items are benchmarked already as "goals" in clients' treatment plans. One manager stated, "those are the things that I could literally go to somebody's chart and check those boxes that those things were accomplished." Participants believed that BH workers would choose to have their performance measured by this category because, as one respondent noted, it "is where we have the most impact." They noted that workers would prefer to have their performance gauged by outcomes they have the capacity to influence. One administrator observed of items in this category, "that stuff we have control over…that's the stuff we can measure best."

**SDH:** Participants associated this category with care management services. They accounted for survey respondents rating its items more difficult to measure than recovery and therapeutic alliance items, noting that although these items are "tangible" there is no objective "standard" for them that is free of bias. One manager expressed his reluctance to endorse measuring workers' performance on the basis of outcomes that clients may not want for themselves, asking "who's creating the standard?" He stressed, "people can make their own goals—we're gonna support you to get to that goal." Explaining why survey respondents would least frequently choose these items to measure their performance, participants observed that items in this category are least under workers' control. One participant noted that outcomes in this category are more likely to reflect "barriers and obstacles" in society than workers' efforts, another that "these are systemic issues," and a third that workers "don't necessarily have control over those things."

**HEDIS:** Participants associated this category with "long-term recovery," "maintenance," and "relapse prevention." They conjectured that survey respondents rated these items most difficult to measure because workers cannot compel clients to achieve them. One direct service provider noted, "you can't force [clients] to follow up with their hospitalizations, you can't force them to adhere to their medications, and you can't force them to manage their chronic physical illness." Another observed, "we're here to support them" but asserted that when it comes to obliging clients to connect to community services following discharge or adhere to their medications, "we don't do that." When asked why respondents would choose these items infrequently, they suggested that measuring workers' performance with these metrics could produce "coercive" practices. Participants hypothesized that these measures might lead direct service providers to compel clients to "adhere" to treatment regimens they did not choose for themselves.

## WHAT THESE FINDINGS MEAN

Performance measurement is an important driver of health systems change. When measures are calibrated to the full spectrum of care as well as workers' perceived goals, they promote effective and cost-efficient service delivery. When measures are misaligned with the conditions and objectives of care, however, they may produce unintended consequences, such as ceremonial inspection of service quality, reports that shield from payors' view realities on the ground, unhealthy work cultures, and worker burnout and turnover. These organizational impacts can translate into poor quality of care and cost-inefficiency. Our findings suggest that there is currently a mismatch between the priorities and goals of BH workers and the measures that state offices, private payors, and integrated health systems use to evaluate their performance. We investigated three empirically supported categories of BH performance measures. We found that BH workers rate the category of recovery and therapeutic alliance significantly less difficult to measure than the other categories and would choose to measure their performance by it over SDH and HEDIS measures. When asked to state in their own words how they perceive and experience this category, BH workers report that it most directly addresses client-centered care, is nearest to the documented goals clients work on, has the greatest impact on client well-being, and is most squarely in their control. As BH VBP models are designed, implemented, and evaluated, it is important that they take into consideration workers' attitudes about their practices. For VBP to deliver on its promise of aligning payments with value, it is essential that performance measures monitor the nature of BH practice, capture BH workers' charge, and tally outcomes that fall within workers' control. The continued misalignment between BH performance measures and key dimensions of workers' practices will likely limit the ability of VBP to deliver the Quadruple Aim. This is true of both the rural context we studied and BH services more broadly.

## ABOUT THE AUTHORS

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