

Title: Making Value-Based Care Models Work for Mental Health Care Providers
Date & Time: October 30, 2024 at 1pm ET

Speaker 1: Hello, and welcome to today's webinar, Making Value-Based Care Models Work for Mental Health Care Providers. This webinar is paid for by Alma. Some important points before we get started. Dr. Elisabeth Morray, one of our panelists, is the VP of Clinical at Alma. As such, she has both a financial and intellectual interest in the webinar content. The purpose of this presentation is to provide a balanced view of making value-based care models work for mental health providers. APA does not endorse any products or services. The content was created by Alma and does not reflect the views of APA or its editorial staff. Email advertising at apa.org to learn more.

Next, this program does not offer CE. However, we will email everyone watching live today a Certificate of Attendance. Certificates will only be issued to those who watch for a minimum of 45 minutes. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slides. During our time together, you will be on mute. You can communicate with us using the Q&A box located on your webinar screen. Have a question for our presenters? Type them in using the Q&A box located on your webinar screen.

A link to the presentation slides will be posted in the chat box of your webinar screen. If you missed them, don't worry. We will email them to you with the recording. Now, we would like to welcome Dr. Dylan Ross, who will begin with introductions of our panel.

Dylan Ross: Thank you so much. Hello, everybody. My name is Dylan Ross. I'm an organizational psychologist and licensed psychotherapist. I currently serve as the chair of the American Psychological Association's National Advisory Committee for Measurement-Based Care in the Mental and Behavioral Health Registry. I also serve as the head of clinical with Blueprint, which is a measurement-based care and AI-powered therapist enablement platform.

Today, we've got some wonderful guests joining us to host this wonderful conversation focused on value-based care. We've got Elisabeth Morray, Sam Nordberg, and Jana Dost. Without me trying to speak to their introductions, I'd like to first start with Elisabeth Morray as she introduces herself for the audience today. Elisabeth?

Elisabeth Morray: Hello, everyone. Welcome, and thanks for being here. My name is Elisabeth Morray. I'm a licensed psychologist and currently serve as VP of Clinical for Alma, a platform that supports the private practices of about 24,000 clinicians across the country. I am trained in ACT and process-based therapies and spend a significant amount of my time bringing those modalities to providers across the country, and also have a strong interest in behavioral health technology that can support the work that clinicians do and the relationships that they build with their clients. Really excited to be joining this panel today. Thank you.

Dylan: Thanks, Elisabeth. Next, we've got Dr. Sam Nordberg. Sam?

Sam Nordberg: Thanks, Dylan. Hi, everyone. My name is Sam Nordberg. I'm also a clinical psychologist and a licensed clinical psychologist. I'm the chair of psychiatry and behavioral health for both Reliant Medical Group and Atrius Health here in Massachusetts. A couple of interesting things to know about those groups together. They have more than a million primary care patients, so one in six primary care patients in the state of Massachusetts. More than 50% of those patients are in some form of value-based contract arrangement.

We have a very large integrated behavioral health department as well as a very strong specialty behavioral health program as well that we offer our patients in that value-based model of care. I'm going to be excited to talk about that.

Dylan: Thanks, Sam. Last, we've got Jana Dost. Jana?

Jana Dost: Perfect. Thank you, Dylan. Hi, everyone. I'm thrilled at the opportunity to join the panel today. My name is Jana Dost. I have worked within the health care space for the past 20 years. First on the provider side, guiding health system provider and service line strategy, including building one of the first population health programs in Colorado for primary care. I then moved to the payer side, leading national network strategy and advocate teams in advancing performance-based partnerships with large groups and health systems. Currently, I lead the Evernorth Behavioral Health national network team and strategy, and I'm working on advancing our adoption of measurement-based care with some of our largest providers, including Alma. Thrilled to be here today.

Dylan: Thanks so much. Just wanted to frame the guiding question for today's discussion, which is sitting here on top of the slide. How can value-based care models benefit both mental health care providers and their clients? That's our North Star, and we hope to unpack that and get into some thoughtful discussion. Before we do so, and feel free to stop sharing slides at this point, I do want to just set the stage with some context.

Let's take a moment and appreciate where we as a practice community are in the field today. For decades, fee-for-service has been the prevailing model of reimbursement in health care, paying providers per session and billed minute, often prioritizing quantity over quality. In behavioral health, this transactional model has been shown to limit innovation while creating misaligned incentives, which ultimately lead to downstream implications. Yet value-based care offers a new path forward for our field, one that ultimately rewards quality, meaningful outcomes, and sustained impact.

Value-based care was born from a desire to shift our health care systems forward towards one that ultimately rewards improved health of individuals and populations, promoting patient centricity in terms of our care delivery models, while also reducing the per capita costs of care, which ultimately benefits consumers, providers, and the system at large. Beginning in earnest with efforts to address rising health care costs and inefficiencies in the traditional fee-for-service models, particularly within Medicaid and Medicare back in the day, this shift to value-based care has continued to progress in the physical health domain, yet behavioral health has really lagged behind. This is in part due to some of the challenges around measuring outcomes.

Today, however, with tools like measurement-informed care, where clients' progress is routinely assessed to guide treatment, we're ready to bring behavioral health fully into the value-based care landscape. With this level set, really excited to jump to the panel discussion. Sam, I'm going to pick on you first here.

Sam: Let's do it.

Dylan: Acknowledging that the audience is coming into today's discussion with a whole range of different levels of familiarity of what types of value-based care arrangements exist, perhaps even what is value-based care. We thought it would be helpful here to actually share out via chat an image that's going to frame this first question, which is a continuum around the range of different alternative payment models, value-based care models that really exist today. For those sitting in front of a computer, hopefully at home or in office, hopefully not on your mobile while driving, please do click into this because I think it's going to be helpful to guide this.

Sam, imagining this continuum far left, we ultimately start with fee-for-service, which I think we're most familiar with. Do you mind just giving us a snapshot of what does that mean in our system today?

Sam: Sure thing. I think I just want to make sure. I just tried clicking on the thing in chat, and I couldn't get it. I don't want to be confusing, although maybe it was just asking me to save it to my hard drive. We're probably in good shape. All right. In fee-for-service, a couple of important things to understand from a value-based perspective. The first is, in terms of risk, when we talk about risk, what we're talking about here is who pays for all of this care. In fee-for-service, that's the payer, the insurance company. They are entirely on the hook for whatever happens to that patient. They're the folks who end up paying, and the providers are just there to maximize, their revenue.

In a fee-for-service environment, what you're incentivized to do is find people with great insurance and keep them for as long as possible and complete as many visits as possible in order to maximize your overall revenue. That's sort of traditionally how we think about fee-for-service.

Dylan: Stepping forward to a pay-for-performance model. These are really proliferated. What are those?

Sam: Pay-for-performance is an effort to migrate a little bit from this notion of, "I'm a therapist and I could see 14 patients a day, but should I. If I see 14 patients a day, am I sacrificing quality on the altar of quantity?" As you think about incentivizing a shift toward more quality, part of what these systems are trying to do is encourage people to at least assess some method of quality and maybe outcome, but lot of these are more process measures as they exist currently today.

Did you follow up appropriately with the patient? Did you vaccinate the patient when they needed a vaccine? Did you do the right tests. A lot of these are process, not outcomes measures today in current state, especially in behavioral health. Eventually, we could get to the point where we're doing more direct outcome measurement as part of this step toward migrating. Again, all the financial risks still

sits with the payer, but now the provider is being asked to measure and demonstrate some things that are related to quality as part of their partnership with the payer.

Dylan: That makes a lot of sense. As we move into the shared savings, bundled payment, and shared risk arenas, moving towards capitation, can you just high level, how do these ultimately shift as we move towards full capitation?

Sam: Yes, so as we move toward full capitation, the broad effort is really to either share more of the risk, the financial risk here or to put all of that financial risk or the bulk of that financial risk onto the provider. The idea here is about aligning incentives. If you can incentivize a provider to efficiently and effectively treat patients to keep them healthy, that you can then promote more of the behaviors that we're really looking to build for our patients, but also as custodians of total healthcare dollars.

The idea is that when a provider gets more at risk, whether that's through shared savings or shared risk or full risk, that they begin becoming interested in not adding additional sessions if that means that the quality will get worse. Therefore, patients are more likely to hit the emergency department or the hospital. It means that they're incentivized to take really hard patients and manage them very, very effectively in order to keep them out of the hospital because managing somebody effectively with lots and lots of outpatient visits is still less expensive than sending them to the hospital for 10 days.

What it does is it actually begins to align the incentives between payers and providers around delivering the most efficient, cost-effective, and highest-quality care because the least expensive patient is the healthy patient. The more you can keep your population super healthy by being proactive, preventative, and by targeting the right treatments to the right patients at the right time, the better you do as you take on more of that risk.

Dylan: Sam, I really appreciate the walkthrough and like the way in which you've sketched the differences as we move from fee-for-service far left to ultimately full capitation far right. Pointing question before we move forward, we've been talking about value-based care in the behavioral health arena for literally decades. While I do believe we're seeing almost every national payer, many regional payers having some sort of activity in terms of design, build or scaling, some sort of a value-based care model in behavioral. I'm curious, where do you think that the field and for those participating in VBC arrangements today, which model are we seeing most of those aligned to?

Sam: That's an interesting question. I'm sure we all have opinions. I come from the luxury of organizations that have decades of experience managing full risk. I think that is the exception, not the rule. I think shared savings is a much safer proposition for people who want to dip their toes in. I think, also, one of the things that keeps people stuck is it's very difficult to dip your toe into value-based care. It is very hard to take 10% of your patient population and build out the preventative care, social work, population health management systems for just that 10% while you're mostly doing fee-for-service with the other 90%.

There's some a tipping point where you have enough scale that it makes sense for an organization to make those investments. I think that's another thing that keeps us stuck, but I'd be interested to hear what Elisabeth and Jana have to say.

Dylan: That's great. On that point, thanks, Sam. Let's use this as the opportunity to shift a bit. Elisabeth, given your work in the clinical domain, and I know Alma is definitely active in this conversation, of course, what do you see as the benefits of value-based care for clients and providers alike?

Elisabeth: Yes, I'll start by talking about three really primary benefits for providers of this shift towards quality. I think when we begin to look at quality as reflected by a variety of client outcomes, rather than the more traditional fee-for-service models that emphasize the productivity of the provider or the quantity of the services provided, we can see that that shift has a pretty impactful influence on the lives, particularly of clinicians in systems that are driven by productivity, you see high rates of burnout.

Across the field overall, we see about 50% of clinicians currently report being burned out. Anything that shifts the focus away from quantity and toward quality is likely going to have a positive impact on their day-to-day life. We also know that many clinicians are interested in more flexibility in terms of the treatment approaches that we provide. Also, in terms of the teams we can assemble to support our patients, and in general, having fewer constraints than what we see when we have to fit ourselves and our services into these neat 45 and 53-minute boxes for services. The opportunity to approach treatment differently and to bring in other players can be really powerful in terms of clinicians making sure that their clients have their needs met.

Then I would add that I think introducing measurement-informed care as a foundation for these value-based care agreements means that we, as therapists, have access to regular feedback. I think all the evidence suggests that when we have regular feedback about the work we're doing, we become more effective, our treatments become more tailored and personalized to our clients. As a clinician, probably what is most impactful to me is that I have the opportunity to think about using these things to strengthen my therapeutic relationships.

From the client perspective, we see some similar benefits. I think clients are able to enter into a more holistic and integrated care system because really, these models typically involve a broader care ecosystem, typically primary and specialty care, therapists and prescribers are working side by side to meet the holistic needs of the clients. As a result, we also see improved engagement for clients because they have not only access to different providers but to typically a broader range of tools than they would be able to access in a more traditional psychotherapy context.

Their treatment plans, as a result of this access to a care team and to tools, can be much more personalized and flexible. Then I think the opportunity to provide regular feedback through these measurements tools to their clinician about their experience of care, what is working, where they're getting stuck, what their needs are, and how their needs evolve over time, ultimately translates into stronger therapeutic alliances for them. I think we see a variety of interconnected opportunities that would benefit both providers and clients in this space.

Dylan: One of the themes that was emerging both from what we've heard from Sam and from you today, Elisabeth, is this idea of being able to shake free of the constraints of fee for service. This idea of you get what you pay for in a fee-for-service model. If we're not paying for it through typical reimbursement, we're probably not going to see it. This idea of where innovation can really take root and the idea of not the holistic, the whole gestalt, if you will, in terms of wellness, promoting activities that a patient could ultimately benefit from has a billable code.

We also know, how do we design models of care that are aligned to best practice and evidence while also doing what's best for the client in front of us. When we can let ourselves out of that, the straight jacket of fee-for-service, we ultimately have that opportunity to really innovate forward in terms of more patient-centric, more frankly, even provider-centric models, which gets me excited. Jana, I haven't wanted you to sit here for so long without jumping into this conversation, but I would love to hear from the payer perspective. How does Evernorth, which really is held up as one of the more progressive payers out there, how does Evernorth think about quality?

Do you have a single definition that's applied to all providers writ large, or how do you all think about that?

Jana: Thank you, Dylan. As Sam mentioned, how do we allow providers to dip their toe in the water? That is from Evernorth, for myself as a staunch provider advocate, we are not forcing providers into using specific quality metrics. We really have focused on first listening to our providers, understanding what would be possible to implement, and focusing more so on shared data. How do we align? How do I, as a payer, not put barriers to a provider practice?

I think one of the areas historically, particularly some lessons learned from the physical health side is, metrics have been put in place that providers could not execute on. They couldn't measure in their practice. That's a barrier. We've purposely kept it simple. We're seeking to ensure that this is easy to implement and track for a provider. We've taken the time to listen and learn. Lots of time, for example, has been spent with Alma as we've been working to establish our program. We're starting with very fundamental metrics.

Time to first appointment. That's really an area where employers, in particularly, and patients want to know that they can get access to care in a timely fashion. Then therapeutic alliance, meaning that patients are getting to the right provider the first time around, and we're tracking that. We're building off of what we're learning as part of the program we're establishing at Evernorth, and we're learning together with our providers.

Dylan: Thank you, Jana. Looks like we've got a request for our APA team supporting today's webinar. Can we please post the PDF once again? That's great. Chairing the APA's Advisory Committee for Measurement-Based Care, one thing that I've heard out there in the practice community is, at times, the confabulation or at least blurring of the lines between the evidence-based practice of measurement-based care or measurement-informed care and its relationship to value-based care.

I just want to be really clear as we step forward in today's conversation that these are very discrete and separate constructs and models. One being an evidence-based

practice, which I'll define here in a second, the latter being a reimbursement or even contracting model. Just to set the table there. For this next set of questions for our panelists, I'm going to be referencing the term measurement-informed care.

I've purposefully adopted this updated terminology of informed versus based because at the end of the day, this isn't treat by numbers. It's really using patient-reported information in a meaningful way as a signal to support case conceptualization and action in terms of treatment. The terminology in this arena, just to soapbox for a minute, it's gotten a bit varied. Measurement-based care, measurement-informed care, feedback-informed care, patient-reported outcome monitoring, routine outcomes monitoring, the list literally goes on. You can find all of these well-represented in the literature.

For today's discussion, we're going to adopt the terminology of measurement-informed care. The definition here is, it's an evidence-based practice using systematic and routine assessment of patient-reported outcomes, such as those that address symptoms, functioning, therapeutic alliance throughout the course of behavioral health care, or treatment to inform treatment decisions and engage patients in their care. That's our placeholder definition. That's what we're talking about.

For those that perhaps are less familiar with this practice, of course, this is using such patient-reported outcome tools as a PHQ-9 or GAD-7, depression, and anxiety against symptom measures, or the PCL-5 for trauma. Moving into therapeutic alliance, it could be the working alliance inventory or functioning, the WHODAS, World Health Organization Disability Assessment Schedule, which is helpful to measure overall functioning.

Just setting the stage again for, we're talking about measurement-informed care separate from, but can be a part of value-based care. I want to pivot back to you, Sam. Given the breadth of work that you've done in this value-based care arena, what role does measurement-informed care play in value-based care arrangements? As a provider, I don't know if you have any ready, but can you give a few examples of how the types of measurement-informed care metrics that are commonly found in value-based care arrangements?

Sam: I can, but I'm not sure that that is the best use of our time because I think those are still pretty primitive and they're not that connected to the stuff that you actually care about when you're trying to manage a population's health. For example, we have metrics, a lot of process metrics related to, did you initiate an antidepressant and did you follow up on that antidepressant? Did you initiate a patient on treatment for substance use disorder and did you follow up on it? Have you screened in primary care when screening is this wide amorphous sort of thing?

I think that I'd like to really focus on the first part of that question, which is how can measurement-informed care really enhance your ability to do value-based care? I think there are a couple of critical pieces here. One is, when you are delivering value-based care, what you are trying to do is not deliver a service, but change a patient's life. One of the things that measurement-informed care allows you to do is empower the patient to tell you whether or not you are being successful in that endeavor.

That is a critically important thing in behavioral health because we usually operate in a black box of data and information. As you are focusing on getting more patients healthier, measurement-informed care not only matters at the individual patient-clinician dyad or at the clinician level as they're working to identify areas for improvement, but it matters at the programmatic level.

We have historically not done a great job of this in behavioral health. Because of that, there's a great deal of skepticism about a lot of our traditional treatments in terms of return on investment. If I spend all this money on therapy, am I actually going to get an outcome? We know from meta-analytic results that so far, the answer is about 4 in 10 times you get a clinically significant improvement. Which is not great.

If we're going to improve the process by which we manage patients, get them connected with the right treatment at the right time with the right clinician, we need to use measurement-informed care to actually not just enhance the clinician's knowledge of the patient or the patient's empowerment in that experience, but also the system's ability to tweak and adjust and build and correct and become a learning health system.

This is a critical part of value-based care because again, you don't care about appointments anymore. They don't actually matter. What matters is outcomes, whether or not you are moving the needle on getting more patients healthy, keeping more of them out of the emergency department, managing them effectively as they transition out of the hospital. Measurement-informed care is data, data that we haven't had historically. This can be incredibly empowering at scale. I know we'll get a chance to talk more about that later, but let me stop there.

Dylan: Sam, I really appreciate your articulation of the differences, but also the multi-level value that's unlocked through the use of standardized clinical measurement, starting first and chiefly at the dyad level, but also at each level of the system. Yet the reality is--

Sam: I remembered something I wanted to add, which is I think important, which is that when we're doing measurement-informed care, our measurement must be as complex as our patients are. I think this is a place where we haven't done a great job either. With more than 300 different diagnoses in the DSM, it is not sufficient to drop a PHQ-9 on every patient. It's just not getting you actionable data. I think that's another critical piece to point out about measurement-informed care is that measurement actually needs to be quite a bit more complicated before going to be able to serve all the different kinds of patients that we are measuring and treating.

Dylan: This has been a lively conversation around that topic, specifically some of the limitations around more symptom-based measures, how few and far between, frankly, functioning measures are adopted and used or at scale, and where might that next wave of assessment take us? Flourishing wellness, these more positive psychology and don't need to be aspirational, but how do we really bring a full humanistic lens to the human experience and that individual sitting across from us?

You talked about that the adoption and use of measurement-based care is really few and far between. Just to drop a stat, less than 20% of practitioners, roughly 18% of psychiatrists, 11% of clinical psychologists, and around 14% of master's level

clinicians report or endorse using standardized clinical measurement as a part of their routine day-to-day care. Acknowledging where we are as a field, rolling that up, sub-20% across all providers, we've got a ways to go.

With that, I want to pivot over to you, Elisabeth. Alma has been doing some phenomenal work to really build out a progressive model to support those in private practice delivering care day-to-day. Alma, you've done some surveys. You've really put the ear to your community of mental health practitioners. I'm curious, what have you learned from your provider community about what matters most to them when it comes to measurement-informed care, including perhaps any concerns you've heard around collecting and sharing outcomes data with payers, as well as what matters most to them? Do you mind speaking to that?

Elisabeth: Sure. I'll start by saying that what is interesting about our providers is that they actually typically have not had the opportunity to participate in measurement-informed care in the way, let's say, clinicians working within SAM system might have the opportunity to take advantage of tooling that is really built-in and available to them.

We have a group of providers who, historically, might not have taken advantage of these tools. I think, Dylan, the stats that you quoted there reflects that. What is really interesting about what we have found at Alma is that we find that when you provide independent clinicians with highly automated, efficient, and tech-enabled tools that allow them to collect data about how their clients are progressing through treatment, they're happy to use them. That one of the biggest limiting factors may very well be not having access to the kind of technology that really supports high-quality measurement-informed care.

That being said, I also want to point to some real concerns that clinicians have about entering into measurement-informed care and value-based agreements. I think, first of all, they have real concerns about how assessment data is used. When we talk about data sharing, our clinicians express that they really expect a high degree of transparency around certain concerns. The first is, how is that data going to be used by insurance companies if it's shared with them? Is that going to be used in order to determine coverage for care or reimbursement for care?

I think about 63% of our providers fear that if they engage in measurement-informed care, it might actually limit the care they're able to provide to their clients. I think that, also, clinicians are concerned about the security of their data, both when it's in the hands of an insurance company, but also when it's in the hands of a tech company like ours. Really making sure that we can provide high levels of transparency about how data is used, and also how it is collected and stored, is really foundational in terms of engaging independent practice clinicians in measurement-informed care.

Then probably most importantly to me, as a clinician, and as the voice to many clinicians, is that we really want our voices to be heard and prioritized in conversations about how we define quality. I think many clinicians have expressed concerns about using these more limited symptom-focused measures, and both Sam and Dylan have pointed to this, as sole indicators of quality, and instead really look to assessments that certainly focus on client functioning. Certainly, they're interested in learning about reductions in symptoms.

Then finally, the strength of the therapeutic alliance, that these are the things that feel clinically relevant and meaningful to our providers. I think all of this, in my mind, really points to the potential that we have to build a foundation in measurement-informed care that will ultimately allow for value-based care, but that ultimately, we really do need to include clinicians and their voices, their expectations, and their hopes into the ways in which we are thinking about quality and outcomes in our patients.

Dylan: That's helpful. For those, I'll see if I can pull up the quick link and send it in, Alma's internal survey, which informed many of those insights that you just shared, is a great resource. Again, back, putting on the APA NBC committee hat as chair, we've spent an inordinate amount of time talking to all different interest holders in and around this topic. I think that what we heard through the Alma survey results really validates and echoes what we've been hearing as we've been talking to different constituents around this. We'll see if we can get that link into the chat.

Jana, back to you in terms of the payer perspective, seemingly a simple question, but I'm just curious, can you speak to the why? What is the purpose or interest from Evernorth's side? Why is Evernorth pursuing value-based care? Why is your organization, why do you care about measurement-informed care?

Jana: Yes, thank you, Dylan. Elisabeth, I think one of the keywords you've said repeatedly is partnership. Partnership is critical to the success as we engage between payers and providers. At Evernorth, we're really focused on care innovation and being a partner. That keeps resonating as you continue to talk through that. As we think about our journey in measurement-informed care, we're really wanting to ensure the very best care for our members, your patients, your clients, and provide the opportunity for our providers to demonstrate the value of the care they're delivering.

Back to the whole fee-for-service versus value-based, it's not just we're churning through, but truly bringing the value of the care that's being delivered. The employers who purchase our services want our members to use their behavioral health benefits. They want to understand how quickly members are getting access to care. We hear that repeatedly. How the health of their population, their employee population, their communities is improving. How do people engage in treatment?

This has been missing, right? It's like we have not had clear metrics. When clinicians do not have the consistent way to demonstrate value, they may have to rely on industry, just generic population data. It's not specific to them. With measurement-informed care, we can show how the clinicians are moving the needle and demonstrate the value of care they're delivering, and that patients are receiving care in a timely manner.

It's really true partnership, as I talked about, between the providers, the payers, the employers. It's not just one single entity. It's collaboration's critical. By embedding the shared metrics in the customer journey, we all are developing insights into access and outcomes that will benefit each of us and the patients we serve. From my perspective, partnering with providers and finding the shared metrics that are easy to track makes measurement-informed care more attainable. That really is.

From Evernorth, we're building the foundation. We've put the foundation down, ready to start framing. It's how do we do this journey together and make it simple and ultimately advanced into true value-based opportunities that are clinically specific?

Dylan: Where do we go next? I really want to stay true to our 45-minute turn-to-pumpkin time timeline here because I want to make sure that we give the respect to the questions and answer portion of this. We've got a handful of other questions here. Let's go here. Maybe building on that last piece, Jana, trust within the practice community in terms of the relationship between providers and payers, it's a real thing. We heard Elisabeth mention it even in some of the survey results.

What gets me excited is, one of the, I think, unintended consequences of a fee-for-service model has created a highly transactional relationship between payers and providers. It's perpetuated that trust gap because-- back to the transactional nature of it. Within value-based care arrangements, it's a more relational, partnership-type model. It's required. You can't do it without it. Not every provider or provider organization is, frankly, well-positioned to participate in some of these alternative payment models.

Even just to get to that point of the conversation, there needs to be a relationship. I actually see that one of the soft benefits of this shift, more broadly, is addressing perhaps even aspirational, but a reparative, if you will, addressing of some of these trust gaps that are longstanding. With that being said, maybe we'll go out with this last question. Maybe I'll turf this to Elisabeth and Sam. What misconceptions do providers commonly hold about the practice of measurement-informed care? What have you learned as it relates to your systems about how best to support providers in its practice, given how important it can and potentially should be in relation to value-based care arrangements?

Sam: Go ahead, Elisabeth. You can start us off.

Elisabeth: I'll start us off. I'll talk about just some of the primary misconceptions that I've heard from our providers at Alma. We are often the first opportunity that an independent practice clinician has to really start using some of these tools and learning from the data. I think what we find is that many of them have some concerns about how that data is going to be used when it is shared. There are fears that it will be used either to influence the treatment of an individual or to penalize a provider and particularly when a provider is working with some of the most complex cases that may not show the kinds of outcomes that that individual clinician might hope for.

I think through our partnerships, including our one with Evernorth, we're really able to convey to our members that data is useful to our partners in aggregate and not at an individual level. It's important for us to be able to share information that reflects the population and how we are being able to, as I think Sam said, really move the needle. I think for many clinicians, it's very reassuring to know that data is really being shared at a very high-level population view rather than as a way of scrutinizing an individual.

I think we also really have responded to our providers who've told us that these efforts and these partnerships need to include the clinician voice and, in many ways, be clinician-centric. I've mentioned in terms of how we define quality. Our providers

have pushed us to look at how we capture quality in ways that have clinical meaning to the provider and demonstrate meaningful impact experienced by the client. Does the client find a therapist who's a good fit for their needs? Do they feel a sense of alignment around what they are doing in treatment? These are the kinds of things that I think providers want to know are going to be captured, not just more simplistic symptom measures.

Through some of these partnerships, we've really been able to build out our ability to tap into quality in a much more multifaceted manner. Then I've mentioned this before, but because we hear so much about it, measurement and care brings up a lot of concerns about data security and privacy. Often, clinicians have not had those opportunities to ask questions and to get direct information about how data is shared, how it's stored, and the security measures that have been put in place. Really making sure they have that information both for their own purposes and to share with their clients has been critical. Sam, I'll pass it over.

Sam: I think you covered a lot of the key points. Broadly, this is a question of psychological safety. We are now opening up this black box. We are shining a light. That light, a lot of our clinicians worry that light's only going to highlight a certain portion of what they do and miss a ton of the other stuff. Lots of clinicians are very smart and well-trained. If you're just assessing a patient with something that doesn't cover the breadth of what they do, they're going to be concerned that you won't capture the value they're adding.

I think also from a systems perspective, and I am a systems design person, the system also has to demonstrate that when an outcome isn't what we hoped it would be, that's just the beginning of a continuous quality improvement process where nobody is at fault. Nobody is blamed. I think we send a lot of the wrong patients into psychotherapy, for example. We know we put a lot of the wrong patients on medications. That's a systems problem.

The faster we can recognize that and identify those patients for whom this isn't the right course of treatment, the faster we can get those patients into something else that's more likely to be helpful for them and slot another patient into that provider's schedule. That's a lot of what we're trying to do now with measurement-informed care is actually use measurement, complex measurement, at the screening point in primary care, at the triage point, as we're getting handoffs, to actually try and use evidence on patients who have come before to triage this next patient into the thing most likely to be helpful for them. Then to identify as quickly as possible, whether or not it's working. I think a lot of clinicians are worried that they're going to be somehow punished if they're not effective with 100% of patients. I think I try to flip that on its head and say, "Listen, we've been sending a whole bunch of the wrong patients to our clinicians for decades, and it's why our outcomes haven't gotten better." A big part of the opportunity with measurement-informed care is at the systems level and being crisp and precise about who goes where.

Dylan: Thanks, Sam. Okay, so we're going to take this moment to pivot to questions and answers from those in the audience. I will just note that for those that have submitted those questions ahead of time, we reviewed those, we grouped them thematically, and we tried to weave these in with, trust me, a late last-minute update

to the questions last night. My hope is that many of the themes were spoken to in what you heard today.

For those just typing in, if you haven't entered a question, please do so. I'm looking at them now. This seems like a darn good one to start. I'm going to-- not knowing what everybody's perspective is in terms of Sam, Jana, and Elisabeth, we'll go to an open-mic moment. We've been espousing the promises of value-based care and all that it can do. Here's the question. What do you think is the most compelling evidence for the efficacy of alternative payment models and value-based care in behavioral health? Why should they believe us?

Sam: Okay, can I go? Can I go?

Dylan: Please [laughs].

Sam: We measure and we try to publish on a lot of this stuff. A couple of things that I will point out. One, since we launched integrated behavioral health at scale in primary care at Reliant, we cut our psychiatric emergency department visit rates in half. It took us about three years to get good at this. Currently, we divert about 2,000 patients a year from the emergency department directly into real-time visits with clinicians who have availability because we're not booking them up to maximize our fee-for-service revenue.

That's one example of how this really can deliver the right care. Because-- I don't know about the rest of you, but my experience in trying to board patients in the emergency department is that it's an absolute nightmare. It adds a ton of value for our folks who can get in, they can get a same-day assessment, they can get immediate access to what they need. We also benefit because emergency department visits, particularly ones that are long and have a lot of boarding, cost a lot of money. That's a great example of how everyone's incentives align, and we've demonstrated that one. I'll keep it short because I know we have a lot of questions.

Dylan: Anybody else want to jump in on that last question or else we can move forward?

Elisabeth: I'll just jump in quickly and say that from a clinician-centric perspective, moving away from a productivity-focused model where you are rewarded for doing more, and I think most of us who are practicing clinicians know that beyond a certain point, doing more does not translate into higher quality care when clinicians are actually liberated and able to work within systems using tools that allow them to focus on the quality and impact of the work that they're doing.

We hope, certainly, that it has a positive impact on patient outcomes, as Sam described. I'd like to say that I think it can actually have a very powerful impact on the experiences of the people actually delivering the services.

Dylan: Thanks, Elisabeth. Jana, I'm going to maybe turf this next one to you, but also it looks like Sam may be typing an answer to the same question here.

Sam: Uh-oh.

[laughter]

Jana: Uh-oh.

Dylan: We may bump into each other, but we'd love to hear from a payer perspective, just high level, speak from payers across the nation. How is payment determined in these models if it's not fee-for-service? What gradations of value, how are they defined, and how is, ultimately, that alternative payment arrived at? What are the mechanisms? How do they measure this? How is it different than fee-for-service?

Jana: From Evernorth's position, we are currently not incentivizing from the provider contract perspective. We are trying to foundationally set the stage as we transition into potentially pay-for-performance, other type models. It really has been around, how do we align with seeing what is shared with us, seeing how we're working with providers, how does the data align, what does it show us, and then, ultimately, how do we restructure our contracts to demonstrate the value that the providers are bringing to the patients and clients.

The other thing I wanted to touch on real quick, Sam, is one thing you mentioned around total cost of care savings. That is such a critical piece, and alleviating the ED boarding. Those areas really stand out as well, that the early intervention to the right provider at the right time, and we stop seeing-- truly from a payer perspective, we want to make sure people are getting to the right providers, and that they're not stuck in a system where they're not with the right provider ultimately, and it takes too long to get them to the right provider.

That early intervention, savings around cost of care, those are all critical, and those are all factors that are going to come into play as we move forward in advancing our alternative payment structures. These are learnings.

Dylan: That's great. I'm going to maybe massage this question to be slightly more broad, but there's a question speaking to, either at present or in the near future, the role of potentially machine learning or other types of more novel technology, AI, in facilitating or,--well, let's just go with it-- facilitating value-based care at scale. Is there a role for tech in this conversation, team?

Sam: Hell, yes.

[laughter]

Dylan: Next question. Okay. Go ahead, Sam.

Sam: I'll go real fast, but tech is how we're going to solve some of this challenge in terms of workforce shortage, and at Reliant, over the last three years, we've been building out an ecosystem of evidence-based digital tools and the technology to recommend those tools based off of the measurement that we're doing in primary care screening. Our outcomes paper is coming out hopefully next week. We just did the proofs, but our outcomes are really good on a couple thousand patients.

What I would say is I am extremely positive about these technologies with the important caveat that they must be precisely matched to the right patient. They are not generalist interventions. They will have significant scale to address a lot of

patients' needs, but they have to be very carefully matched to the right patient because they can't be flexible and adaptive the way a clinician could if they see things getting worse and they need to pull in more resources.

Measurement-informed care is a critically important part of this. If we're going to put people into an app or a technology that doesn't have a clinician necessarily overseeing it on a day-in, day-out basis, we need to be measuring how patients are doing, and that's exactly what we do. We measure the patients periodically as they go through their digital intervention, and then we have a dashboard. If anybody's getting worse or if anybody drops out, our clinicians reach out to them. That's critically important. Sorry, [crosstalk] go ahead, Elisabeth.

Elisabeth: I have to jump in with my own particular point of enthusiasm in terms of looking at AI as a tool that demonstrates quality within the individual practitioner space. We just launched a tool called Note Assist, which basically takes data from a session and creates a highly customized and detailed note based on that session that I think really captures the quality of the work that a clinician does in a way that they could never do without spending hours and hours and hours devoted to their documentation.

Part of the way we demonstrate quality is through capturing the interventions that we are doing in each and every session, and using AI as a way of doing that means the burden on each of us as individual providers is lifted and it makes the data that we have to share with our partners more precise and more meaningful. I'm extremely excited about that particular application of AI.

Dylan: I think that's going to be our last comment here from our esteemed panelists. First off, Elisabeth, thank you and the Alma team for making this possible. On behalf of the APA, our relationship and your paid endorsed creating of this venue for us to have this conversation is deeply appreciated. Sam, your work in this space, longstanding, has really contributed to the field taking some important steps forward. I always learn something from you, so thanks so much for joining. Jana, hats off to you at Evernorth and the good work you're doing to move things forward where it matters most.

I'm going to say thank you to our audience and pass the mic back to our APA handlers that have taken good care of us. Thank you all for joining. APA team, please take us out.

Speaker 1: Thank you so much for joining us, and thank you to all of our listeners for your participation. We'd also like to thank Alma for making this webinar possible. A recording of this presentation will be emailed to everyone in two weeks' time. The recording will include the presentation slide. As soon as the webinar has ended, a short survey will appear on your screen. Please take the survey and give us your feedback. We thank you for your attention and hope you have a great day.

[00:57:13] [END OF AUDIO]