Identifying and Filling Gaps to Promote Value-based Care through Quality Measures and Client-centered Supervision

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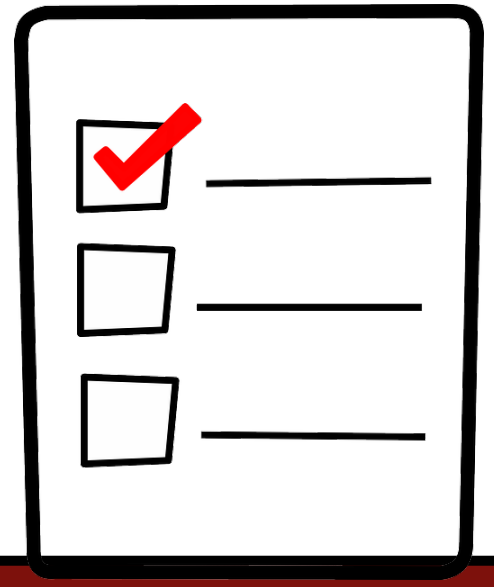
Objective

- Propose **client-centered supervision** as a key mechanism to identify and fill/link **gaps in quality measures across systems (i.e., policy, practice, client)** to promote value-based care across the behavioral care continuum.

Outline

- Continuing struggles in the paradigm shift from the medical model to the recovery model in behavioral health policies and structures.
- Gaps between behavioral health policies and practices.
- Quality measures as a tool to identify gaps.
- Client-centered supervision to fill/link gaps.



Continuing Struggles in Behavioral Health Care

- Paradigm Shift from the Medical Model to the Recovery Model
  - ➢ *Value for supporting a whole person to pursue their identified life goals beyond merely treating behavioral conditions.*

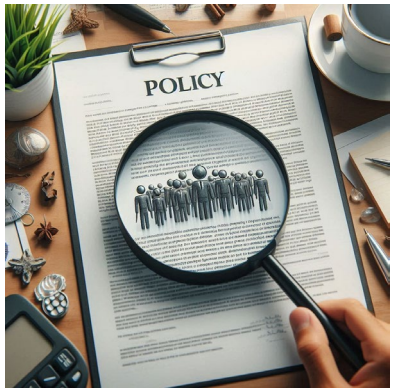
- Challenges to Transform Recovery-Oriented Structures/Policies
  - ➢ *Struggles for transforming the value to daily practices in the current policy and structures.*

A Gap between Policy and Practice

- Policy designed for populations
- Practice is at the individual level

❖ **Gaps** between the population-based policy and individual-based practice **in implementing quality measures** to promote value-based care across the behavioral health continuum.

A Gap between Policy and Practice: Population-based Policy



- **Behavioral Health Policy**
  - Set for the *population model* to minimize opportunity costs and maximize the efficiency and equity for addressing the aggregated needs of individuals.
  - The population model drives policies and care systems (e.g., payment systems, care delivery structures, desired outcomes).
  - Successful indicators include productivity and cost management.
  - Become barriers if the individuals do not fit within the population model.

A Gap between Policy and Practice: Population-based Policy (Cont.)

- **Population Model in Behavioral Health Care**
  - ➢ People with behavioral health conditions/ diagnosis (Medical Model).
  - ➢ Driven by the *medical model*, which best addresses isolated targets (e.g., specified behavioral symptoms and causes).
  - ➢ Focus on the isolated causes for treatment action (e.g., care), resulting in *segmentation* in the service structures.

A Gap between Policy and Practice: Individual-based Practice

- **Behavioral Health Practice**
  - Set for the *individual model* to maximize the benefit of unique individuals.
  - Tailored to meet individual needs and goals through evidence-based recovery-oriented practice.
  - Successful indicators include recovery and community integration (e.g., stable housing, secondary education, competitive employment, meaningful social connection).
  - Interpreted and implemented within existing policies.

A Gap between Policy and Practice: Individual-based Practice (Cont.)

- **Individual Model in Behavioral Health Care**
  - A person who has recovery goals that are hindered by behavioral health conditions (Recovery Model).
  - Driven by the recovery *model*, which works best when engaging with a whole person through active participation in addressing holistic needs and life goals (e.g., wellbeing, recovery, community integration).
  - Focus on the effect of the course of treatment action (e.g., care) on the whole person (holism).

A Gap between Policy and Practice

***Population Model**: People with behavioral health conditions/ diagnoses (Medical Model)*

Gaps (misalignments) between Population and Individual Models

- Individual variations in causes of, responses to, and effects of behavioral health conditions (the population model) in the contexts of recovery (the individual model).
- Top-down policy and system development without established or with weak feedback loop/mechanisms to inform policy and system changes based on the individual model.

***Individual Model**: A person who has recovery goals that are hindered by behavioral health conditions (Recovery Model)*

Quality Measures as Links in a System Chain Necklace

***Population Model**: People with behavioral health conditions/ diagnoses (Medical Model)*

Ensuring Quality Measure Across Systems in Three Quality Domains

- Structure. Recovery-oriented & culturally competent programs
- Process. Evidence-based client-centered practices.
- Outcome. Recovery and community integration.

Evaluating Success and Gaps in Quality Measures across Three Levels

- Organizational-level. Incentive for value-based care (client-centeredness).
- Provider-level. Job engagement and the quality of care.
- Client-level. Improved experiences and outcomes.

Evaluating the Linkage among Three Domains

- Linking the fidelity (quality care structures and processes) and outcomes.

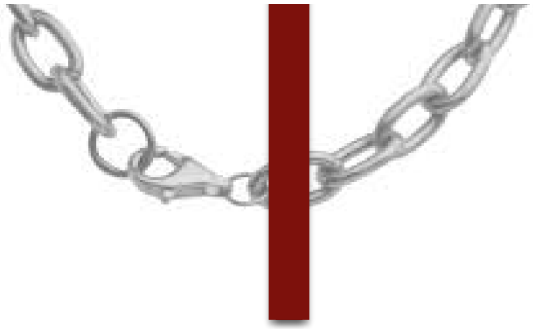
***Individual Model**: A person who has recovery goals that are hindered by behavioral health conditions (Recovery Model)*

Supervision as the Fastener to the Chain Necklace

***Population Model**: People with behavioral health conditions/ diagnoses (Medical Model)*

- **Gaps in Quality Measures**
  - Misalignment in quality measures (what matters most) among different systems and stakeholders.

- **Lack of feedback loop**
  - Mechanisms for class advocacy/policy and system changes.



- **Supervision Functions**
  - Supervisors are key actors in class advocacy for providers' goals to help clients achieve the clients' identified goals.
  - Embedding the feedback loop in daily practice.

***Individual Model**: A person who has **recovery goals** that are hindered by behavioral health conditions (Recovery Model)*

Client-centered Supervision to Fill/Link the Gaps

Traditional Supervision Functions (*Kadushin & Harkness, 2014*):

- Administrative function.
  - ➢ Focusing on the operation of the organization.
- Educational function.
  - ➢ Supporting professional development.
- Supportive function.
  - ➢ Meeting the socioemotional needs of providers.

Client-Support Function:

Client-centered supervision *(Rapp, Goscha, Fukui, 2015)*

Client-centered Supervision to Fill/Link the Gaps (Cont.)

Client-centered supervision

Frame supervision functions through strengths and recovery lens

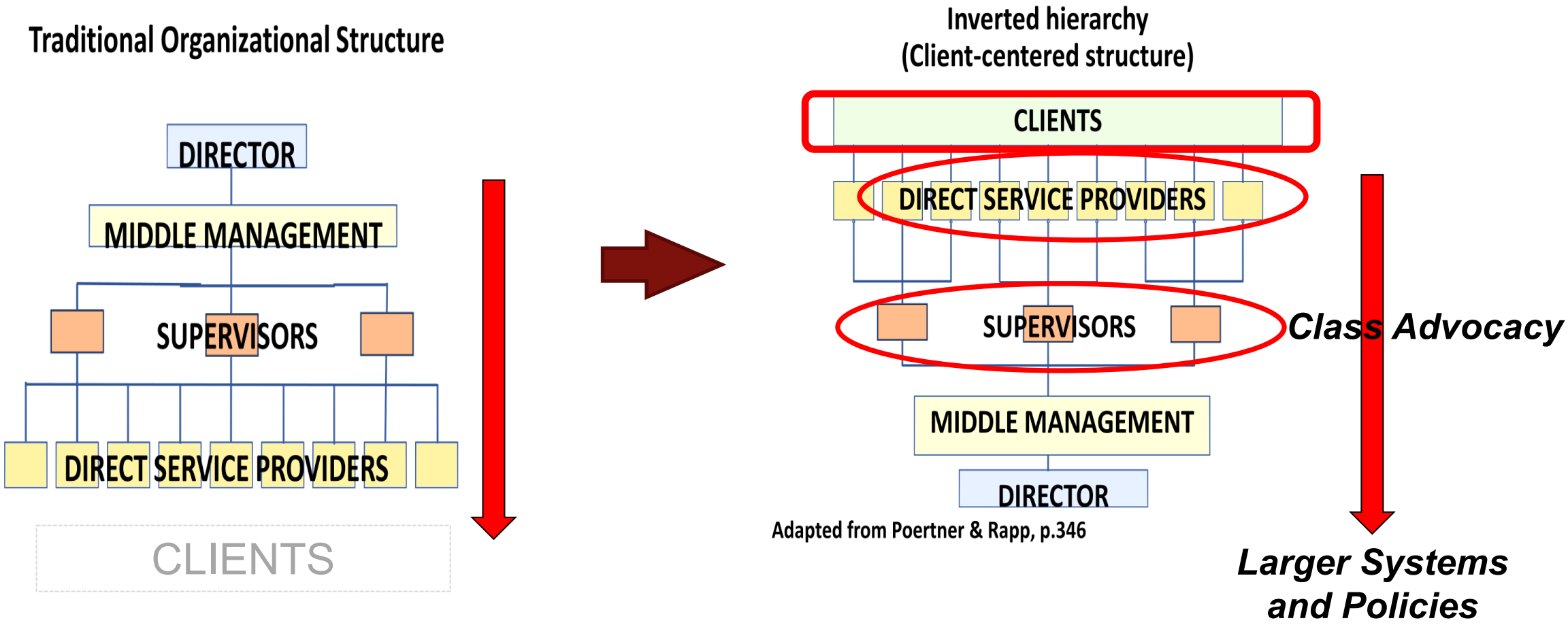
Administrative function

Educational function

Supportive function

Client-centered Supervision: Purposefully address each function based on client strengths, needs, and goals.

Client-centered Supervision/Management in Inverted Hierarchy



Class Advocacy for Policy and System Changes through Client-centered Supervision/Management

***Population Model**: People with behavioral health conditions/ diagnoses (Medical Model)*

Client-centered Supervision/ Management

Does the measured quality matter to the clients and lead to improved systems and policies to support the recovery process and outcomes in the population?

Implement and Evaluate Quality Measures in Daily Practice

- Direct Provider. Support and advocate for client recovery goals?
- Supervisor. Support and advocate for providers to help clients achieve their recovery goals?
- Upper management. Support and advocate for policy and system changes to support client recovery goals?

***Individual Model**: A person who has recovery goals that are hindered by behavioral health conditions (Recovery Model)*

Conclusion

- The population model (Medical Model) drives policies and care systems.
- The client-centered practice (Recovery Model) may not always fit under the population model.
- Quality measures need to be embedded in daily practice to inform policy and system changes (creating opportunities to eventually promote recovery-oriented systems and policies as a whole).
- Supervisors are the key actors—system transformers—for building the feedback loop to fill and link the gaps.
- Bring our priority back to providing the quality of care that matters most to the clients in a consistent way (i.e., filling the gaps between the policy and practice expectations through client-centered supervision). This also helps retain a quality workforce.

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