Behavioral Health Data-Sharing for Large-Scale Care Integration Programs

Mark Elson, PhD
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Integrating Physical and Behavioral Health

• Benefits
  • Treating patients holistically
  • Improved outcomes

• Challenges
  • Navigating restrictions on behavioral health data sharing
  • Overcoming organizational silos
Government’s Right and Left Hand

• Increasingly substantial federal and state funding /requirements for behavioral–physical health care integration, but …

• Federal and state rules to protect privacy make behavioral–physical health data sharing challenging
Large-Scale Programs Driving Integration

Medicaid / Medi-Cal
  • Whole Person Care (WPC)
  • Health Homes for Patients with Complex Needs (HHP)
  • Public Hospital Redesign & Incentives in Medi-Cal (PRIME)

Medicare
  • Merit-Based Incentive Payment Program (MIPS)
Whole Person Care
Whole Person Care Overview

• 5-year program to coordinate physical and behavioral health, and social services
• Improve outcomes for vulnerable, high-utilizing groups of Medi-Cal beneficiaries
• Pilot entities will:
  • Identify target populations
  • Share data between systems
  • Coordinate care in real-time
  • Evaluate individual and population progress
• 18 pilot sites selected in first round, annual funding of $300M
• Second round of applications currently being evaluated
## Whole Person Care – Pilot Participants (Phase 1)

<table>
<thead>
<tr>
<th>Participant</th>
<th>Location</th>
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<tbody>
<tr>
<td>Alameda County HSA</td>
<td>Riverside University Health System</td>
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<tr>
<td>Arrowhead Regional Medical Center</td>
<td>San Diego HHS</td>
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<tr>
<td>Contra Costa Health Services</td>
<td>San Francisco Dept. of Public Health</td>
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<tr>
<td>County of Orange Health Care Agency</td>
<td>San Joaquin County HSA</td>
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<tr>
<td>Kern Medical Center</td>
<td>San Mateo County Health System</td>
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<tr>
<td>Los Angeles County Dept. of Health Services</td>
<td>Santa Clara Valley HHS</td>
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<tr>
<td>Monterey County Health Dept.</td>
<td>Shasta County HHS</td>
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<tr>
<td>Napa County HHS</td>
<td>Solano County Health &amp; Social Services</td>
</tr>
<tr>
<td>Placer County HHS</td>
<td>Ventura County Health Care Agency</td>
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Whole Person Care – Target Populations

Lead Entities may propose target populations with one or more of the characteristics in this table; pilots typically target individuals with more than one.

<table>
<thead>
<tr>
<th>Target Populations May Include Individuals:</th>
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<tbody>
<tr>
<td>With repeated incidents of avoidable emergency use,</td>
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<tr>
<td>hospital admissions, or nursing facility placement</td>
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<tr>
<td>With 2+ Chronic Conditions</td>
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<tr>
<td>With Mental Health and/or Substance Use Disorders</td>
</tr>
<tr>
<td>Who are currently experiencing homelessness and/or at risk</td>
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<tr>
<td>of homelessness, including individuals who will be experiencing</td>
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<tr>
<td>homelessness upon release from institutions</td>
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Whole Person Care – Behavioral Health Metrics

• Universal Metrics
  • Follow-up After Hospitalization for Mental Illness (HEDIS)
  • Initiation and Engagement of AOD Dependence Treatment (HEDIS)

• Variant Metrics
  • PHQ-9: Depression Remission at 12 Months (NQF 0710)
  • Major Depression Disorder: Suicide Risk Assessment (NQF 0104)

• More Information:
  http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx
Whole Person Care – Data Sharing Activities

- Expansion of existing data sharing framework (18 Pilots)
- Bi-directional data sharing with MCPs (18 Pilots)
- Health Information Exchange (12 Pilots)
- Patient population software (11 Pilots)
- Data warehouse (9 Pilots)
- Query-based real-time data (7 Pilots)
- Case management software (7 Pilots)
- Real-time data sharing (6 Pilots)
- New data sharing systems (3 Pilots)
Health Homes for Patients (HHP)
With Complex Needs
HHP Overview

• Authorized under the Affordable Care Act
• Led by Medi-Cal Managed Care Plans (MCPs)
• Medi-Cal program will serve high-utilizer beneficiaries with multiple chronic conditions
• Centered on Community-Based Care Management Entities (CB-CMEs)
  • Must staff care managers and multi-disciplinary care team
  • Coordinate person-centered Health Action Plans with patients
  • Manage referrals, coordination, and follow-up to needed services and supports
  • Reimbursed with HHP funds through MCP
# WPC and HHP Eligible Populations

<table>
<thead>
<tr>
<th>WPC Target Populations May Include Individuals:</th>
<th>HHP-Eligible Populations Include Individuals With:</th>
</tr>
</thead>
<tbody>
<tr>
<td>With 2+ Chronic Conditions</td>
<td>2+ Chronic Conditions, or</td>
</tr>
<tr>
<td><strong>With Mental Health and/or Substance Use Disorders</strong></td>
<td>Hypertension and: COPD, diabetes, coronary artery disease, chronic or congestive heart failure, or</td>
</tr>
<tr>
<td></td>
<td>Major depression disorders, bipolar disorder, psychotic disorders (including schizophrenia), or</td>
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<tr>
<td></td>
<td>Asthma and a risk of at least one of the following: diabetes, SUD, depression, or obesity, and</td>
</tr>
<tr>
<td>With repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement</td>
<td>A chronic condition predictive risk score above 3, or</td>
</tr>
<tr>
<td>Who are currently experiencing homelessness and/or at risk of homelessness, including individuals who will be experiencing homelessness upon release from institutions</td>
<td>At least one inpatient stay in past year, or</td>
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<tr>
<td></td>
<td>3+ ED visits in past year, or</td>
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<tr>
<td></td>
<td>Chronic homelessness, and</td>
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<td></td>
<td>At least two separate claims for the eligible conditions</td>
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## WPC and HHP – BH Measures Crosswalk

<table>
<thead>
<tr>
<th>Behavioral Health Measures</th>
<th>WPC</th>
<th>HHP</th>
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<tbody>
<tr>
<td>Follow-up Hospitalization for Mental Illness (NQF 0576)</td>
<td>Universal</td>
<td>X</td>
</tr>
<tr>
<td>Initiation and Engagement of AOD Dependence Treatment (NQF 0004)</td>
<td>Universal</td>
<td>X</td>
</tr>
<tr>
<td>Major Depression Disorder: Suicide Risk Assessment (NQF 0104)</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>PHQ-9: Depression Remission at 12 Months (NQF 0710)</td>
<td>Variant</td>
<td></td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-up Plan (NQF 0418)</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Health Homes – Data Sharing and IT Needs

• Data sharing for care coordination and transitional care
  • Shared Health Action Plans among care teams across organizations
  • Monitoring conditions, health status, medications
  • Providing linkages/referrals to other services and supports
  • Transmitting summary care records and discharge summaries

• Additionally use EHR/HIT/HIE to:
  • Provide an HHP Member Portal
  • Register HHP members
  • Perform Point-of-Care Charting

• More Information: 
  http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
Public Hospital Redesign & Incentives in Medi-Cal (PRIME)
PRIME Overview

• Funding for Designated Public Hospitals and District/Municipal Hospitals throughout CA to generate improvements in:
  • Ambulatory care
  • Behavioral health integration
  • Managing high-risk populations
  • Efficiency

• Projects covering 3 domains
  • Outpatient Delivery System Transformation and Prevention
  • Targeted High-Risk or High-Cost Populations
  • Resource Utilization Efficiency
PRIME – Required Projects for Public Systems

1. Outpatient Delivery System Transformation and Prevention
   1.1 Integration of Physical and Behavioral Health
   1.2 Ambulatory Care Redesign: Primary Care
   1.3 Ambulatory Care Redesign: Specialty Care

2. Targeted High-Risk or High-Cost Populations
   2.1 Improved Perinatal Care
   2.2 Care Transitions: Integration of Post-Acute Care
   2.3 Complex Care Management for High Risk Medical Populations

3. Resource Utilization Efficiency
   3.1 Antibiotic Stewardship or
   3.2-3.4 Resource Stewardship
PRIME – Behavioral Health and SUD

• Project 1.1: Integration of Physical and Behavioral Health
  • Strengthen public health systems’ ability to deliver coordinated and patient-centered care to patients with both physical and behavioral health needs
  • Assessed by performance on 6 metrics:
    • Alcohol and Drug Misuse
    • Care Coordinator assignment
    • Comprehensive Diabetes Care: HbA1c Poor Control (>9%)
    • Depression Remission at 12 Months CMS 159v4
    • Screening for Clinical Depression and follow-up
    • Tobacco Assessment and Counseling
PRIME – Data Sharing Activities

• 1.1 Integration of Physical and Behavioral Health
  • Integrate screening tools & decision support into E.D. for recognition of patients with MH and SUD problems
  • Development of a single Treatment Plan including BH issues, medical issues, substance abuse, social and cultural and linguistic needs
  • Treatment Plan maintained in a single shared EHR/clinical record accessible across the treatment team to ensure coordination of care planning
  • Implement data systems to support pre-visit planning, point of care delivery, population management
  • Develop programs to implement telehealth, eReferral/eConsult to enhance access to behavioral health services

• More Information: http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx
Merit-Based Incentive Payment System
Merit-Based Incentive Payment System (MIPS)

• MACRA requires Medicare Part B providers under Physician Fee Schedule to report for MIPS or participate in an Advanced APM
  • Applies to physicians, psychiatrists, PAs, NPs, clinical nurse specialists
  • But not to clinical psychologists, LCSWs, hospitals, SNFs, FQHCs

• MIPS consolidates previous PQRS, Value Modifier, and MU programs, plus additional Clinical Practice Improvement Activities

• Composite score generated and compared against other providers to determine incentive payments or penalty adjustments
## MIPS – Behavioral Health Quality Measures

<table>
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<tr>
<th>Measure</th>
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<tbody>
<tr>
<td>Anti-Depressant Medication Management</td>
<td>Dementia: Neuropsychiatric Symptom Assessment</td>
<td>MDD: Coordination of Care of Patients with Specific Comorbid Conditions</td>
<td>Adherence to Antipsychotic Medications for Individuals with Schizophrenia</td>
</tr>
<tr>
<td>Care Plan</td>
<td>Dementia: Functional Status Assessment</td>
<td>Depression Remission at 6 Months</td>
<td>Depression: Utilization of the PHQ-9 Tool</td>
</tr>
<tr>
<td>BMI Screening &amp; Follow-up Plan</td>
<td>Dementia: Cognitive Assessment</td>
<td>Depression Remission at 12 Months</td>
<td>Follow-Up Care for Children Prescribed ADHD Medication</td>
</tr>
<tr>
<td>Documentation of Current Medications in Medical Record</td>
<td>Dementia: Management of Neuropsychiatric Symptoms</td>
<td>Preventive Care &amp; Screening for High Blood Pressure &amp; Follow-up Documented</td>
<td>Unhealthy Alcohol Use: Screening and Brief Counseling</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-up Plan</td>
<td>Dementia: Counseling Regarding Safety Concerns</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>Follow-Up After Hospitalization for Mental Illness</td>
</tr>
<tr>
<td>Elder Maltreatment Screen and Follow-up Plan</td>
<td>Dementia: Caregiver Education and Support</td>
<td>Tobacco Use and Help with Quitting Among Adolescents</td>
<td>Tobacco Use: Screening and Cessation Intervention</td>
</tr>
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MIPS – Clinical Practice Improvement Activities

- Depression screening and follow-up plans
- Diabetes screening for people with schizophrenia or bipolar who are using antipsychotic medication
- EHR enhancements for BH data capture
- Implementation of Co-location Primary Care and MH services
- Implementation of Integrated Patient-Centered Behavioral Health model
- MDD prevention and treatment interventions
- Integrated prevention and treatment interventions for tobacco use or unhealthy alcohol use
Recommended Process for Program Participation
Participation in Care Integration Programs

- Identify relevant programs
- Review program requirements
- Determine measures for reporting
- Select data elements, sources, and workflows
- Analyze privacy & security implications
- Identify data sharing needs and strategy
Questions

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