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

Mark Elson, PhD

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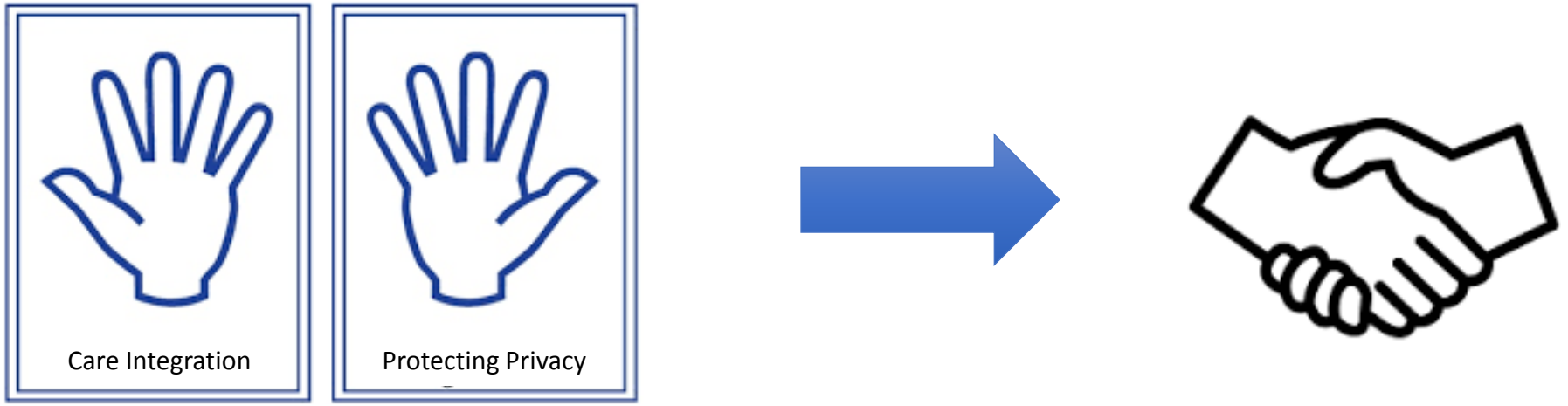
Integrating Physical and Behavioral Health

- 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)

Alameda County HSA	Riverside University Health System
Arrowhead Regional Medical Center	San Diego HHS
Contra Costa Health Services	San Francisco Dept. of Public Health
County of Orange Health Care Agency	San Joaquin County HSA
Kern Medical Center	San Mateo County Health System
Los Angeles County Dept. of Health Services	Santa Clara Valley HHS
Monterey County Health Dept.	Shasta County HHS
Napa County HHS	Solano County Health & Social Services
Placer County HHS	Ventura County Health Care Agency

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.

Target Populations May Include Individuals:
With repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement
With 2+ Chronic Conditions
With Mental Health and/or Substance Use Disorders
Who are currently experiencing homelessness and/or at risk of homelessness, including individuals who will be experiencing homelessness upon release from institutions

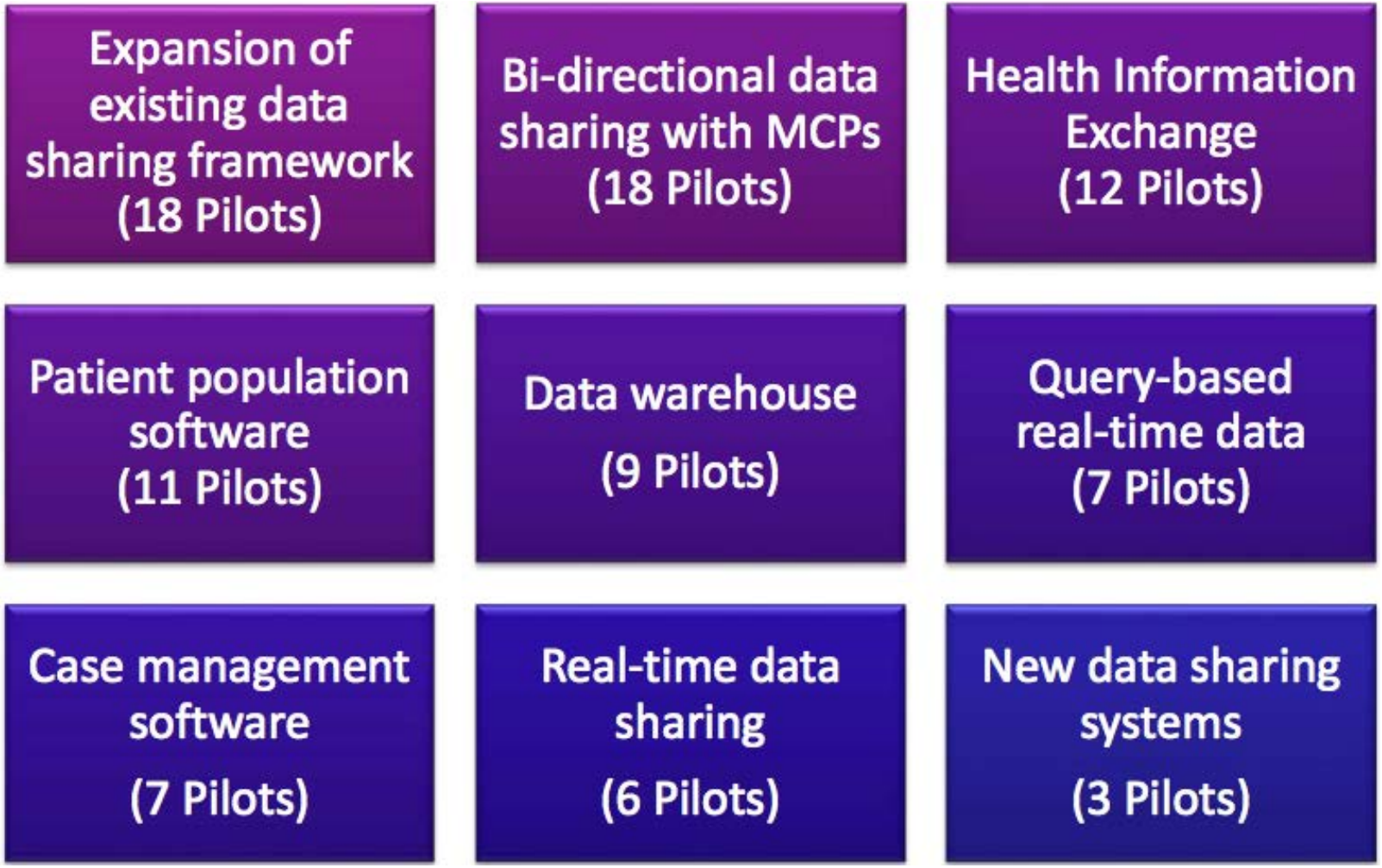
Whole Person Care – Behavioral Health Metrics

- 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



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

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

WPC and HHP – BH Measures Crosswalk

Behavioral Health Measures	WPC	HHP
Follow-up Hospitalization for Mental Illness (NQF 0576)	Universal	X
Initiation and Engagement of AOD Dependence Treatment (NQF 0004)	Universal	X
Major Depression Disorder: Suicide Risk Assessment (NQF 0104)	Variant	
PHQ-9: Depression Remission at 12 Months (NQF 0710)	Variant	
Screening for Clinical Depression and Follow-up Plan (NQF 0418)		X

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

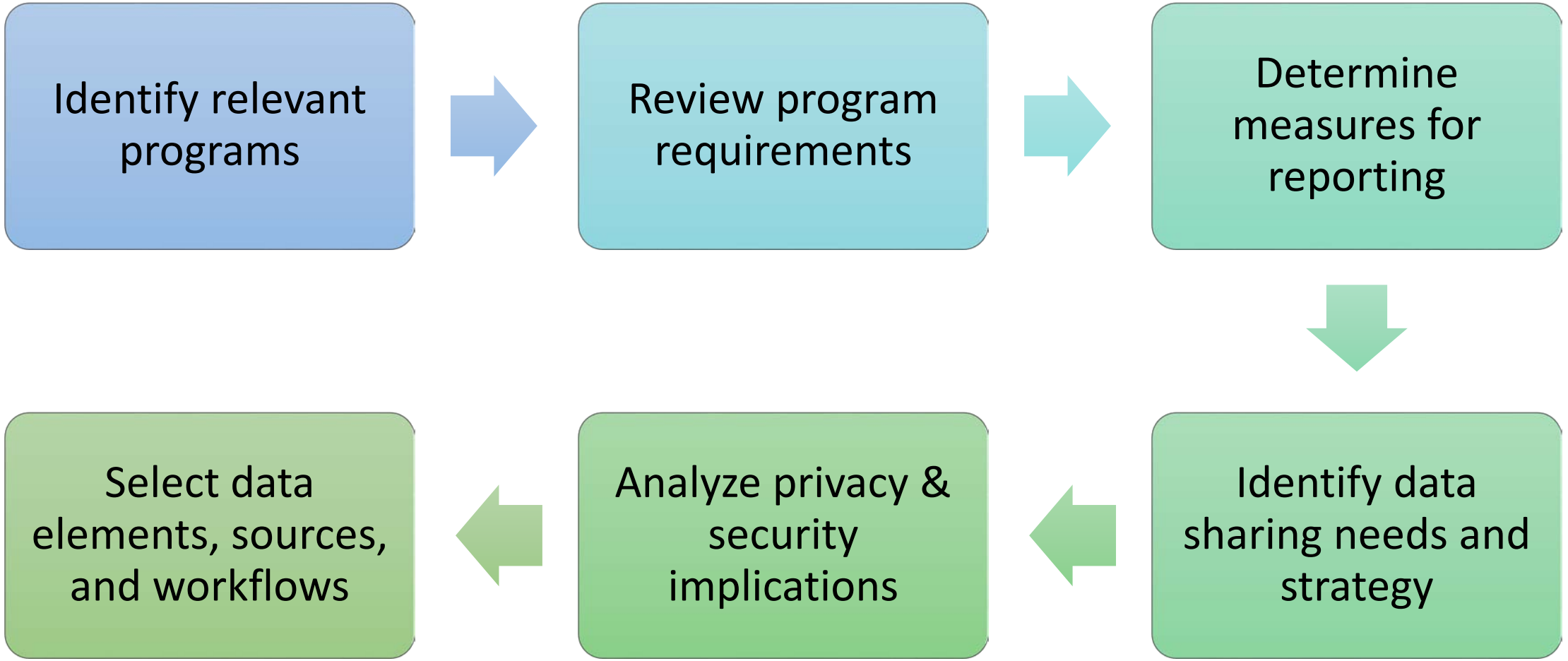
Anti-Depressant Medication Management	Dementia: Neuropsychiatric Symptom Assessment	MDD: Coordination of Care of Patients with Specific Comorbid Conditions	Adherence to Antipsychotic Medications for Individuals with Schizophrenia
Care Plan	Dementia: Functional Status Assessment	Depression Remission at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

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



Questions

Mark Elson, PhD

Executive Director

SJCHIE

mark@intrepidascent.com