Choppy Waters Overcoming the Challenges of Behavioral Health Integration

A Discussion with:

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Compass Health Network

Andrea Cuneio
Vice President of EHR solutions
Compass Health Network

Natalie Dykman
Compliance & Value Based Programs Manager
Missouri Primary Care Association

Tara Crawford
VP of Clinical Operations
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Julie Hiett
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SVP of Clinical Innovation
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Panelists

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Agenda

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BEHAVIORAL HEALTH INTEGRATION

The challenges and opportunities

THE PLAYERS: A PCA PERSPECTIVE

Missouri PCA

THE PLAYERS: AN FQ – CCBHC – CMH PERSPECTIVE

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DISCUSSION

Interoperability & Changing BH Landscape

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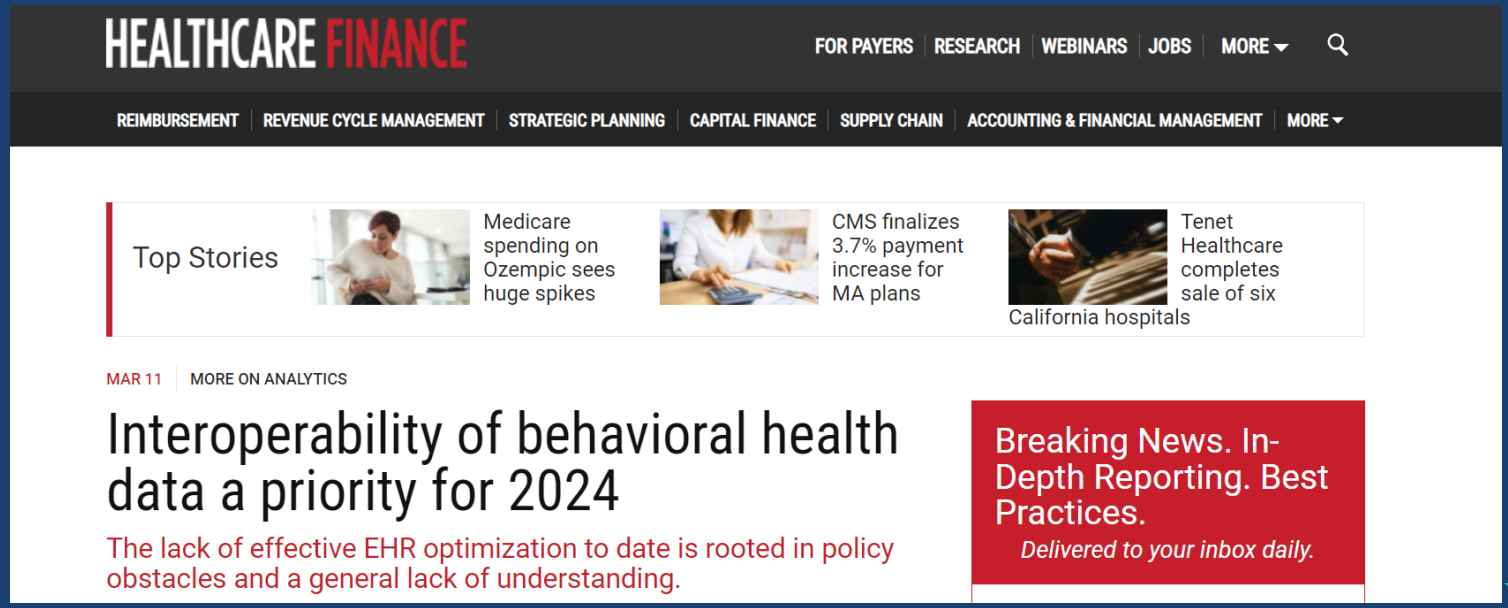
Insufficient data exchange exists among behavioral, mental and physical healthcare providers.

Without information exchange among EHR vendors, patient information cannot be accessed by all providers – impacting the level of care received.



https://www.healthcarefinancenews.com/news/interoperability-behavioral-health-data-priority-2024

Behavioral Health & Primary Care | Impact

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- **80%** of people with a behavioral health disorder **will visit a PCP at least once** a year
- **50%** of all behavioral health **disorders are treated in PC**
- **67%** of people with a behavioral health disorder **do not get BH treatment**
- **30-50%** of patient referrals from PC to outpatient BH **do NOT make first appt**
- **2/3rd of PCPs** report **not being able to access** outpatient BH for patients

https://thepcc.org/content/benefits-integration-behavioral-health

Behavioral Health Integration & DRVS

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1

Use the Patient Visit Planning Report to provide insight at the point of care.

2

Use custom registries (& cohorts) to identify and track key populations.

3

Track metrics through measures to monitor operations & workflows

DRVS Measures – Core Clinical | BH

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- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 161v16)
- Anxiety Screening for Adults with Anxiety Diagnosis
- Diabetes Screening – Antipsychotics
- Depression Remission at Twelve Months (CMS159v11)
- Child & Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 177v9)
- Screening for Depression & Follow-Up Plan (CMS 2v12)
- Depression Screen – Adolescents with Depression
- Depression Screen – Adults with Depression
- Depression Utilization of the PHQ-9 Tool (CMS 160v6)
- Antidepressant Medication Management – Effective Acute Phase Treatment
- Antidepressant Medication Management – Effective Continuation Phase Treatment

Create custom scorecards with any collection of measures

DRVS Measures – Core Clinical | BH

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- Screening for Depression & Follow-Up Plan 12-17 yrs (CMS 2v12 Modified)
- Screening for Depression & Follow-Up Plan 18+ years (CMS 2v12 Modified)
- Depression Screen – Positive Result (CMS 2v12 Modified)
- Depression Screen Positive w/Follow-Up (CMS 2v12 Breakout)
- Screening for Depression (CMS 2v12 Modified)
- Annual Anxiety Screen 8+
- Metabolic Testing – Antipsychotics

Netsmart & Azara Partnership

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Netsmart

Healthcare IT company and population health management platform for *health home organizations, managed care organizations (MCOs), human services and post-acute care providers*

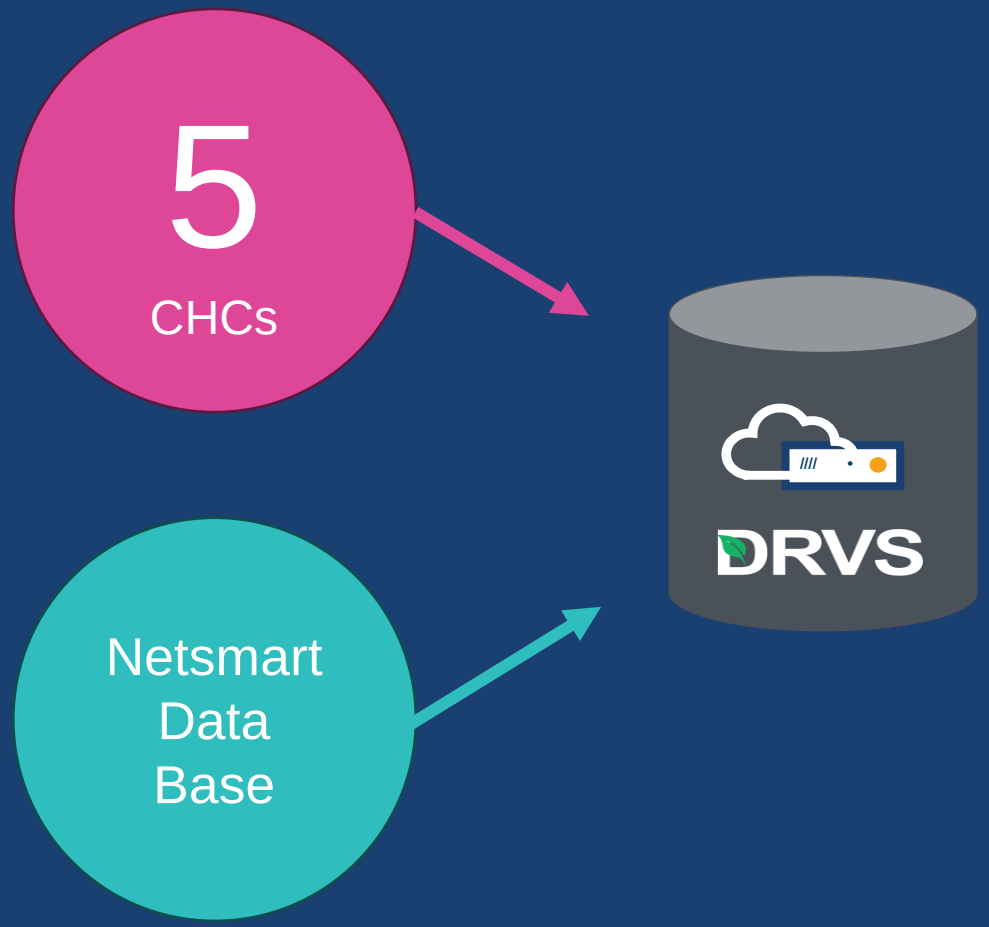
Aim of Collaboration

Advance primary care and behavioral health integration with the goal of improved care delivery and health outcomes for individuals throughout the state

Data Exchange

Data sharing for patients treated at participating Missouri Certified Community Behavioral Health Clinics (CCBHCs) who also receive services from a Missouri FQHC

Data Sharing in Missouri



WHAT IS “SHARED”?

PVP & CMP

- Visits at Other practices
- SDOH
- Shared medication + diagnosis data
- Shared patient cohort

Future state

- Antipsychotic medications alert
- Medications
- Shared diagnosis data

Shared Data on the PVP

9:45 AM Tuesday, October 17, 2023 | DATA FROM MULTIPLE PRACTICES | Visit Reason: **Medication Review**

Indicates shared data

ACC

Sex at Birth: M
GI: Man/Cisgender Man
SO: heterosexual

Lang: ENG
Risk: Low (5)

Portal Access: N
Cohorts: Consent to Share - GLB

Indicates data source

DIAGNOSES (4)

Anxiety	**Asthma** GLB	Depression
PD		

RISK FACTORS (3)

Pre-DM GLB	SMI	TOB

SDOH (2)

FPL<200% GLB	INSURANCE

RAF GAPS DIAGNOSIS CATEGORIES (1)

Psychiatric

ALERT	MESSAGE	DATE	RESULT

VISITS AT OTHER PRACTICES	PROVIDER	VISIT DATE	LOCATION
ABC Health Care	Unassigned Provider	8/2/2023	ABC Health Care Main St. USA

Visits at other practices

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Missouri Primary Care Association

MO-PCA Behavioral Health Integration

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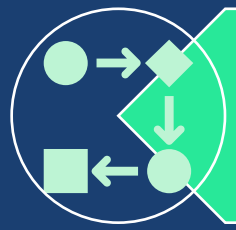
MPCA BEHAVIORAL HEALTH NETWORK

Purpose:

Integration of BH services into primary care

Focus:

Grow BH presence in population health management



Develop workflows and strategies to improve data capture for quality reporting (SDOH, BH/SUD screenings)

Enhance data options available to BH providers (Clinical, operational, payer)

MO-PCA Behavioral Health Integration

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BEHAVIORAL HEALTH WORKGROUP

Purpose:

Develop collaborative BH initiatives – FQHC/CMHC/CCBHO

Focus:

Improve understanding: FQHC/CMHC/CCBHO capacities

- Leverage services & data
- Strengthen referral relationships
- Create symbiotic relationship of shared patients

Utilize **centralized data** analytics

- Integrate payer & clinical data to support VBC
- Align Value Based Contracting with overlapping quality incentives and metrics
- Establish standard set of reports and metrics to improve model of care outcomes (total cost of care, hospital utilization, med adherence, TOC)
- Develop Interagency EHR access, DRVS connectivity for CMHCs, multi-system data sharing, DRVS Payer Integration

MO-PCA Behavioral Health Integration

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NETSMART DATA INTEGRATION PROJECT: 5 FQHCS | 5 CCHBCS

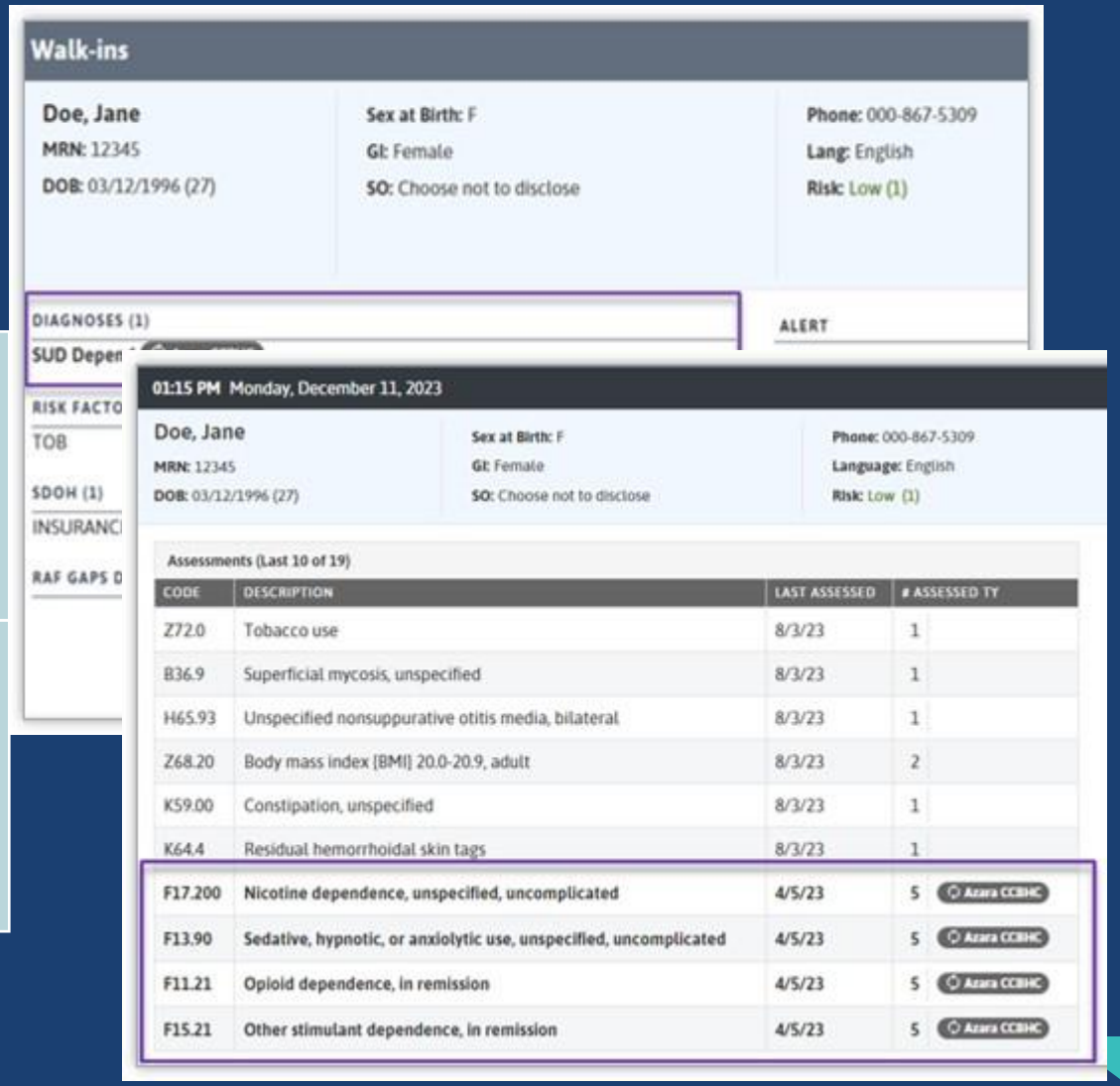
Multi-phase pilot 2023-present

Successes

- Great initial interest/engagement
- Successful incorporation of all data elements (dx and assessments)

Challenges

- Ongoing connectivity disruptions
- Low utilization



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Netsmart & Missouri Behavioral Health Council

MISSOURI BEHAVIORAL HEALTH COUNCIL

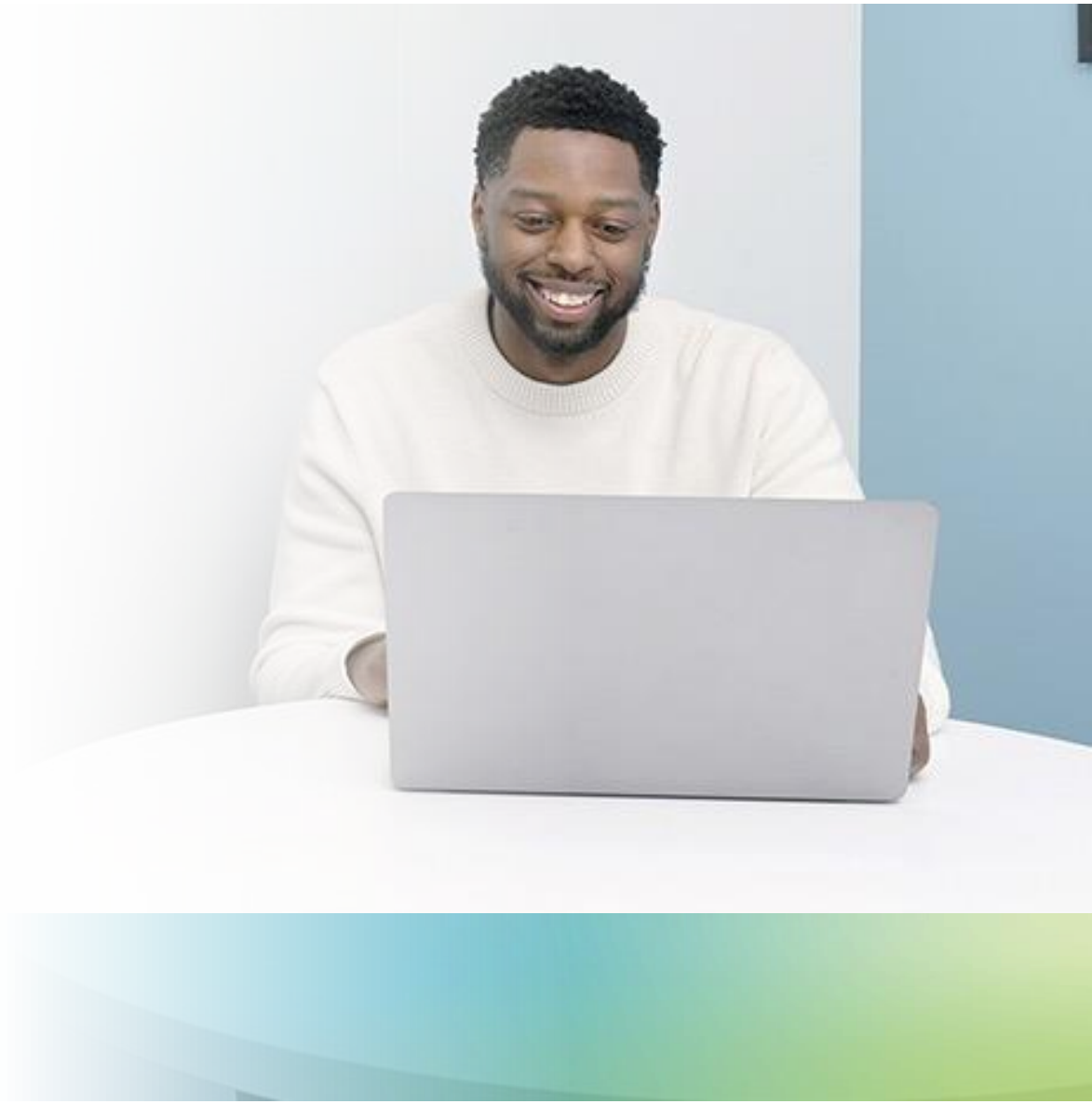
SERVING OUR COMMUNITIES

Our **2,500+** associates are motivated to equip providers for success

754,000+ providers

Together, we have impacted over

143+ MILLION LIVES



Netsmart

Adult Day Care

Addiction Treatment

Assisted and Independent Living

Autism

Behavioral Health (Inpatient, Outpatient)

Certified Community Behavioral Health Clinic (CCBHC)

Child and Family Services

Federally Qualified Health Centers (FQHC)

Home Care

Hospice

Integrated Care

Netsmart is driven to push towards positive change for **the communities we serve**

Intellectual and Developmental Disabilities

Life Plan Community (CCRC)

Long-Term Care Practices

Memory Care

Therapy Practices and Rehabilitation

Palliative Care

Private Duty

Public Health

Public Sector

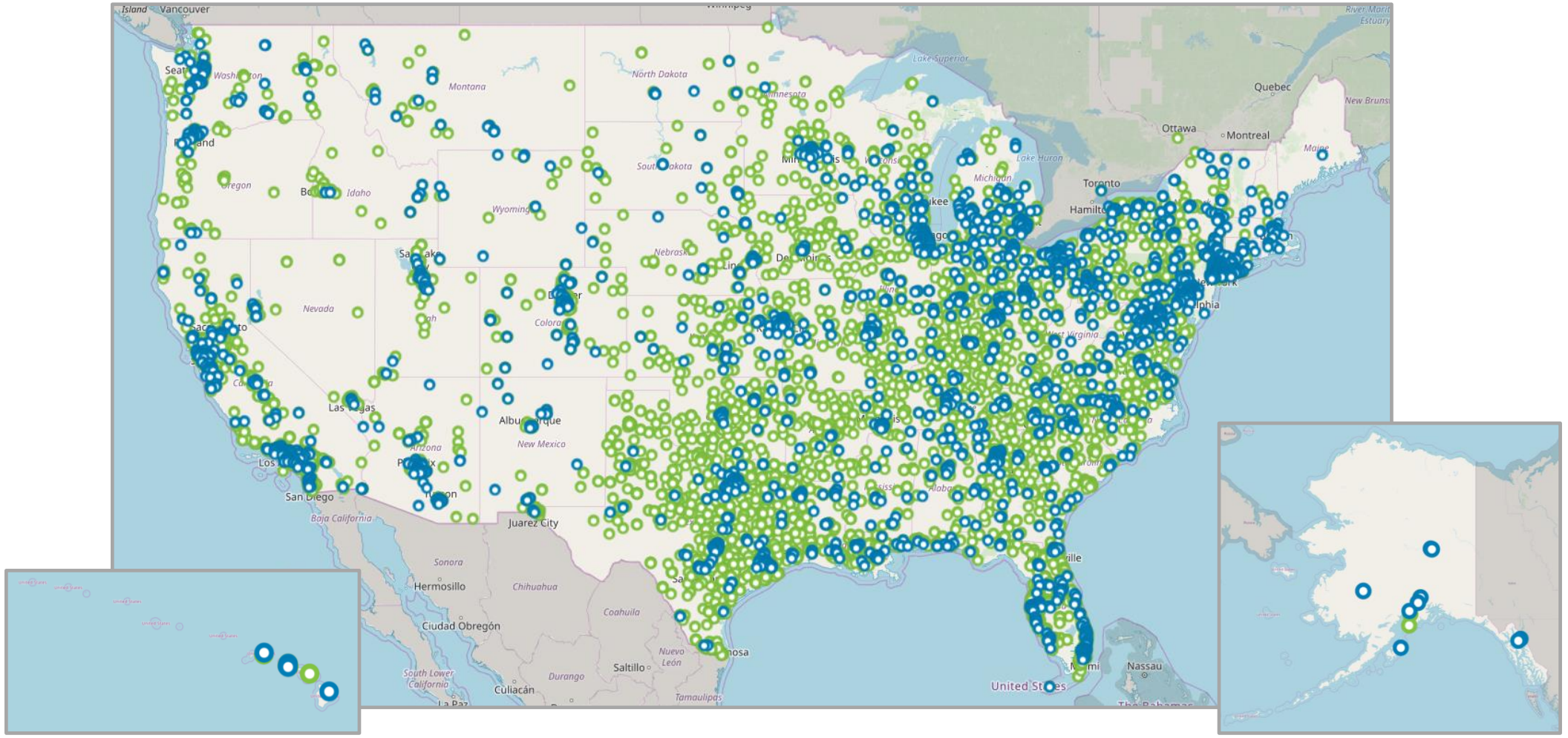
Senior Living

Skilled Nursing

Netsmart

Human Services

Post-Acute



Behavioral Health = 800+ Counties = 250+ Substance Abuse = 600+

Netsmart

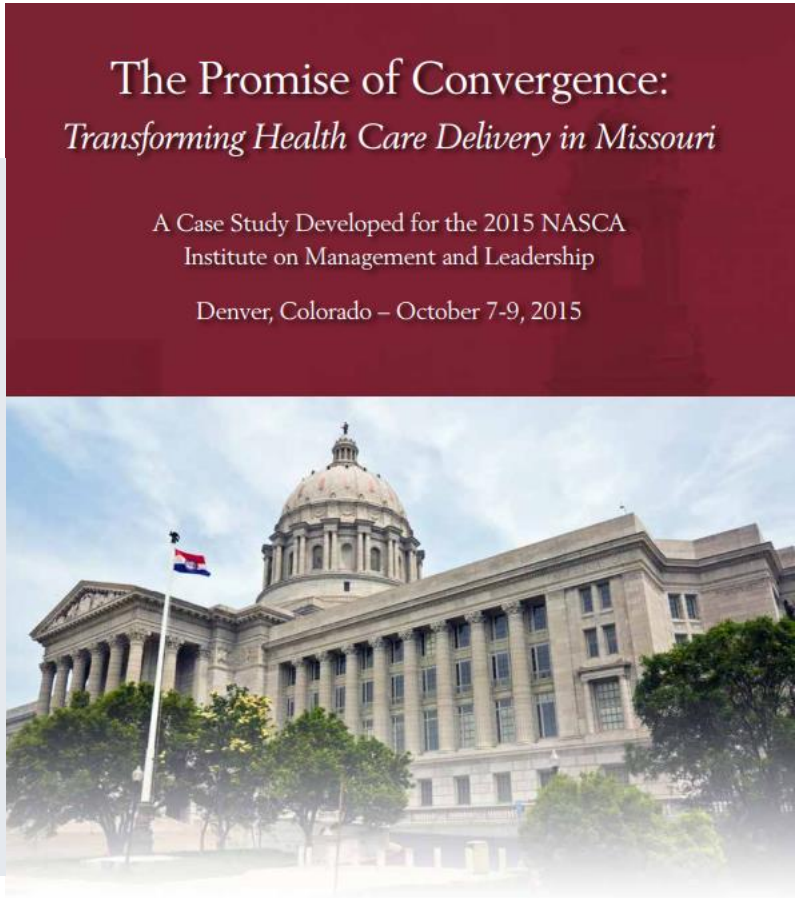
Challenges with Behavioral Health Integration

- 42cfr part 2, unique programming (domestic violence, AIDS)
  - Need for filters, data sharing consents
- Federal & State mandates
  - CCBHC, CMS, SAMHSA
- Access to the data
  - Hospitals, claims, HIEs, EHRs, Pop Health platforms, spreadsheets
- Data Governance
  - Tech is typically easier than policies around data sharing
- Real time or near real time ingest
  - Can only move the needle if data is “fresh”
- Lack of standardization with certain data, even across “same” EHRs
  - SDOH and other information often lives in a Bio-Psycho-Social Assessment for example
- Workforce challenges
  - 24/7 operations with crisis, lack of people to do the work, rural vs. urban

State Partnerships | Culture of Collaboration

- **Missouri Department of Mental Health**
  Division of Behavioral Health
- **Missouri Department of Social Services**
  MO HealthNet (Medicaid) Division
- **Missouri Department of Health & Senior Services**
- **Missouri Behavioral Health Council**
- **Missouri Primary Care Association**
- **Missouri Hospital Association**

> Furthermore, several key themes emerged from this study that are priority issues for state chief administrators and their staff, including **data governance, leading culture change, creating an agile workforce, and developing sustainable funding models for new initiatives**.



LEADERSHIP FOR A NETWORKED WORLD

"The Promise of Convergence: Transforming Health Care Delivery in Missouri"

Missouri CCBHCs

20 CCBHC Providers

375 CCBHC site locations

114 counties served of 114

160,568 individuals served by a CCBHC in 2021

8 STATES	State Population (in millions)	CCBHC Organizations	CCBHC Service Locations	Year 1 Total to receive CCBHC services (all pay source)	Year 1 Projected CCBHC Consumers who are Medicaid Recipients
MINNESOTA	5.52	6	22	17,600	15,000
MISSOURI	**6.09**	**15**	**201**	**127,083**	**87,284**
NEVADA	2.94	4	5	7,305	5,844
NEW JERSEY	8.94	7	20	79,782	50,882
NEW YORK	19.75	13	77	40,000	32,000
OKLAHOMA	3.92	3	19	23,076	11,077
OREGON	4.09	12	21	61,700	50,000
PENNSYLVANIA	12.80	7	7	27,800	17,800
	64.05	67	372	381,346	269,887

Arthur Center, BJC Behavioral Health, Bootheel Counseling Center, Burrell Behavioral Health, Clark Community Mental Health Center, Community Counseling Center, Compass Health Network, Family Guidance Center, FCC Behavioral Health, Hopewell Center, Mark Twain Behavioral Health, North Central MO Mental Health Center, Ozark Center, Ozarks Healthcare, Places for People, Preferred Family Healthcare, ReDiscover, Swope Health Services, Tri-County Mental Health Services, University Health Behavioral Health

CCBHC Outcome Measures & Value-Based Payments

9 Clinic-Led Measures

- Time to Initial Evaluation
- Adult BMI Screening/Follow Up
- Youth Weight Assessment/ Counseling
- Tobacco Use Screening/Cessation
- Alcohol Use Screening/Counseling
- **Youth MDD: Suicide Risk Assessment** $
- **Adult MDD: Suicide Risk Assessment** $
- Screening for Depression/Follow Up
- Depression Remission at 12 months

$ = VBP measures

CCBHCs must meet all 9 measure goals, statewide benchmark, and/or show improvement over previous FY

13 State-Led Measures

- Housing Status
- Patient Experience of Care Survey (adult)
- Youth/Family Experience of Care Survey
- Follow-up after ED visit for MI
- Follow-up after ED visit for AOD
- **MI Hospitalization Follow-up (adult)** $
- **MI Hospitalization Follow-up (youth)** $
- All Cause Readmission Rate
- Diabetes Screening
- **Adherence to Antipsychotic Medication** $
- Follow-up for Children ADHD Medication
- Antidepressant Medication Management
- **Initiation/Engagement of AOD Treatment** $

Missouri Evolution of Integrated Care & Data

2008

25-Year Mortality Study

Nurse Care Managers

+ Medicaid Claims Data (diagnosis, procedures, pharmacy)

2010

Chronic Disease Prevalence Studies

Metabolic Screening & High Cost/Risk Outreach

+ Vitals, Labs, Health Risk Factors (Metabolic Screening)

2012

Section 2703, Affordable Care Act

26 Behavioral Healthcare Homes

+ Hospitalizations
+ ED Visits

2017

Excellence in Mental Health Act

15 Certified Community Behavioral Health Clinics

Statewide Care Management & Population Health Tool

+ Medicaid Eligibility
+ Hospital Follow Up
+ Health Risk Profile

2024

20 CCBHCs

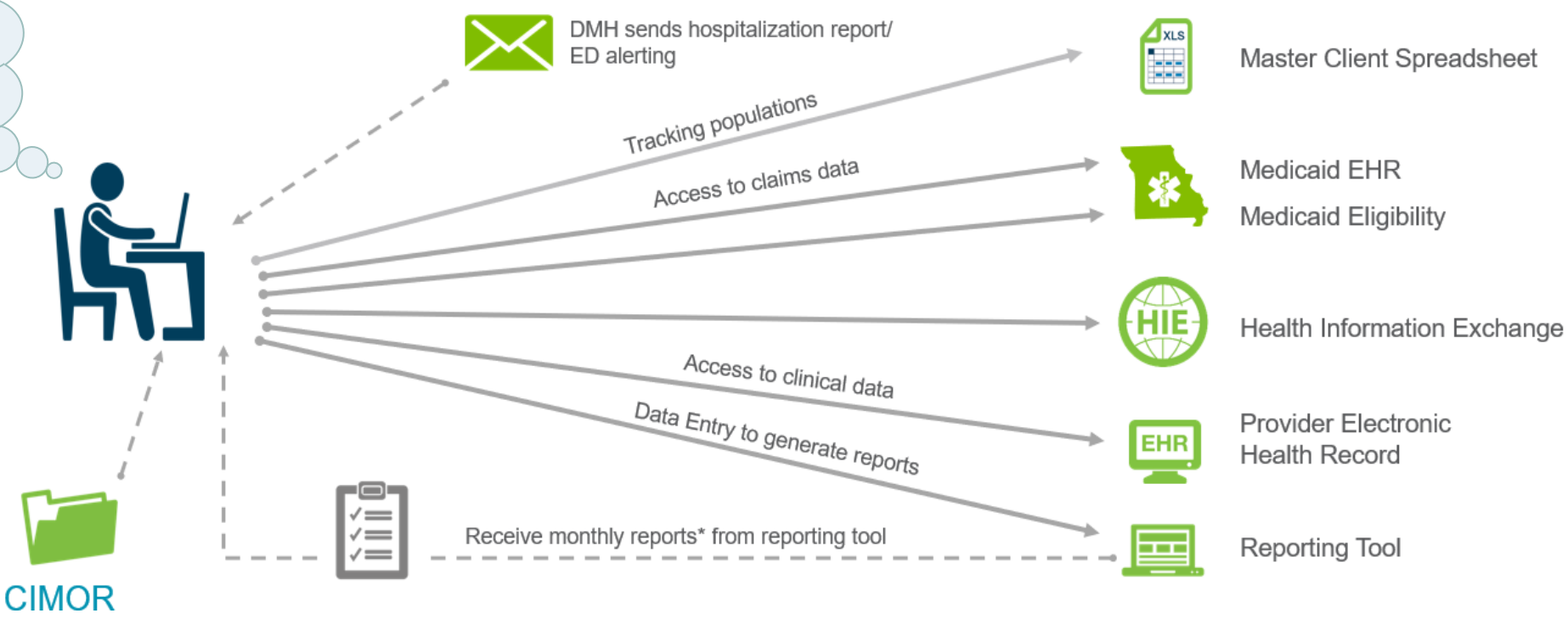
CLIVE

Council Data Warehouse

+ EHR Data

Evaluation of the workflow to gather information.
Conclusion: It's a hot mess – we need a one stop shop.

How can we eliminate the silos and integrate our data?



[1] Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.

"Case Managers spend roughly 40% of their time searching for patient data"[1]

Data Needs Assessment | "Shopping List"

One Stop Shop | Aggregate and display meaningful data in one system for behavioral health providers to inform their day

(claims data, hospital and ER notifications, clinical data, assessment scores, demographics)

- Access to data in **near real-time** (daily)
- Eliminate double entry of clinical data - **interoperability with EHRs**
- **Custom reporting** from the aggregate data set at the state and provider level
- Automated **risk stratification** methodology
- Display data in a meaningful way to enable **population health** in team workflows

CareManager & Population Health

CareManager was selected as Missouri's new health technology tool for behavioral health providers to use in **care management** and **population health**.

- **34** providers
- **1,000+** end users
- **275,000** lives managed

CareManager combines **Medicaid claims** data + DMH **client detail** + **hospital** and **ER notification** + **clinical** data from providers to:

- **alert** the care team of ER and hospital events
- **assess** populations for risk
- **monitor** health outcomes
- **manage** interventions to address gaps in care

MBHC

Health Risk Profile

Demographics

NAME | Blaine L Bambooson
DCN # | 5378434
NURSE CARE MANAGER ASSIGNMENT | Cecilia Rahardjo
DATE OF BIRTH / AGE | 06/06/1981 36 years Adult
GENDER | Male
RACE | Caucasian

Risk Summary

Metabolic Screening		**6.5**
Physical Health Diagnosis		**3**
Medication Use		**2.2**
ER & Hospitalizations		**3**
TOTAL RISK SCORE	MODERATE-HIGH RISK	14.7

Program Enrollment

Primary Care Health Home - enrolled 1/3/2017

Health Plan

BCBS KC - enrolled 01/03/2017

Category Details

Metabolic Screening

Adult BMI 18.5 - 24.9 (Healthy Weight)	0
BP > 140/>90 mmHg (High)	1.7
No A1c or Blood Glucose, Unable to Calculate, or Opt Out in last 12 months	0.8
No LDL, Unable to Calculate, or Opt Out in last 12 months	0.8
HDL > 60 mg/dL (Normal)	0
Triglycerides 150 ? 199 mg/dL (Borderline)	0
No Total Cholesterol, Unable to Calculate, or Opt Out in last 12 months	1
Tobacco Use	2.2

Physical Health Diagnosis

Thyroid Disorders (Thyroid, Acquired Hypo; Thyroid, Goiter, Nodular; Thyroid Disorder, Other)	1
Blood Disorders (Anemia, NOS; Anemia, Other Deficiency; Anemia, Hemolytic, Hereditary; Sickle-cell Disease)	1
Other Physical Health Diagnosis- Not Cancer	1

Medication Use

Taking Aripiprazole (Abilify), Ziprasidone (Geodon), or first-generation antipsychotics	2.2

ER & Hospitalizations

1-2 ER Visits in last 6 months	3
No Hospitalizations in last 6 months	0

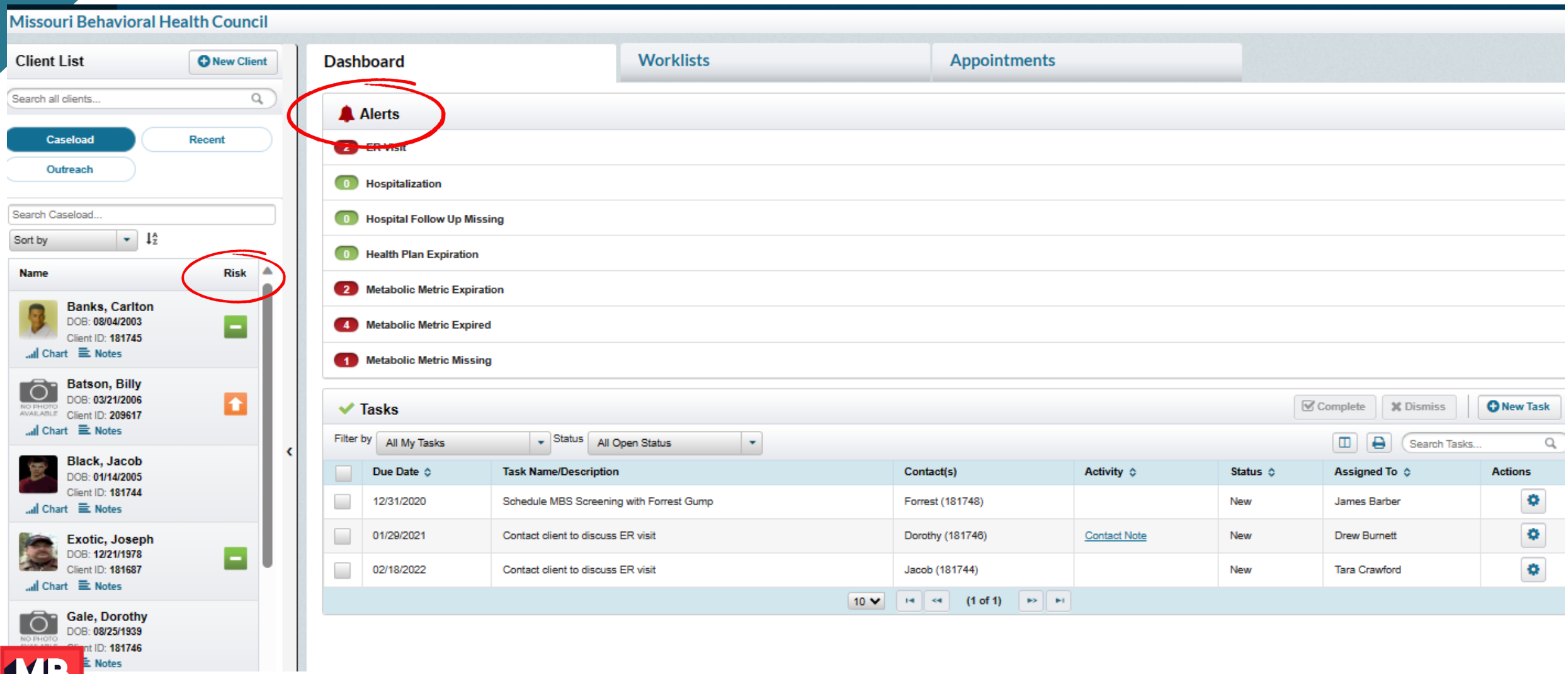
TOTAL RISK SCORE	MODERATE-HIGH RISK	14.7

Low Risk	< 7.5
Moderate Risk	7.5 – 11.5
Mod-High Risk	11.6 – 15
High Risk	> 15

Client Profile	› Demographics › Program Enrollment › Health Plan
Risk Factors	› Metabolic Screening Profile › Diagnosis: • Physical, Behavioral, Substance Use, Developmental Disability, Other Chronic Conditions › Medication Use › ER & Hospitalizations + Housing, Employment Status + PHQ-9, Suicide Risk + Functional Assessment Scores

DEMO PATIENT DATA ONLY

CareManager



Missouri's Health Information Landscape

34 Provider organizations

7 EHR vendors

- Metabolic screening
- Demographics
- SDoH
- Hospital follow up
- PHQ-9
- Suicide risk assessment
- CPS status report

RELIAS

- Medicaid claims

Dept of Mental Health

- Patient census
- Program assignment
- Demographics
- Medicaid eligibility
- Hospital and ER notifications

Data Integration

CLIVE
Council Data Warehouse

Reporting Warehouse
Ad-hoc Queries

CareManager

Driving quality care in the field.

CareManager equips the Care Team on the ground to make informed, data-driven decisions with access to real-time, comprehensive health information.

CareManager combines **Medicaid claims** data + DMH **client detail** + **hospital** and **ER notifications** + **clinical** data from providers to:

- Alert the Care Team of ER and hospital events
- Assess populations for risk
- Monitor health outcomes
- Identify gaps in care

Measures Reporting & Population Health

Measuring quality real-time.

Measures Reporting is integrated within CareManager and allows providers and the state to develop and standardize measures across the system for population health management.

Population | Managed | Intervention Needed

populations can be further stratified by:

- Medicaid Coverage or MCO
- Program Enrollment
- CCBHO-specific or State Totals
- Team Role or Staff Name

Opportunities for data sharing & collaboration

- Managed Care Plans
- Federally Qualified Health Centers
- CIMOR

MISSOURI BEHAVIORAL HEALTH COUNCIL

Netsmart

MPCA
Missouri Primary Care Association

azara healthcare

Primary Care & Behavioral Health Bi-Directional Data Sharing

Collaborators

Primary Care	Missouri Primary Care Association	Azara Healthcare
Behavioral Health	Missouri Behavioral Health Council	Netsmart Technologies

Pilot Organizations

(PARTICIPATING IN THE FQHC/CCBHC INTEGRATION PARTNERSHIPS)

FQHCs	CCBHCs
Access Family Affinia Healthcare Fordland Clinic Katy Trail Swope Health Services	Clark Center BJC Behavioral Health Burrell Behavioral Health Compass Health Heartland Center

CHIPS Report

Council Health Information Program Summary

Data Transparency

August 2022

HCH Chronic Health Condition Measures - Statewide

Exceeds Goal
Meets Goal
Below Goal
Top Agency

	Metabolic Screening Complete		Asthma Medication Adherence		Blood Pressure Control for Hypertension	Blood Pressure Control for Diabetes	Hemoglobin HbA1c Control for Diabetes		LDL Control for Diabetes	LDL Control for Cardiovascular Disease	Obesity Weight Loss	Severe Obesity Weight Loss	Tobacco Use Control	
	Adult	Youth	Adult	Youth	Adult	Adult	Adult	Youth	Adult	Adult	Adult	Adult	Adult	Youth
Statewide	85%	90%	78%	61%	60%	65%	59%	44%	62%	65%	32%	39%	45%	88%
Adapt of Missouri	68%		82%		36%	45%	60%		54%	50%	38%	30%	40%	
Arthur Center	98%	100%	92%	0%	88%	93%	57%	67%	59%	63%	28%	45%	49%	97%
BJC Behavioral Health	72%	79%	81%	75%	61%	62%	55%	60%	59%	65%	34%	38%	81%	82%
Bootheel Counseling Services	93%	95%	100%	80%	76%	83%	75%	83%	71%	69%	31%	42%	58%	92%
Burrell Behavioral Health	74%	83%	73%	57%	43%	50%	28%	37%	56%	64%	29%	41%	34%	87%
Clark Community Mental Healt..	88%	93%	63%	50%	45%	40%	76%	0%	55%	63%	30%	40%	38%	88%
Community Counseling Center	78%	86%	93%	100%	51%	55%	54%	19%	56%	51%	29%	32%	38%	82%
Compass Health	95%	96%	75%	46%	60%	65%	55%	25%	64%	64%	31%	36%	44%	94%
Comprehensive Health Systems	79%		100%		66%	65%	65%		69%	64%	46%	38%	39%	
Comprehensive Mental Health ..	47%				50%	100%	75%		75%	50%	33%		20%	
COMTREA	85%	100%	75%		63%	71%	66%		65%	62%	30%	38%	43%	100%
Family Guidance Center	80%	79%	62%	100%	77%	74%	75%	100%	69%	73%	36%	41%	29%	74%
FCC Behavioral Health	93%	92%	84%	69%	67%	72%	76%	65%	65%	72%	32%	42%	42%	90%
Hopewell Center	61%	35%	64%	57%	27%	35%	52%	25%	42%	38%	37%	42%	30%	28%
Independence Center	98%		67%		62%	69%	84%		70%	92%	41%	56%	52%	
Mark Twain Behavioral Health	91%	89%	85%	100%	78%	80%	72%	0%	69%	63%	28%	41%	44%	89%
New Horizons Community Sup..	95%		89%		86%	87%	74%		66%	80%	39%	31%	51%	
North Central Missouri Mental ..	99%	98%	89%	100%	76%	82%	85%	100%	81%	90%	24%	32%	44%	91%
Ozark Center	92%	78%	86%	100%	68%	73%	74%	67%	66%	71%	26%	35%	47%	75%
Ozarks Healthcare Behavioral ..	88%	92%	100%	100%	67%	72%	69%	29%	54%	60%	29%	42%	39%	86%
Places for People	75%	64%	87%	100%	70%	67%	55%	0%	58%	57%	38%	41%	25%	68%
Preferred Family Healthcare	86%	89%	94%	100%	67%	69%	41%	50%	64%	64%	34%	38%	35%	86%
ReDiscover	74%	88%	65%	44%	50%	54%	67%	30%	55%	67%	34%	49%	42%	84%
Swope Health Services	86%	92%	38%	33%	84%	86%	71%	100%	57%	69%	31%	35%	46%	100%
Tri-County Mental Health Servi..	88%	100%	86%	100%	74%	81%	61%		67%	54%	31%	41%	55%	95%
University Health Behavioral H..	81%	85%	72%	40%	60%	68%	65%	0%	67%	69%	36%	39%	40%	82%

Goal | 12 Month Trend

Goal
Adult
Youth

	Goal	12 Month Trend
Metabolic Screening Complete	80%	82% 73% 85%
Asthma Medication Adherence	70%	96% 78% 61%
Blood Pressure Control for Hypertension	60%	54% 60%
Blood Pressure Control for Diabetes	65%	59% 65%
Hemoglobin HbA1c Control for Diabetes	60%	48% 43% 59% 44%
LDL Control for Diabetes	36%	55% 62%
LDL Control for Cardiovascular Disease	70%	56% 65%
Obesity Weight Loss	no goal set	30% 32%
Severe Obesity Weight Loss	no goal set	38% 39%
Tobacco Use Control	56%	83% 39% 88% 45%

Oct 21 Jan 22 Apr 22 Jul 22

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Compass Health Network

MISSION

Inspire Hope.
Promote Wellness.

VISION

Full, productive, healthy lives for everyone.

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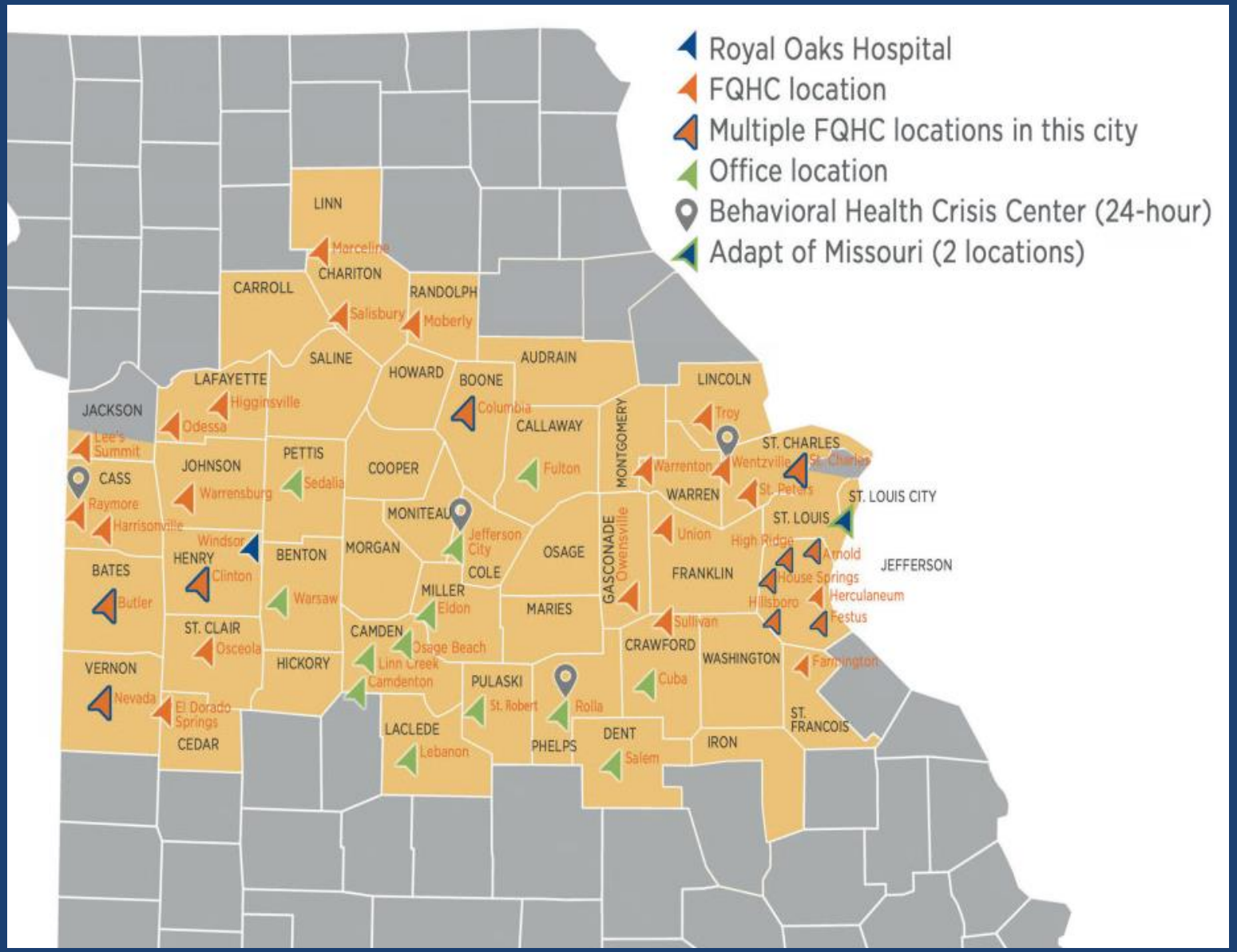

133,034

Customers served in multiple lines across Missouri in 2023

- $524 Million Budget
- Over 4,900 Employees
- 90 Service Locations
- 5 FQHC Partnerships
- 121 Psychiatrists/PA/APRN
- 51 Primary Care Physicians/APRN
- 903 Community Support Specialists
- 75 Dentists
- 493 Therapists and Psychologists

Integration Report

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CQM performance for integrated patients vs non-integrated

- **Report build** (EHR team)
  - SQL report; all EHR's / service lines
- **Output**
  - Breakout / %
- **QA utilizes raw report and DRVS for further analysis**
  - Cohorts - static
  - Priority Metric scorecard comparison

Client Count (Mar 23 to Feb 24) : 137088

Group Type	Distinct Clients	Percent
BH Only	57279	41.78
DNT Only	29690	21.66
PC Only	27680	20.19
PC/DNT	7929	5.78
PC/BH	6536	4.77
DNT/BH	4909	3.58
PC/DNT/BH	3064	2.24

DRVS Cohorts / Outcome

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Consistently see **better** outcomes for integrated patients

	PC Pts	PC+DNT+BH PTS	PC+DNT PTS	PC+BH PTS
Measure	Result	Result	Result	Result
Childhood Immunization Status	24.2%	0.0%	37.0%	0.0%
Cervical Cancer Screening	45.7%	57.9%	53.5%	47.5%
Child Wt Screening/BMI/Nutr /Phys Act Counseling	74.3%	81.6%	77.1%	78.0%
BMI Screening and Follow-Up 18+ Years	83.7%	89.7%	83.5%	87.0%
Tobacco Use: Screening and Cessation	88.4%	87.3%	91.2%	86.6%
Use of Appropriate Medications for Asthma	92.6%	94.3%	96.3%	92.6%
Statin Therapy CVD	74.7%	76.9%	76.6%	79.3%
IVD Aspirin Use	82.2%	83.3%	100.0%	85.7%
Colorectal Cancer Screening	48.0%	63.3%	46.7%	53.0%
Screening for Depression and Follow-Up Plan	85.3%	71.4%	91.0%	74.5%
Hypertension Controlling High Blood Pressure	73.5%	82.5%	71.4%	74.3%
Diabetes A1c > 9 or Untested	32.9%	33.6%	29.2%	30.2%

OVERALL UDS SCORECARD FOR ALL PRIMARY CARE			COMBINED INTEGRATED PATIENTS		
Result	Nume	Denon	Result	Nume	Denon
24.2%	31	128	35.7%	10	28
45.7%	1380	3020	51.7%	788	1525
74.3%	1803	2426	78.4%	1039	1326
83.7%	6037	7211	86.8%	2916	3359
88.4%	4142	4686	87.9%	2078	2364
92.6%	174	188	94.0%	109	116
74.7%	925	1238	78.2%	426	545
82.2%	185	225	88.1%	74	84
48.0%	1266	2635	53.6%	593	1107
85.3%	5781	6781	79.4%	2267	2855
0.0%	0	21	0.0%	0	12
73.5%	1031	1403	75.7%	504	666
32.9%	334	1016	30.9%	146	473

BHC Impact on UDS Measures

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BHC encounters report

Utilize DRVS to compare outcomes with & without BHC

Consistently *better outcomes* for those utilizing BHCs

Screening for Depression and Follow-up *rate lower*?

Next Steps

Priority Measures-Calendar Year 2023	Target	Result With BHC	Result Without BHC
Breast Cancer Screening Ages 50-74	45.0%	53.9%	50.8%
Cervical Cancer Screening	55.0%	64.1%	58.7%
Colorectal Cancer Screening	48.0%	50.2%	47.9%
Screening for Depression and Follow-Up Plan	75.0%	75.7%	80.0%
Depression Remission at Twelve Months	18.2%	13.5%	14.9%
Chlamydia Screening for Women	58.0%	74.5%	72.5%
Hepatitis C Lifetime Screening	45.0%	63.3%	54.9%
HIV Screening	40.0%	65.5%	59.1%
Asthma Self-Management Plan	10.0%	44.6%	43.1%
Diabetes A1c > 9 or Untested	15.0%	20.5%	20.5%
Diabetes BP < 140/90	68.0%	82.2%	81.9%
Diabetes: Eye Exam	58.0%	63.3%	52.8%
Hypertension Controlling High Blood Pressure	80.0%	76.3%	76.6%
IVD Aspirin Use	85.0%	87.6%	84.0%
Statin Therapy for the Prevention and Treatment of CVD	80.0%	87.8%	85.1%
Lead Screening	68.0%	82.6%	75.0%
Adolescent Immunizations	30.0%	36.4%	24.4%
Childhood Immunization Status	33.0%	32.6%	20.4%
Well-Child Care Visits (15-30 months)	50.0%	60.4%	43.6%
Well-Child Care Visits (3-21 Yrs)	60.0%	74.6%	72.7%

% Measures Met with BHC	
Primary Target	80.00%
Secondary Target	15.00%
Not Met	5.00%

% Measures Met without BHC	
Primary Target	55.00%
Secondary Target	20.00%
Not Met	25.00%

CCBHC & UDS Quality Measures

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Challenges

Variance between required CCBHC & UDS Quality Measures

- Ex – Depression Remission at 12 Months

Different reporting periods

- Fiscal year vs Calendar year

Opportunities

Multiple EHRs have required creative reporting solutions for monitoring

- Streamline with DRVS integration

Improve care coordination between service lines/providers

- PC care coordinators will work directly with BH clients

Next Steps | Compass Health Network

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1. Integrate current behavioral health EHR (Netsmart myAvatar) and 2 legacy EHRs **into DRVS**

2. Use DRVS to **monitor all UDS measures** and serve as source of truth across all service lines (currently in initial connectivity/mapping)

3. Implement **updated workflows** for capturing all applicable UDS measures in Behavioral Health & Dental EHRs

DRVS Tools to Support Behavioral Health

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Behavioral Health Integration & DRVS

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1

Use the Patient Visit Planning Report to provide insight at the point of care.

2

Use custom registries (& cohorts) to identify and track key populations.

3

Track metrics through measures to monitor operations & workflows

1 Alerts | Depression

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Alert	Description
Depression Remission	Alert will trigger if patient has a diagnosis of depression or dysthymia and has not had a follow-up PHQ9, or has had a follow-up PHQ9 >=5. Alert will begin firing 1 month before the follow-up period starts (i.e., 9 mo. After the initial screen), and will be capped by 12 months after the follow-up period closes (i.e., 26 mo. After initial screen). This alert is not configurable.
Depression Screen with Diagnosis	Alert will trigger if Depression Screen has not occurred in the last 1 year. Alert only applies to patients >12 yrs old. Patients must have active diagnosis of Depression. This alert is not configurable.
Depression Screening	Alert will trigger if Depression Screen Result has not occurred in the last 1 years. Alert only applies to patients >=12 yrs old. Patient must not have Depression Screen Refused or Depression Screen Contraindicated or Depression or Bipolar Dx.
Depression Screening Follow-up	Alert will trigger if patient had positive depression screen results AND had a qualifying encounter on the same day of or within 14 days after the positive screening, AND had no depression follow-up performed on the same day of the encounter. Patient must not have Depression/Bipolar. This alert is not configurable

1 Alerts | PHQ9

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Alert	Description
PHQ-9 Follow-Up	Alert will trigger if a patient PHQ-9 screen is >=10 and there is no follow-up on the same day as the positive screening. Patient must not have Depression/Bipolar. This alert is not configurable.
PHQ-9 Screen	Alert will trigger if PHQ-9 Depression Screen has not occurred in the last 1 years. Alert only applies to patients >=12 yrs old. Patient must not have Depression or Bipolar Dx.
PHQ-9 Utilization	Alert will trigger if a patient has a diagnosis of depression or dysthymia and has not completed a PHQ9 during each applicable 3-month period in which there was a qualifying visit. This alert is not configurable.
Positive PHQ-9 Follow-Up	Alert will trigger for patients age >=18 with a diagnosis of depression whose last PHQ9 was positive and was over 90 days to 1 year old, but has not had a recurrent PHQ9 to follow up. This alert is not configurable.

1 Alerts | Behavioral Health

Alert	Description
Diabetes Screen – Antipsychotics	Alert will trigger if A1C has not occurred in the last 1 years. Patient must have Antipsychotic Medications. Patient must not have Palliative Care or hospice care.
Metabolic Monitoring – Antipsychotics	Alert will trigger for patients prescribed an antipsychotic medication in the last year who have not had metabolic testing (CMP, TSH, CBC w/dif AND LDL) within the last 12 months. This alert is not configurable.
Anxiety Screen	Alert will trigger if Anxiety Screen has not occurred in the last 1 years. Alert only applies to patients >=18 yrs old. Patient must not have Anxiety,
Anxiety Screen with Diagnosis	Alert will trigger if GAD-7 Score has not occurred in the last 1 years. Alert only applies to patients >=16 yrs old. Patient must have Anxiety.

1 Alerts | Suicide Assessments

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Alert	Description
MDD Suicide Risk Assessment	Alert will trigger if Suicide Risk Assessment has not occurred in the last 0 days. Alert only applies to patients >=6 yrs old and <=17 yrs old. Patient must have Major Depressive Disorder.
Suicide Risk Assessment Ages 10-17	Alert will trigger if Suicide Risk Assessment has not occurred in the last 6 months. Alert only applies to patients >=10 yrs old and <=17 yrs old. Patient must have Suicide Risk Assessment.
Suicide Risk Assessment Ages 18+	Alert will trigger if Suicide Risk Assessment has not occurred in the last 1 years. Alert only applies to patients >=18 yrs old. Patient must have Suicide Risk Assessment.

2 RDEs | Behavioral Health

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ADHD

- ADHD Diagnosis
- ADHD Medications
- ADHD Self Management
- Vanderbilt ADHD Assessment

Anxiety

- Anxiety
- Anxiety Disorders
- Anxiety Screen
- GAD-2
- GAD-7

Bipolar

- Bipolar Diagnosis
- Bipolar Disorder

CAT-MH

- CAT-MH ANX Severity
- CAT-MH DEP Severity
- CAT-MH MHM Severity
- CAT-MH PTSD Severity
- CAT-MH SS Severity
- CAT-MH SU Severity

Depression

- Beck Depression Inventory (BDI-II)
- Beck Depression Inventory – Fast Screen (BDI-FS)
- Clinically Useful Depression Outcome Scale (CUDOS)
- Depression Assessment PHQ-9 >9
- Depression Diagnosis
- Depression Follow-Up
- Depression Follow-Up Assessment Period CY
- Depression Follow-Up Assessment Period for PHQ-9 >9
- Depression Screen Primary Care
- Depression Screen Refused
- Depression Screening
- Depression Self Management
- Depression/Bipolar

2 RDEs | Behavioral Health

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Geriatrics

- Geriatric Depression Scale Long Form
- Geriatric Depression Scale Short Form
- Geriatric Depression Screen

Major Depressive Disorder in Remission

Medication

- Antidepressant Medication
- Antipsychotic Medications

Operational

- Next Behavioral Health Appointment
- Collaborative Care Next Due
- Collaborative Care Referral
- Behavioral Health Assessment
- Behavioral Health Assessment Next Due
- Behavioral Health Encounter
- BH Counselor
- BH Interaction

Pediatric

- CES-DC
- Child Adolescent Psychiatry Screen
- SED
- Vanderbilt ADHD Assessment

PHQ

- PHQ-2 Depression Screen
- PHQ-9 Depression Screen
- PHQ-2 Question 9
- PHQ-9 Utilization – Q1, Q2, Q3, Q4

Postpartum Depression

PSC

- PSC-17 Internalizing
- PSC-17 Total

Psychosocial Assessment

2 RDEs | Behavioral Health

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Psychosocial Assessment

PTSD

- PTSD
- PTSD Checklist for DSM-5
- PTSD Primary Care Screen for DSM-5
- PTSD Screen
- PTSD Severity Short Scale

SAD (Seasonal Affective Disorder)

Schizophrenia

Stress

- Stress
- Stress Disorder
- Stress ICD-10

Suicide

- Suicidality
- Suicide Attempt Self Harm
- Suicide Risk Assessment
- Columbia Suicide Severity Score

3 Measures – Core Clinical | BH

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- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 161v16)
- Anxiety Screening for Adults with Anxiety Diagnosis
- Diabetes Screening – Antipsychotics
- Depression Remission at Twelve Months (CMS159v11)
- Child & Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 177v9)
- Screening for Depression & Follow-Up Plan (CMS 2v12)
- Depression Screen – Adolescents with Depression
- Depression Screen – Adults with Depression
- Depression Utilization of the PHQ-9 Tool (CMS 160v6)
- Antidepressant Medication Management – Effective Acute Phase Treatment
- Antidepressant Medication Management – Effective Continuation Phase Treatment

Create custom scorecards with any collection of measures

3 Measures – Core Clinical | BH

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- Screening for Depression & Follow-Up Plan 12-17 yrs (CMS 2v12 Modified)
- Screening for Depression & Follow-Up Plan 18+ years (CMS 2v12 Modified)
- Depression Screen – Positive Result (CMS 2v12 Modified)
- Depression Screen Positive w/Follow-Up (CMS 2v12 Breakout)
- Screening for Depression (CMS 2v12 Modified)
- Annual Anxiety Screen 8+
- Metabolic Testing – Antipsychotics

Questions?

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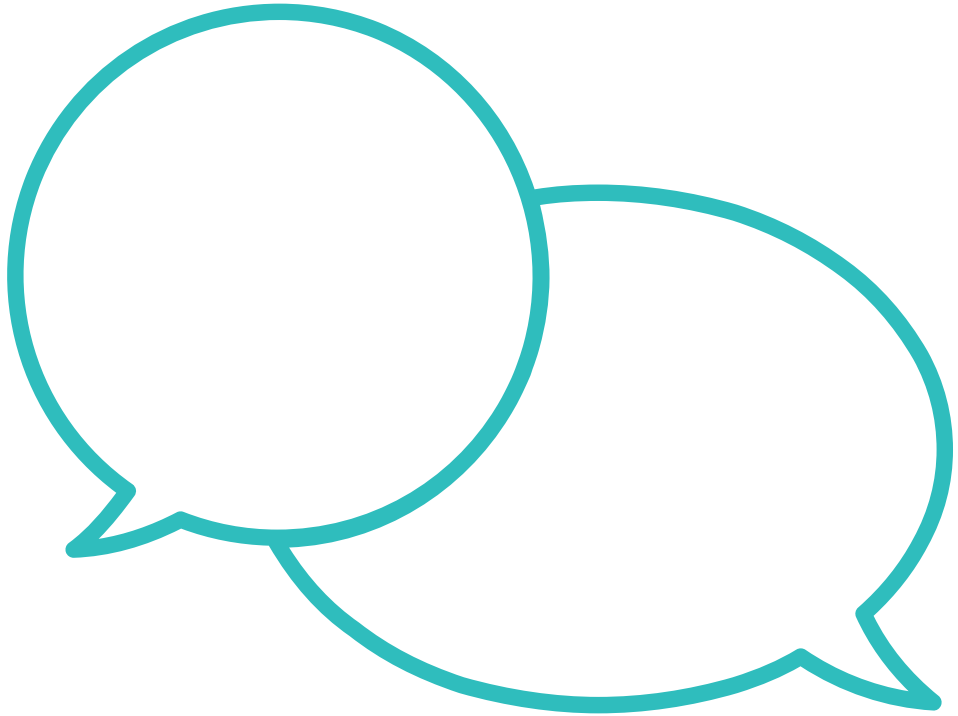

Azara healthcare

@AzaraDRVS

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

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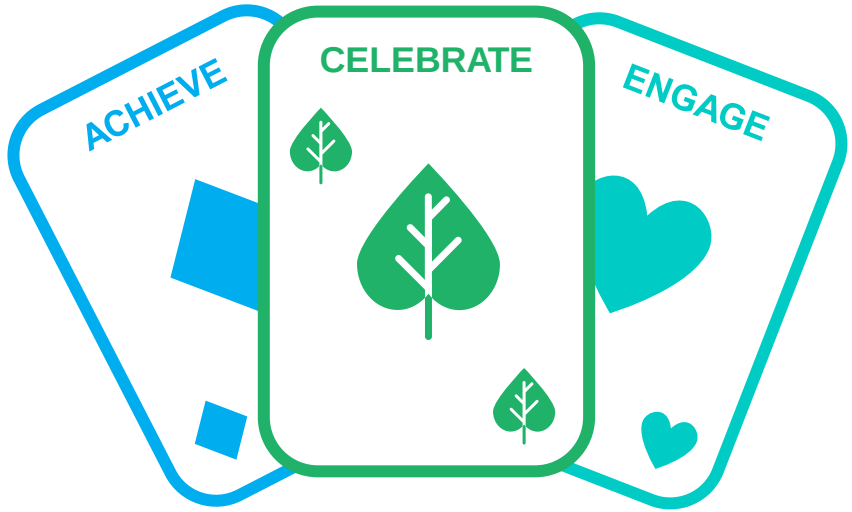
ACE Program



Benefits:

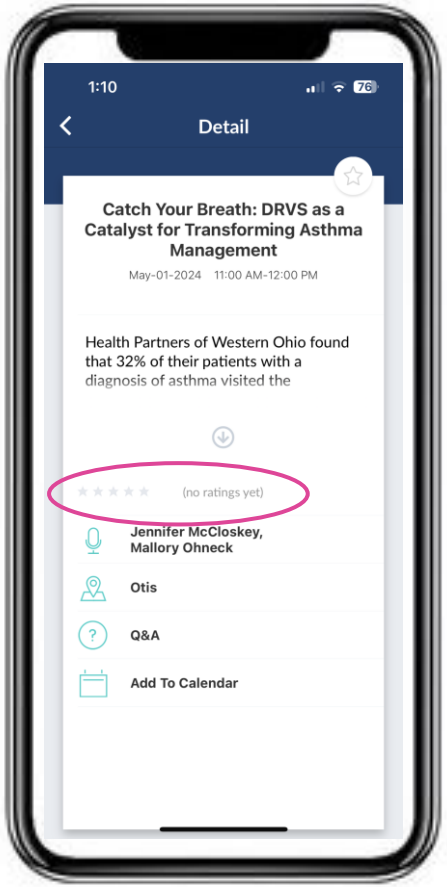
- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link or scan our QR code:

See this year's ACE posters in the Ballroom Foyer!

We Want to Hear From You!

Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

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Thanks for attending!

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Appendix

Entity Overview

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Federally Qualified Health Center

- The “backbone” on which DRVS was created
- **Primary Care** focused
- Reporting is **required** (UDS)
- An FQ can also be a CCBHC, a CMHC, or Both
- An FQ can be engaged in a VBC contract with a Payer for Behavioral Health

Certified Community Behavioral Health Clinic

- Required to **provide** or **collaborate** with **Primary Care** Services (*i.e. an FQ*)
- Serves **anyone** walking in the door
- Reporting is **required**

Community Mental Health Clinic

- **Not required** to provide or collab with **Primary Care** Services
- Reporting is **not required**
- Centers select measures & submit **Quality Improvement plan** to CMS (CMS does not *check* performance metrics)

CCBHCs & FQHCs | Services

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CCBHC

- Ensure access to integrated, MH and SUD services, including 24/7 crisis response & MAT
- Meet stringent criteria
- Receive funding to support real costs of expanding services to fully meet need for care in communities

FQHC

- Community-based and patient centered organizations that deliver comprehensive primary care services
- Integrate w/ pharmacy, MH, SUD, oral health services
- Provides services regardless of ability to pay
- Meet clinical, administrative and financial requirements (HRSA)

https://www.thenationalcouncil.org/wp-content/uploads/2022/01/CoE_Webinar_Considerations-for-Becoming-FQHC-8.31.21-FINAL.pdf

Challenges of CMHC & CCBHCS

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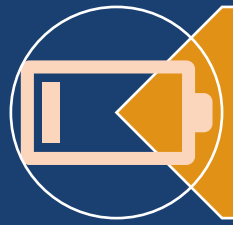

Located in medical shortage areas w/ limited access to comprehensive PC

Hard time supporting high risk individuals with comorbid conditions as struggle with providing comprehensive care

Coordination of care across organizations varies in models and capabilities

Barriers to sustainability due to fragmentation:

data, quality measures, reimbursement

https://www.thenationalcouncil.org/wp-content/uploads/2022/01/CoE_Webinar_Considerations-for-Becoming-FQHC-8.31.21-FINAL.pdf

Benefits of Being an FQHC as a CCBHC or CMH

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Population Health Management:

- Provide comprehensive integrated care for those most in need

Improved whole-person care:

- Ability to better address Social Drivers Of Health (SDOH) through warp around services

Billing & Financing:

- Increased flexibility and ability to bill for primary care

Competitive edge for CCBHCs:

- Taking advantage of HEDIS measures and credit for quality care

https://www.thenationalcouncil.org/wp-content/uploads/2022/01/CoE_Webinar_Considerations-for-Becoming-FQHC-8.31.21-FINAL.pdf

Interoperability Benefits | Integrated Care

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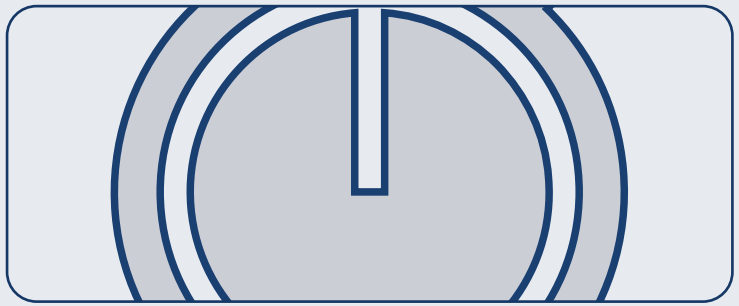
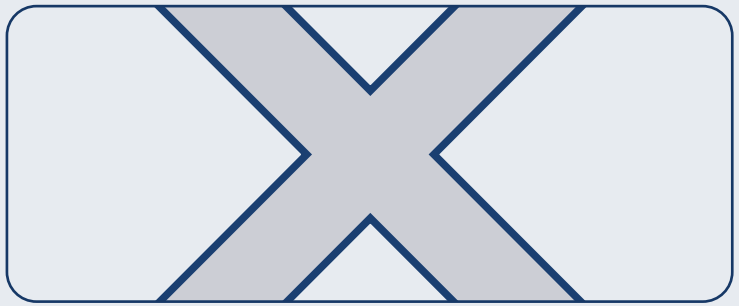
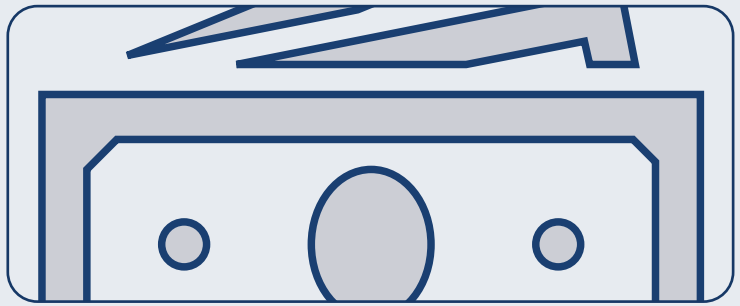


Improved and timely access to information allows for quicker and more informed treatment decision making



Less likely to make errors in treatment planning, medication management, care coordination



More opportunities for cost-reduction through efficient workflows

https://go.continuumcloud.com/Interoperability-Changing-Behavioral-Health-PDF