

Sustaining Your Integration Efforts: The Role of Data and Measurement

Presented by:
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Levels of Integration

		Co-Located		Integrated	
Key Element: Communication		Key Element: Physical Proximity		Key Element: Practice Change	
Level 1 <i>Minimal Collaboration</i>	Level 2 <i>Basic Collaboration at a Distance</i>	Level 3 <i>Basic Collaboration On-Site</i>	Level 4 <i>Close Collaboration On-Site with Some System Integration</i>	Level 5 <i>Close Collaboration Approaching an Integrated Practice</i>	Level 6 <i>Full Collaboration in a Transformed/ Merged Integrated Practice</i>
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:

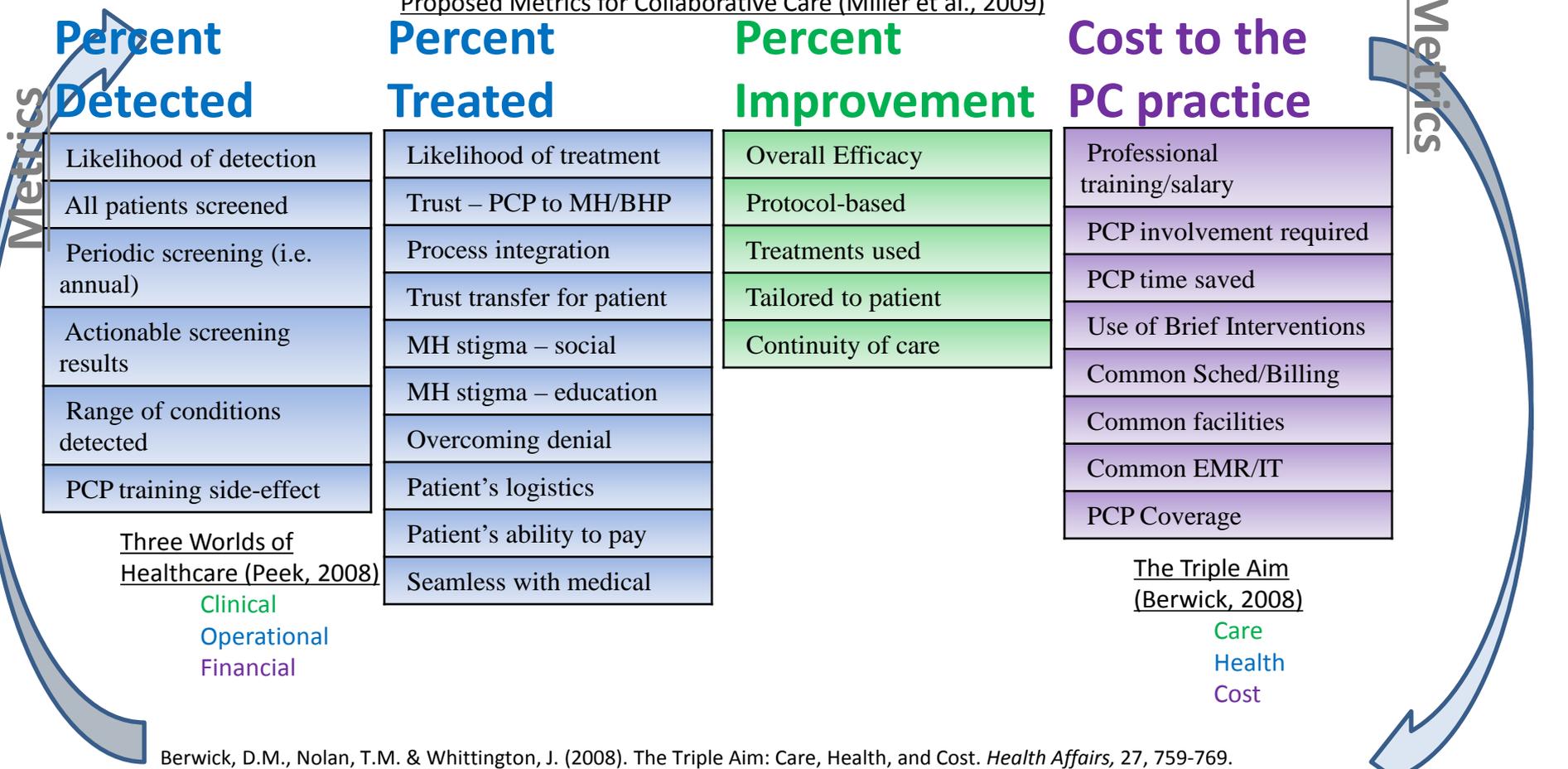
Defining Integration

<ul style="list-style-type: none"> • Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles 	<ul style="list-style-type: none"> • Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of larger community • Appreciate each other's roles as resources 	<ul style="list-style-type: none"> • Have separate systems • Communicate regularly about shared patients, by phone or e-mail • Collaborate, driven by need for each other's services and more reliable referral <ul style="list-style-type: none"> • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet ill-defined team 	<ul style="list-style-type: none"> • Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture 	<ul style="list-style-type: none"> • Actively seek system solutions together or develop work-a-rounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture 	<ul style="list-style-type: none"> • Have resolved most or all system issues, functioning as one integrated system • Communicate consistently at the system, team and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend
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- **C. J. Peek suggests that in order to impact healthcare, three worlds must be addressed simultaneously**
 - ✓ Clinical
 - ✓ Operational
 - ✓ Financial

- **Berwick (et al) Improvement in healthcare requires three aims:**
 - ✓ Improving the patient experience of care
 - ✓ Improving health
 - ✓ Attending to costs and financing

Proposed Metrics for Collaborative Care (Miller et al., 2009)



Percent Detected

Likelihood of detection
All patients screened
Periodic screening (i.e. annual)
Actionable screening results
Range of conditions detected
PCP training side-effect

Three Worlds of Healthcare (Peek, 2008)

Clinical
 Operational
 Financial

Percent Treated

Likelihood of treatment
Trust – PCP to MH/BHP
Process integration
Trust transfer for patient
MH stigma – social
MH stigma – education
Overcoming denial
Patient’s logistics
Patient’s ability to pay
Seamless with medical

Percent Improvement

Overall Efficacy
Protocol-based
Treatments used
Tailored to patient
Continuity of care

Cost to the PC practice

Professional training/salary
PCP involvement required
PCP time saved
Use of Brief Interventions
Common Sched/Billing
Common facilities
Common EMR/IT
PCP Coverage

The Triple Aim (Berwick, 2008)

Care
 Health
 Cost

Berwick, D.M., Nolan, T.M. & Whittington, J. (2008). The Triple Aim: Care, Health, and Cost. *Health Affairs*, 27, 759-769.
 Miller, B. F., Mendenhall, T. J., & Malik, A. D. (2009). Integrated primary care: An inclusive three-world view through process metrics and empirical discrimination. *Journal of Clinical Psychology in Medical Settings*, 16, 21-30.
 Peek, C.I. Planning care in the clinical, operational, and financial worlds. In: Kessler R, Stafford D, eds. *Collaborative Medicine Case Studies: Evidence in Practice*. New York: Springer; 2008.

- **Shared Medical Records**
- **Common Waiting Area**
- **Shared Scheduling Procedures**
- **Single Treatment Plan**
- **Phone Follow Up**
- **Ability to Bill**
- **MH Provider in Medical Staff Activities**
- **Shared Office Space**
- **Use of EMR and IT**

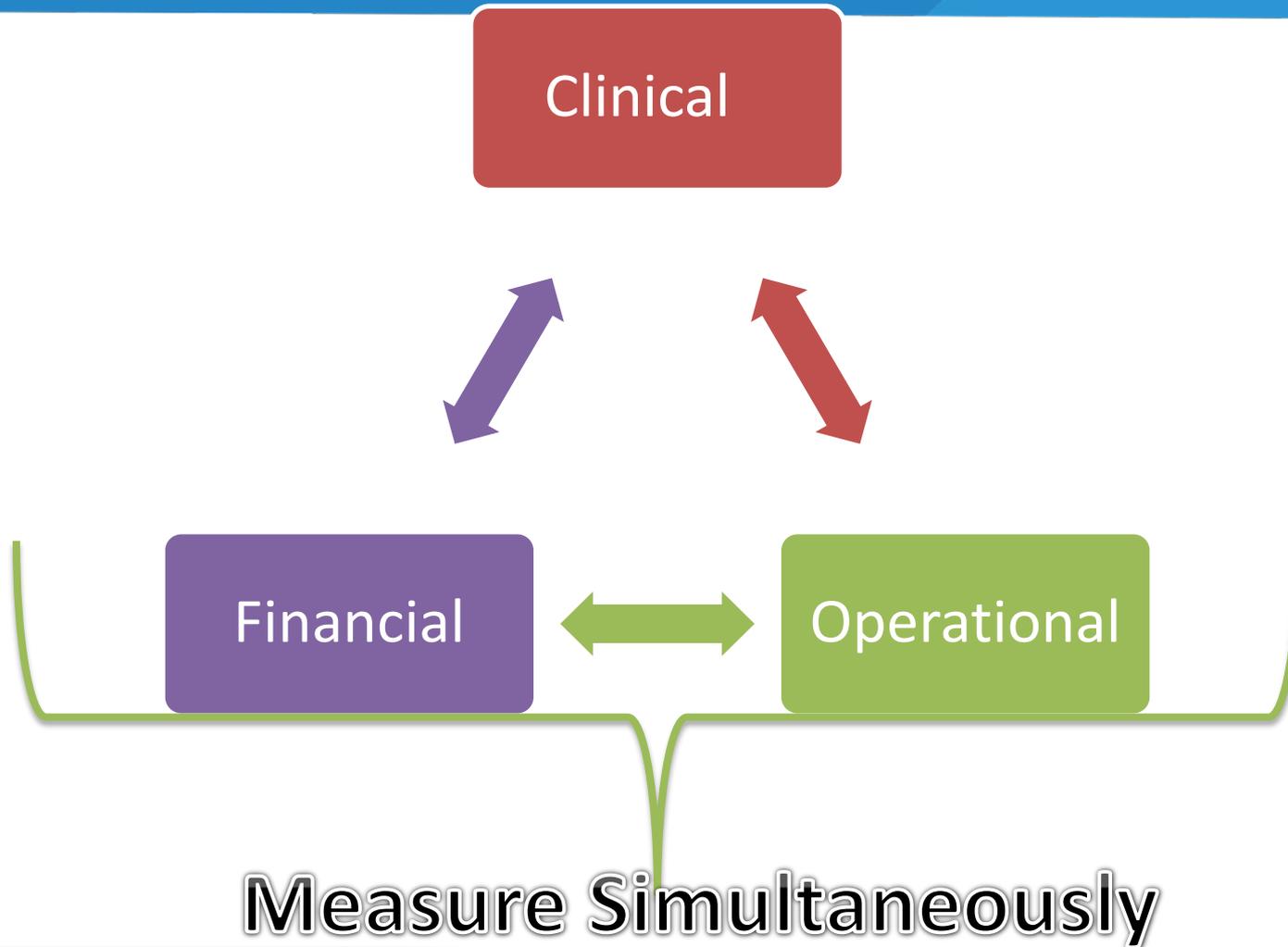
- **Open Access**
- **Procedure for Immediate Referral and intervention**
- **Shared Clinical Notes**
- **Shared Scheduling**

- **Systematic Screening Procedures**
- **% Screened**
- **% Detected**

- **% Referred who initiated treatment**
- **% Referred who complete treatment**
- **Protocols for evidence based treatment**
- **Protocols for disease specific problems**
- **Treatment available irrespective of ability to pay**
- **Seamless medical care**
- **Immediate and regular contact between providers to discuss treatment**
- **Consultation**
- **Joint appointments**
- **Care management functions**

- **% Referred who initiated treatment**
- **% Referred who complete treatment**
- **Protocols for evidence based treatment**
- **Protocols for disease specific problems**

- **Cost**
- **Professional training/salary**
- **PCP Involvement required**
- **PCP Time Saved**
- **Use of brief interventions**
- **Shared billing**
- **PCP Coverage**
- **Practice management**
- **Tracking outcomes**
- **Use of data for practice improvements**
- **Case mix tracking**
- **Use of data to assess cost outcomes/effectiveness**
- **Use of data in financial planning and resource decision making**



What do you Measure?

- **% of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 on initial evaluation**
- **% of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 4-6 weeks**
- **% of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 12 weeks**
- **% of mental health consumers receiving atypical antipsychotic agents whose Weight/Height/Body Mass Index (BMI) [calculated value using weight and height] is > 25 at 6 months**

- **POLLING QUESTION: ARE YOU CURRENTLY COLLECTING BMI'S ON YOUR CONSUMERS?**

- % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ on initial evaluation
 - % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ at 4-6 weeks
 - % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ at 12 weeks
 - % of mental health consumers receiving atypical antipsychotic agents whose blood pressure systolic/diastolic reading is $>125/90$ at 6 months
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- **POLLING QUESTION: DO YOU ROUTINELY CHECK BP AT EACH MEDICATION REVIEW APPOINTMENT?**

- **% of patients in PC with evidence of an assessment for hyperglycemia within 16 weeks after initiating treatment with an atypical antipsychotic agent**

- **POLLING QUESTION: ARE YOU CURRENTLY COLLECTING GLUCOSE MONITORING INFORMATION ON YOUR CONSUMERS ON A REGULAR BASIS?**

- % of primary care patients with diagnosis of depression at 12 weeks,
 - % of primary care patients with diagnosis of depression at 6 months
 - % of primary care patients with depression with PHQ-9 on initial evaluation
 - % of primary care patients with depression with PHQ-9 at 4-6 weeks
 - % of primary care patients with depression with PHQ-9 at 12 weeks
 - % of primary care patients with depression with PHQ-9 at 6 months
 - % of patients screened annually for depression in primary care
 - % of patients treated for depression who were assessed, prior to treatment, for the presence of current and/or prior manic or hypomanic behaviors
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- **POLLING QUESTION: ARE YOU ROUTINELY USING THE PHQ 9 AS A SCREENING AND OUTCOME TOOL FOR DEPRESSION?**

- **% of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for risk of suicide**
- **% of patients diagnosed with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for current or past alcohol or chemical substance use**

POLLING QUESTION: ARE YOU ROUTINELY USING AN EVIDENCE BASED TOOLS FOR SCREENING FOR SUICIDE?

- **% of mental health consumers receiving atypical antipsychotic agents assessed for family history of diabetes, hypertension, cardiovascular disease**
- **% of mental health consumers receiving atypical antipsychotic agents assessed for Tobacco Use/History**
- **% of mental health consumers receiving atypical antipsychotic agents assessed for Substance Use/History**
- **% of mental health consumers receiving atypical antipsychotic agents evaluated for social supports using the LOCUS/IV. Recovery Environment (Level of Stress, Level of Support) score**
- **% of mental health consumers receiving atypical antipsychotic agents with an identified primary care provider and a physical examination within the last year**
- **% of primary care patients with major depressive or bipolar disorder meeting severity/complexity criteria for specialty MH services (as established by state and local payers) referred for specialty MH care**
- **% of patients referred to MH specialty care who attend initial visit**
- **% of patients referred to Primary Care from MH who attend initial visit**

SAMPLE Objectives and Measures Required in 2011

- **Maintain an up-to-date problem list of current and active diagnosis based on ICD-9 or SNOMED**
- **% of diabetics with A1c under controls**
- **% hypertensive patients with BP under control**
- **% of smokers offered smoking cessation counseling**
- **Record vital signs; calculate and display BMI**
- **% of consumers with recorded BMI**
- **Prevention measures (flu vaccine, mammogram, colorectal cancer screenings)**

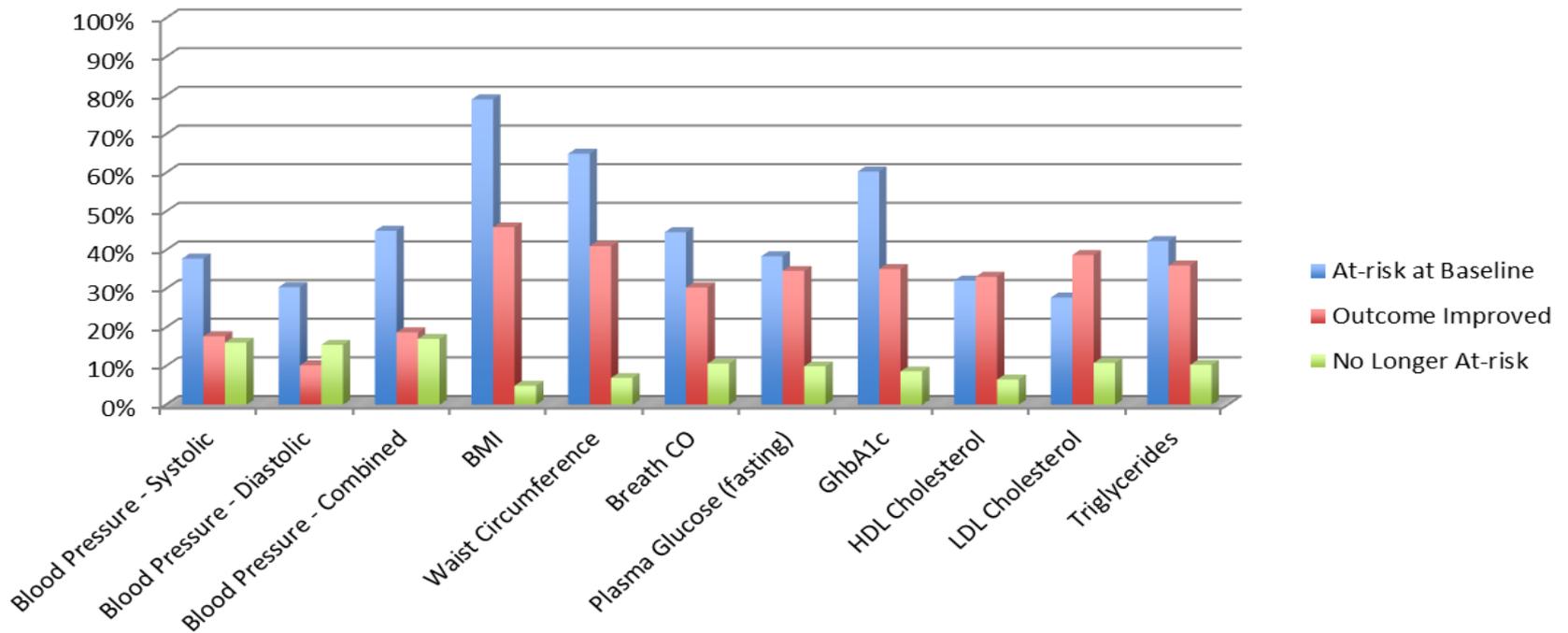
SAMPLE Objectives and Measures Required in 2013

- **Manage chronic conditions using patient lists and decision support**
- **Preventable ER visits**
- **Access for all patients to PHR populated in real time with patient health**
- **% of patients with full access to PHR in real time**
- **Provide summary care data for visits**

- **Track and Trend**
 - HGA1c
 - Metabolic Syndrome Measures
 - Blood Pressure
 - Asthma/Corticoid Steroid Inhaler
 - NOMS – National Outcome Measures
 - PHQ 9
 - GAD 7
 - CAGE – AID, AUDIT, MAST, DAST

What Are We Seeing?

Change in Section H Indicators from Baseline to Most Recent Recording - Oct 11, 2012



Missouri State Data

Base Period (CY2006)			\$1,556
Expected Trend			16.67%
Expected Trend with no Intervention			\$1,815.81
Actual PMPM in Performance Period (FY2007)			\$1,504.34
Gross PMPM Cost Savings			\$311.47
Lives			6,757
Gross Program Savings			\$25,254,928
Vendor Fees			\$1,301,560
Net Program Savings			\$23,953,368
NET PMPM Program Savings			\$295.41
Net Program Savings/(Cost) as percentage of Expected PMPM			16.3%

Independent Living increased by 33%

Vocational Activity increased by 44%

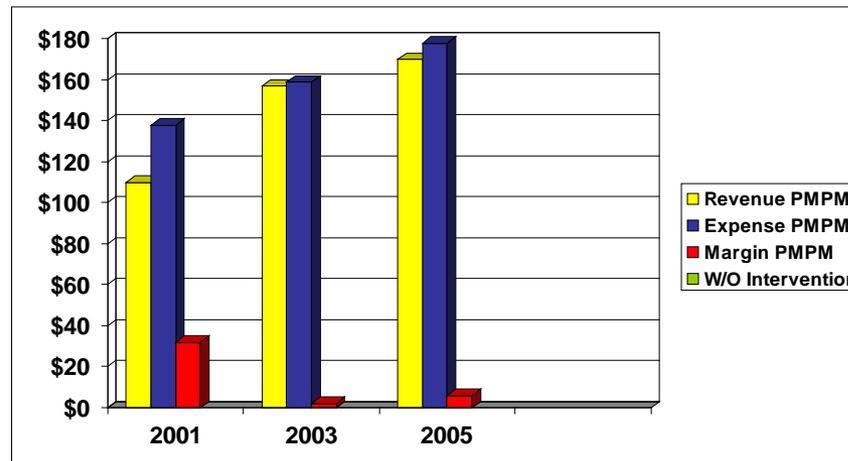
Legal Involvement decreased by 68%

Psychiatric Hospitalization decreased by 52%

Illegal Substance use decreased by 52%

IN ADDITION- Study shows CMHCs services substantially decrease overall medical cost

Impact on Costs



Sharing Data and Confidentiality

Overview of HIE Activity Informing Consent Management Issues

42 CFR Part 2 Consent Management “To Whom”

Predominant Challenge:

- **Development of a 42 CFR Compliant Consent that is Computable in a HIE Environment**

- **Awareness of What is Possible Today**
- **Planning for What Will be Possible in the Future**
- **Recognize we are in a Transition Period**
 - **Not all 42 CFR conditions can be fully met, however, patient still has complete control of consent**

Our Approach:

- **Build on What is Already Developed**
- **Coordinate with ONC & S&I Workgroups**
- **Coordinate with SAMHSA**
- **Ensure Legal Input**
 - **3 of 5 HIEs have their legal experts regularly involved on the calls**
- **Identify current “Better Practices”**

- **42 CFR Regs and SAMHSA FAQs 1 and 2 side by side as Consent developed**
- **HIEs obtained input from their Behavioral Health Workgroups**
- **HIEs invited their vendors to participate and comment as well**
- **Everything in “Black” was reviewed and found acceptable by everyone**
- **“Red” indicates problem areas not yet resolved (as of 6/29/12 still in process of determining a resolution)**

42 CFR Requirements for Consent (SAMHSA FAQs 2010)

A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

- 1) the specific name or general designation of the program or person permitted to make the disclosure;
- 2) the name or title of the individual or the name of the organization to which disclosure is to be made;
- 3) the name of the patient;
- 4) the purpose of the disclosure;
- 5) how much and what kind of information to be disclosed;
- 6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;
- 7) the date on which the consent is signed;
- 8) a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and
- 9) the date, event or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.



**PATIENT CONSENT AND AUTHORIZATION FORM FOR
DISCLOSURE OF CERTAIN HEALTH INFORMATION**

*****PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW*****

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): _____ Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____ State: _____ Zip: _____

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize access, use and disclosure of my:

Check all of the boxes to identify the information you authorize to disclose:

- Drug or alcohol abuse treatment information
- Mental health treatment information



FROM WHOM: Specific name or general description of person(s) or organization(s) who I am authorizing to release my information under this form:

- All health care providers involved in my care.
- All programs in which the patient has been enrolled as an alcohol or drug abuse patient, or
- Any drug or alcohol treatment program or other health care provider, pharmacy or organization providing care coordination that is affiliated with the XYZ HIO
- Only these providers

Person/Organization Name:	Phone:	Address:	Secure email address:



TO WHOM: Specific person(s) or organization(s) permitted to receive my information:

- To the HIE [Name]
- The HIE and any provider(s) involved in my care in the HIE as of today's date **ONLY**
- The HIE and only these specific providers
- Only these specific providers
- The HIE and any current and future provider(s) involved in my care in the HIE**

Organization Name:	Phone:	Address:	Secure email address:	
ONLY THESE INDIVIDUAL PROVIDERS				Most HIEs cannot manage only specific individual providers at this point in time



States Recommended that this wording in the “To whom” Section

❑ The HIE and any current and future provider(s) involved in my care in the HIE

Be interpreted as acceptable in the same way that:

“Provider of On Call Coverage” is acceptable as the “name or title of the individual or the name of the organization to which disclosure is to be made”

Legal Action Center *“Confidentiality and Communication: A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA”, pg. 40-41*

A Patient/Client/Consumer would know who a provider “involved in their care” is but would not really know who “Provider of On-Call coverage” is.

Amount and Kind of Information: The information to be released may include but not be limited to:
Laboratory, Medications, Medical Care & HIV/Aids, Alcohol & Substance Abuse and Mental or Behavioral Health information

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PURPOSE: The information shared will be used:

- To help with my Treatment and Care Coordination
- To assist the provider or organization to improve the way they conduct work
- To help Pay for my Treatment

Treatment

Operations

Payment

**ONLY USE
 WHAT IS
 APPROPRIATE
 FOR THE HIE.
 SOME HIEs
 ONLY PROVIDE
 EXCHANGE FOR
 "TREATMENT"**



EFFECTIVE PERIOD: This authorization/consent/permission form will remain in effect until (enter date, event or condition upon which this authorization/consent expires): _____

OR

This authorization/consent/permission form will remain in effect for (X Year(s) or X Month(s)) from the date the form is signed.

OR

This authorization/consent/permission will remain in effect until such time as XYZ HIO ceases to exist.

If there is no date entered the consent will be valid for one year from the date this form is signed.

Best practice is to always ask for a date any date. Events are not computable e.g. how to tell when someone dies. HIE would never know



REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in the “To Whom” or “From Whom” sections “except to the extent the disclosure agreed to has been acted on.



In addition:

- I understand that an electronic copy of this form can be used to authorize the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other persons according to state or federal law.
- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.
- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

“This HIE consent does not permit use of my protected health information in any criminal or civil investigation or proceeding against me without an express court order granting the disclosure unless otherwise permitted under state law.”



X _____

Signature of Patient or Patient's Legal Representative
(mm/dd/yyyy)

Date Signed

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

Parent of minor

Guardian

Other personal representative (explain: _____

)

NOTE: Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.

This form is invalid if modified. You are entitled to get a copy of this form after you sign it.



Issues/Challenges:

- **Some HIEs cannot process only specific providers in the “To Whom” Section**
 - **Is “All or Nothing”**
- **Is “All or Nothing” for “Type and Amount” of Data**
 - **Data Segmentation is not available in all systems today to support Data Segmentation**
- **HIEs cannot currently process “Only providers in the HIE as of the date of signing the form”**
 - **Barriers due to technology, cost & operational issues for HIEs and providers**

Possible Solutions:

- **Use DIRECT only with a Provider Locator Service provided and supported by the HIE**
 - **Can work in an HIE that is not storing any data and just providing the “pipes” e.g. IL HIE**
- **Other solutions are in development**

Possible Solutions:

- **Bring behavioral health data into the HIE but do not “render” it to the provider until the provider has attested with a second sign on that they have a treating relationship with the patient**
 - **4 of the 5 HIEs do require this attestation**
 - **All have audit trail capabilities to track access**
- **Other solutions are in development**

ONC S&I Data Segmentation Workgroup

- **Each Data element will be tagged at the EHR level with data describing the actual data to be delivered**
 - **“Metadata”**

- **Metadata will include attributes of the data to be shared in relation to consent e.g.**
 - **Is “Restricted” or “Confidential” in nature**
 - **Effective Date of consent**
 - **Termination date of consent**
 - **If not “all providers” which specific providers are allowed access etc.**

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