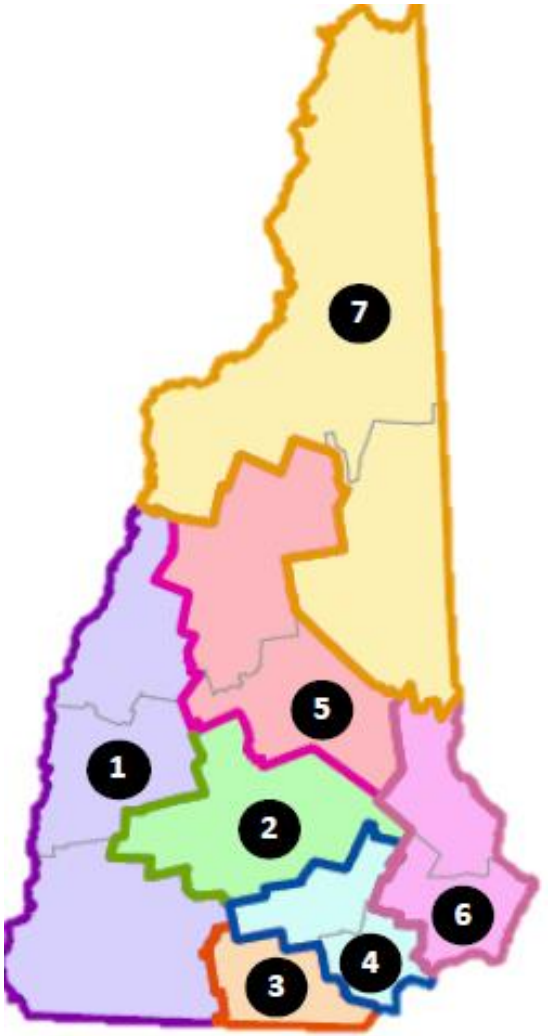
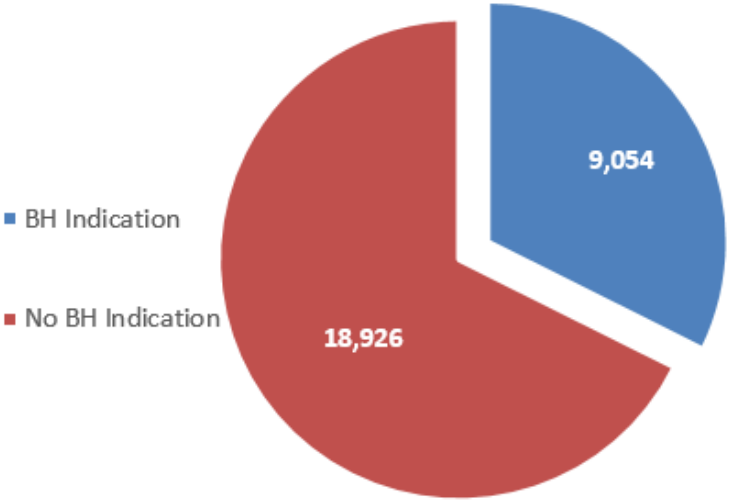
Building Connective Tissue for Integrated Care
The Unfolding NH Medicaid Story

April 17, 2018

Who Are We Supporting In IDN-1?



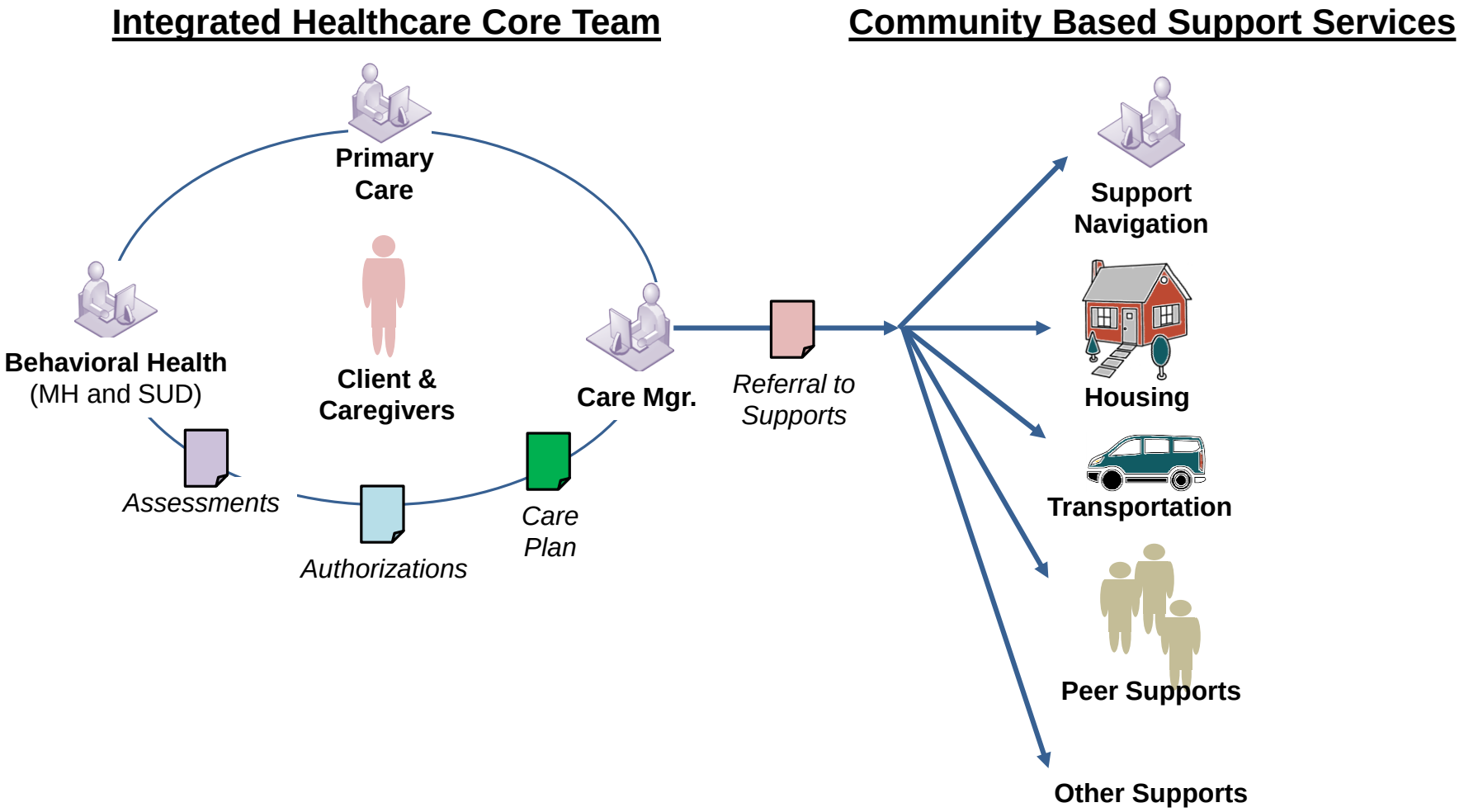


Findings:

- Of the 9,054 IDN-1 Medicaid members with Behavioral Health Indicator:
  - 40% (3,578) are women age 18-64
  - 33% (2,990) are minors (male and female age 0-17)
  - 23% (2,111) are men age 18-64
  - 4% (375) are men and women age 65+

Source: MAeHC Analysis, NH Medicaid IDN Region 1 Data Book Release 1

What Will We Do Differently?



What Connective Tissue Are We Building?

Build Relationships Among Formerly Siloed Organizations and People

Formalize Inter-Organizational Processes and Transitions

Deploy Supporting Technology

- Information Sharing Along All Viable Paths
- Situational Awareness Building
- Clinical Quality Reporting

Modernize Privacy Protections To Meet Current Day Challenges

Today's Focus

Information Sharing Along All Viable Paths

All Paths to Information Sharing:

- People Talking
- Shared Care Plan
- Direct Secure Messaging
- CommonWell and Carequality
- (and even fax)

National Framework for Standardizing Data

Common Clinical Data Set elements available from most certified EHR systems and transmittable by CCDA

- Patient Demographics
- Health Insurance Provider
- Problem/Condition
- Allergy/Drug Sensitivity
- Medication
- Immunizations
- Vital Signs
- Results
- Encounter
- Procedure
- Social History

Consistently available in certified EHR systems – Transmittable in C-CDA

CCDS elements Required in 2015 Edition Certification to support MU Stage 3 and MIPS

- Care Team Members
- Goals
- Health Concerns
- Assessment and Plan of Treatment

Coming to an EHR near you! But with delay of Meaningful Use these fields will not be consistently available in EHRs until 2019 at the earliest

Not Required for EHR Certification, No Standards Available

Other Data Elements For Discussion

- Social Determinants of Health:
  - Food security
  - Housing security
  - Domestic violence
  - Transportation
  - Employment
  - Education
- Care Coordination Instructions

Not consistently available in most EHR systems – No plan for standardized capture or transport of these fields

Shared Care Plan Example (1 of 4)

Care Team:
Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:

Health Concerns:

Plan of Treatment:

Shared Care Plan Example (2 of 4)

Care Team:
Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:
Prevent the voices in my head from getting louder in the evenings
Continue working part time and volunteering

Health Concerns:

Plan of Treatment:

Shared Care Plan Example (3 of 4)

Care Team:
Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:
Prevent the voices in my head from getting louder in the evenings
Continue working part time and volunteering

Health Concerns:
Schizophrenia
Social isolation
Member manages voices in head by going to the ED non-emergency
4 years since last visit to primary care

Plan of Treatment:

Shared Care Plan Example (4 of 4)

Care Team:
Dr. X, Community Mental Health Center
Case Manager, Community Mental Health Center
Primary Care Team, Primary Care Office
Dr. Y, Psychiatry Specialist Office
Contact, Peer Support Organization

Patient Goals:
Prevent the voices in my head from getting louder in the evenings
Continue working part time and volunteering

Health Concerns:
Schizophrenia
Social isolation
Member manages voices in head by going to the ED non-emergency
4 years since last visit to primary care

Plan of Treatment:
In the ED: Contact CMHC on call nurse 603-123-4567. ED diversion plan on file.

Refer to peer support organization for evening volunteer and social support opportunities (Status: Open) (Owner: CMHC Case Manager)

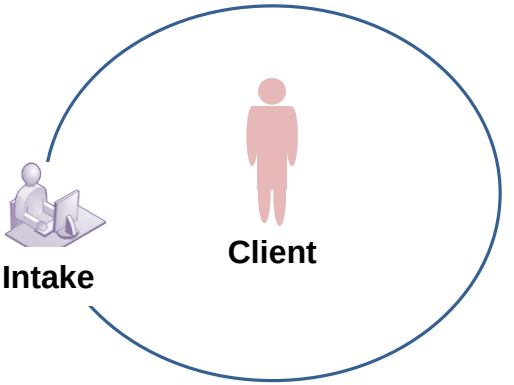
Recommend getting a companion pet at next visit (Status: Open) (Owner: CMHC Counselor)

Continue to manage Schizophrenia with current plan. Plans on file (Status: Ongoing) (Owner: CMHC, Psychiatry Specialist)

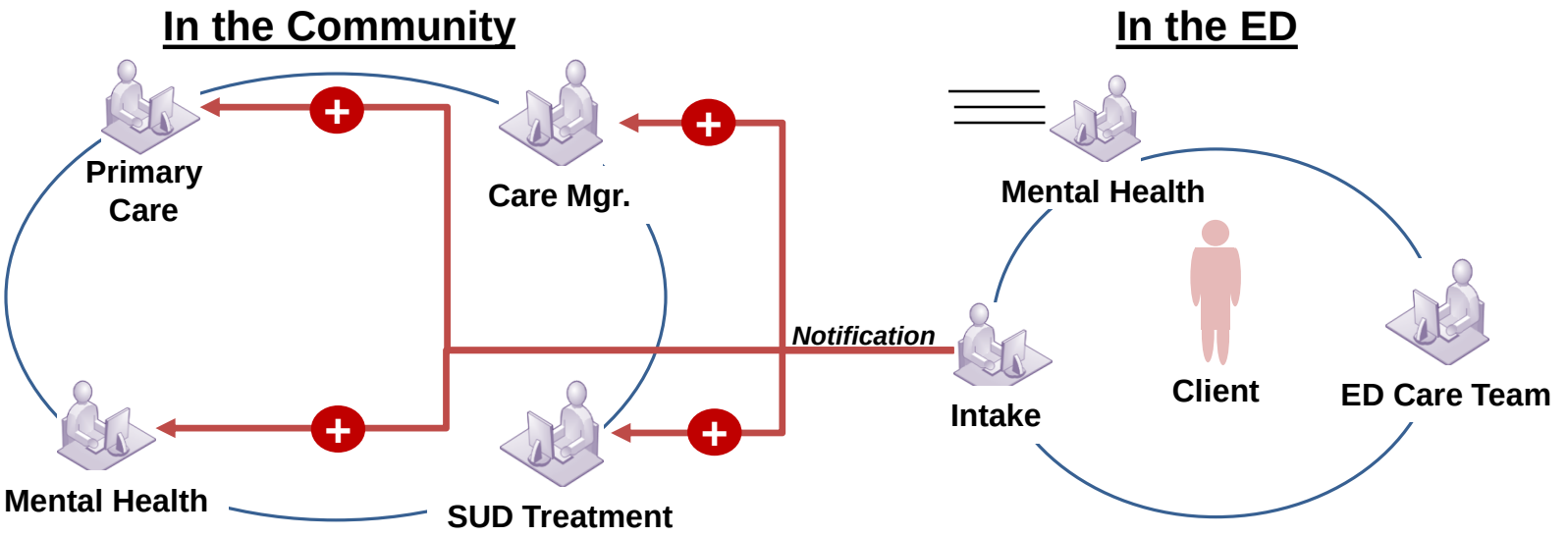
Schedule annual well visit with PCP (Status: Open) (Owner: CMHC Case Manager)

Situational Awareness Building – Deploying ENS

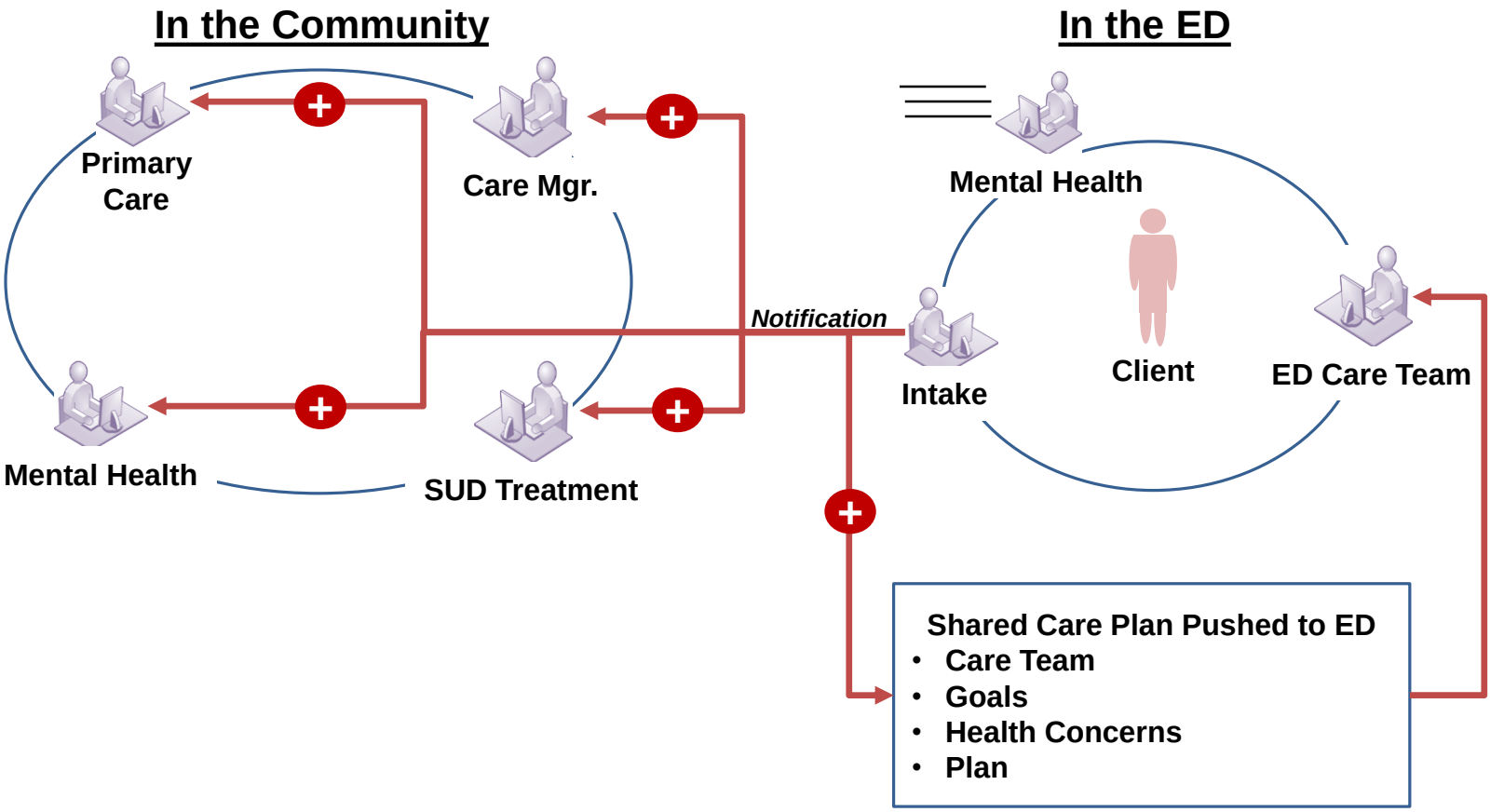
In the ED



Situational Awareness Building – Deploying ENS



Situational Awareness Building – Deploying ENS



Clinical Quality Reporting

Benefits of Clinical Quality Reporting Infrastructure:

1. Provides Feedback Loop
2. Fundamental To Payment Reform
3. Essential To Formal Clinical Quality Improvement
4. Provides Evaluation Data For Government Programs

Clinical Quality Reporting

Behaviors Encouraged By The NH 1115 Measures Set

1. Screen And Follow Up
2. Provide Timely Intake and First Visit At CMHCs
3. Manage Med Adherence and Metabolic Monitoring For Members with Schizophrenia and Antipsychotic Users
4. Manage Chronic Disease Within BH Population
5. Provide Positive Patient Experience
6. Reduce Avoidable Hospitalization And Readmissions
7. Provide Adolescent well-care visits
8. Send Hospital Discharges
9. Prescribe Opioids Cautiously

Program Assessment – Full Measure Set (1 of 2)

Desired Behavior	Measures
Screen aggressively and timely follow up on positive screenings for SUD, Depression, Smoking, and USPSTF recommendations for intimate partner violence, high blood pressure, lipid disorders, obesity	• ASSESS_SCREEN.01 Use of Comprehensive Core Standardized Assessment Process by IDN Primary Care and BH Providers • ASSESS_SCREEN.02 Appropriate Follow-Up for Positive Screenings for Potential Substance Use Disorder and/or Depression by IDN Primary Care and BH Providers • ASSESS_SCREEN.03 Recommended U.S. Preventive Services Task Force (USPSTF) A&B Services Provided for Behavioral Health Population by IDN Primary Care and BH Providers • ASSESS_SCREEN.04 Smoking and Tobacco Cessation Screening and Counseling for Tobacco Users by IDN Primary Care and BH Providers • CARE.04 Initiation of Alcohol and Other Drug Dependence Treatment • CARE.05 Engagement of Alcohol and Other Drug Dependence Treatment • CMHC.01 Community Mental Health Center Intake Appointment Timeliness • CMHC.02 Community Mental Health Center First Follow-up Visit Timeliness • CMHC.03 Community Mental Health Center First Psychiatrist Visit Timeliness
Manage medication adherence and metabolic monitoring for patients with Schizophrenia and/or patients using antipsychotics	• CARE.01_Sub_A MH HEDIS: Antidepressant Medication Management - Continuation Phase • CARE.01_Sub_B MH HEDIS: Adherence to Antipsychotic Medication for Individuals with Schizophrenia • CARE.01_Sub_D MH HEDIS: Metabolic Monitoring for Children and Adolescents on Antipsychotics • CARE.01_Sub_E MH HEDIS: Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic medications • CARE.01_Sub_F MH HEDIS: Diabetes Monitoring for People with Diabetes and Schizophrenia
Provide Adolescent well-care visits	• CARE.02 Adolescent (Age 12-21) Well-Care Visits
Manage Chronic Disease within BH Population: High Blood Pressure, Comprehensive Diabetes Care (HbA1c testing and control, eye exam, nephropathy), COPD, Asthma	• CARE.03_Sub_A PH HEDIS for BH Population: Controlling High Blood Pressure • CARE.03_Sub_B PH HEDIS for BH Population: Comprehensive Diabetes Care - HbA1c Testing • CARE.03_Sub_C PH HEDIS for BH Population: Comprehensive Diabetes Care - HbA1c Control <8.0% • CARE.03_Sub_D PH HEDIS for BH Population: Comprehensive Diabetes Care - Eye Examine • CARE.03_Sub_E PH HEDIS for BH Population: Comprehensive Diabetes Care – Nephropathy • CARE.03_Sub_F PH HEDIS for BH Population: Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid • CARE.03_Sub_G PH HEDIS for BH Population: Medication Management for People with Asthma

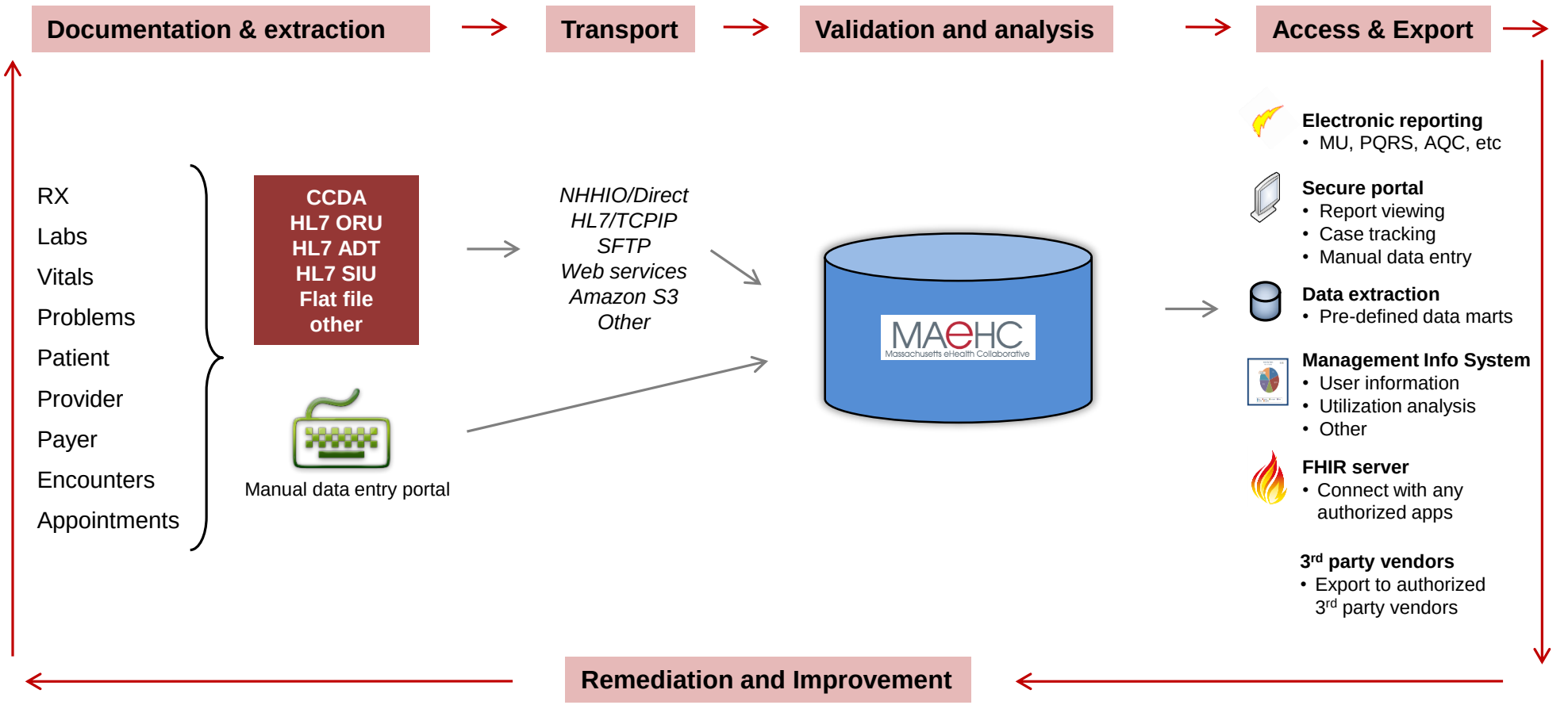
Program Assessment – Full Measure Set (2 of 2)

Desired Behavior	Measures

Provide Positive Patient Experience	• EXPERIENCE.01 Experience of Care Survey: Care Coordination Composite Score
	  • Availability of medical records at the time of appointment;
	  • Follow up from ordering provider office regarding results of a blood test, x-ray, or other test;
	  • How informed and up-to-date personal doctors related to care received from specialists;
	  • Frequency and review of all current prescription medications with personal doctor;
	  • Frequency of assistance from personal doctors office to manage care among different providers and services.

Reduce avoidable hospitalization and readmission	• HOSP_ED.01 Frequent (4+ per year) Emergency Department Use in the Behavioral Health Population • HOSP_ED.02 Potentially Avoidable Emergency Department Visits • HOSP_ED.03 Follow-up After Emergency Department Visit for Mental Illness Within 30 Days • HOSP_ED.04 Follow-up After Emergency Department Visit for Alcohol and Other Drug Dependence Within 30 Days • HOSP_INP.01 Readmission to Any Hospital for Any Cause by Adult Behavioral Health Population Within 30 Days • HOSP_INP.03 Follow-up After Hospitalization for Mental Illness Within 7 Days • HOSP_INP.04 Follow-up After Hospitalization for Mental Illness Within 30 Days
Send Hospital Discharge	• HOSP_INP.02 Timely Transmission of Transition Record After Hospital Discharge
Prescribe Opioids Cautiously	• OPIOIDRX.01 Extended Daily Dosage of Opioids Greater Than 120mg Morphine Equivalent Dose

Clinical Quality Reporting



Modernize Privacy Protections To Meet Current Day Challenges

Current Day Challenges:

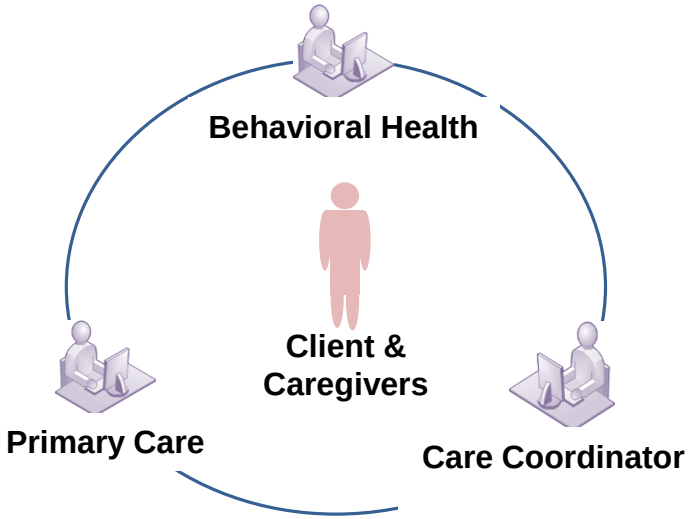
- Increasing Levels of Information Sharing and Disclosure
- Escalating Substance Use Crisis
- Piloting of Models That Rely on Non-HIPAA Covered Entities
- Persistent Misunderstanding of HIPAA and 42 CFR Part 2

Actions:

- Encouraging Information Sharing Under Current Protections of HIPAA
- Shoring Up Consent Processes For Sensitive Information
- Working With Community Supports Without Disclosure
- Understanding HIPAA and Staying Current With 42 CFR Part 2

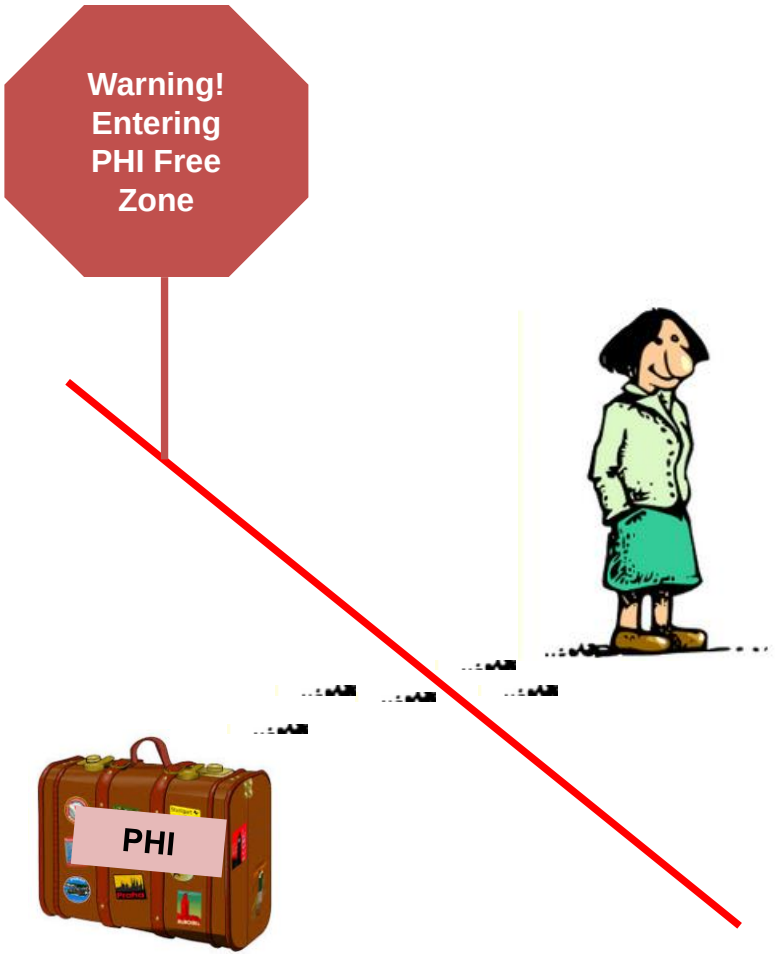
Disclosure Among Integrated Core Team

Integrated Core Team



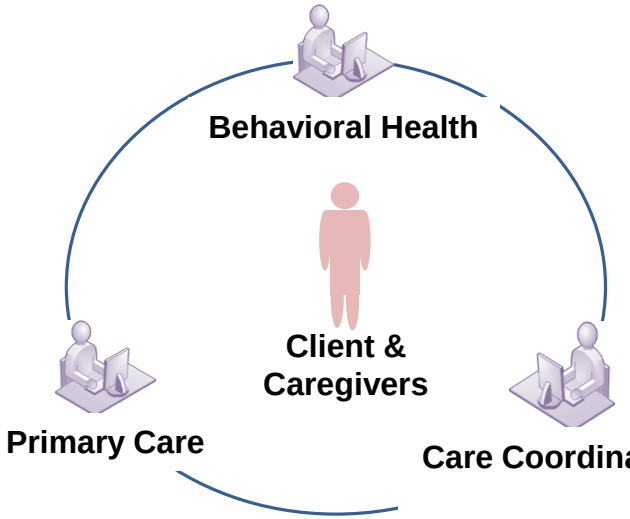
Consent Model:

- Personal Health Information (PHI) shared per HIPAA
- Written consent for sensitive conditions

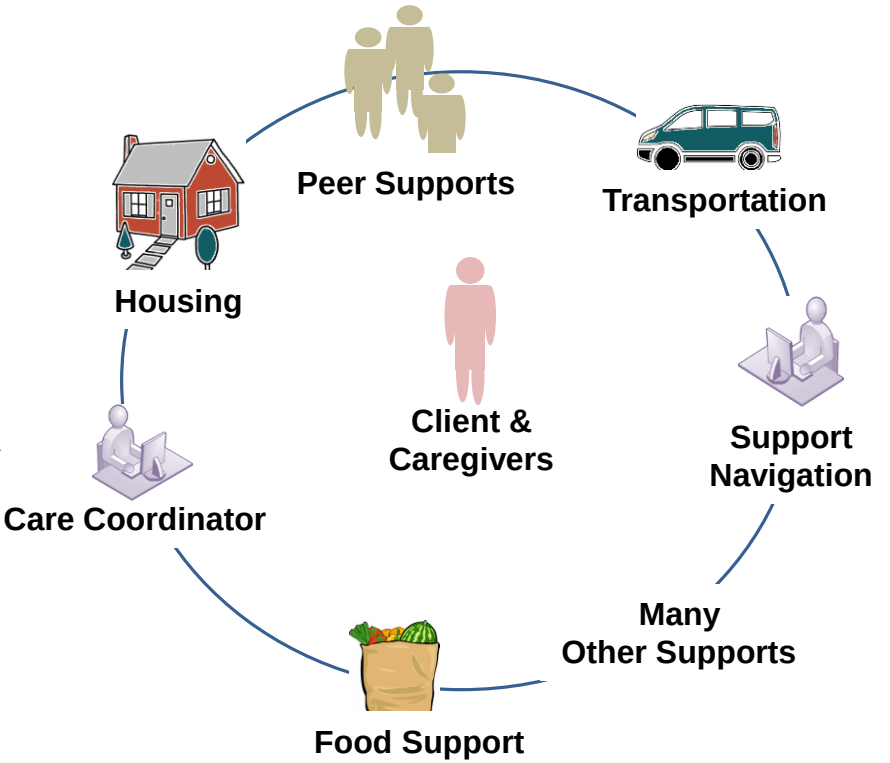

Warning!
Entering
PHI Free
Zone
PHI

Utilizing "Boundary Crossers" To Line Up Community Supports Without Disclosure

Integrated Core Team



Community Based Support Services



Consent Model:

- Personal Health Information (PHI) shared per HIPAA
- Written consent for sensitive conditions
- Care Coordinators are privy to but do not disclose PHI and Sensitive Conditions

Lessons Learned So Far

Lessons Learned:

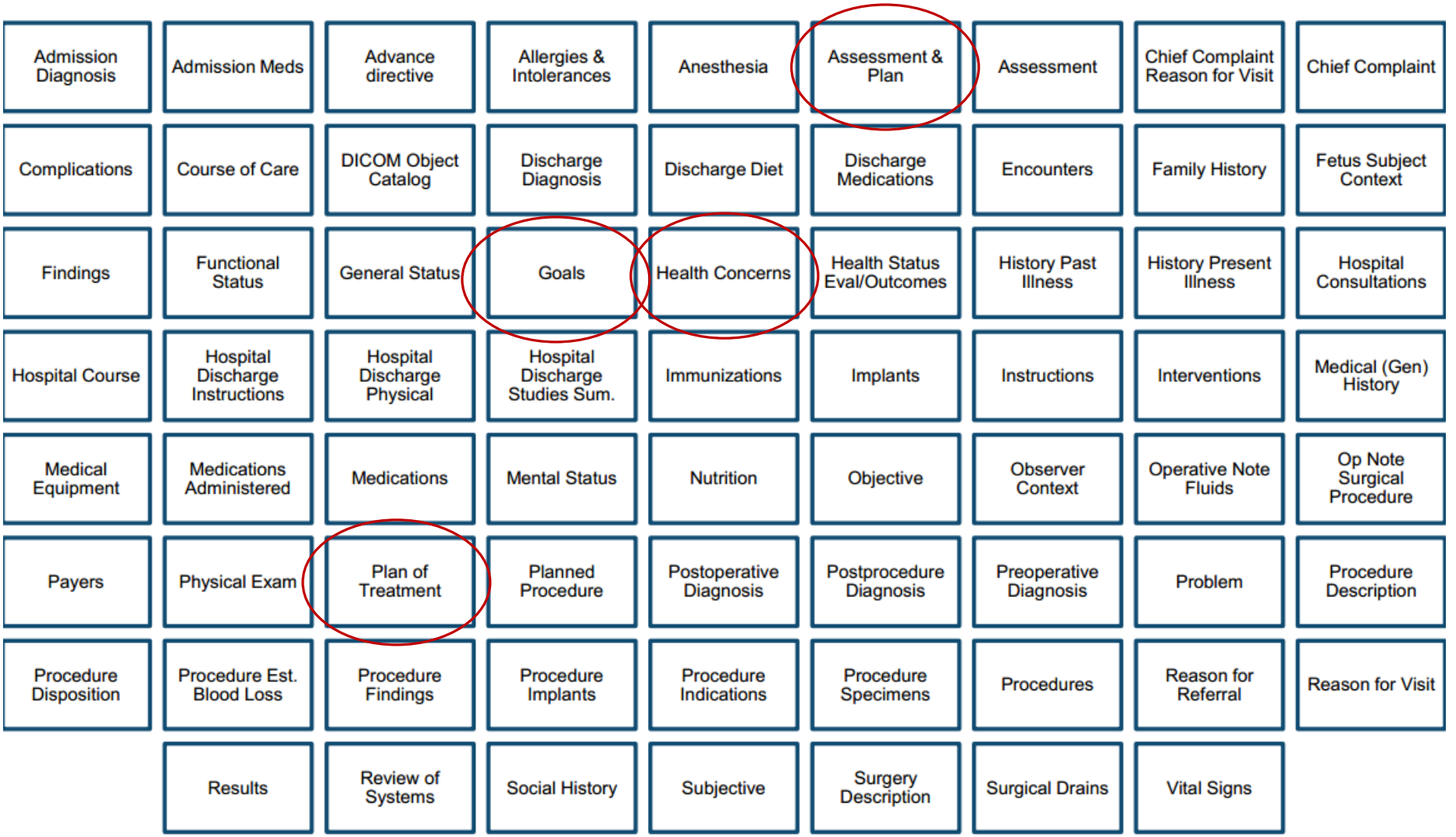
1. Healthcare Integration is an Endurance Sport – Dress For Heartbreak Hill
2. People First – Technology Follows
3. 42 CFR Part 2 Will Take Years Off Your Life and Leave You Crying – Engage Good Counsel
4. Over Invest In Staff, Under Invest In System Integration
5. Simplify At Every Opportunity

Photo: 2018 Boston Marathon Coverage, April 16, 2018, Boston Globe, https://www.bostonglobe.com/news/bigpicture/2018/04/16/boston-marathon/nsoWo6i6bFjM77Xwis5PRI/story.html

Questions?

Appendix

Crosswalk to C-CDA R2.1 Sections



Crosswalk to C-CDA Document Types

	Continuity of Care Document (CCD)	Discharge Summary	History & Physical	Consultation Note	Referral Note	Transfer Summary	Procedure Note	Operative Note	Care Plan	Progress Note
Patient Goals	X	X			X				X	
Health Concerns	X	X			X				X	
Plan of Treatment	(X)	X	(X)	(X)	(X)	(X)	(X)	(X)		(X)
Assessment & Plan of Treatment			(X)	(X)	(X)	(X)	(X)			X

X = Required Field

(X) = Optional Field

Goals Template Definition – HL7

Goals Template Definition (from HL7 Clinical Data Architecture R2.1)

- This template represents patient Goals. A goal is a defined outcome or condition to be achieved in the process of patient care.
- Goals include patient-defined over-arching goals (e.g., alleviation of health concerns, desired/intended positive outcomes from interventions, longevity, function, symptom management, comfort) and health concern-specific or intervention-specific goals to achieve desired outcomes.

Source: HL7 CDA R2.1 IG: Consolidated CDA Templates for Clinical Note (US Realm), DSTU R2—Vol. 2: Templates Page 301, August 2015

Health Concerns Template Definition – HL7

Health Concerns Template Definition (from HL7 Clinical Data Architecture R2.1)

- This section contains data describing an interest or worry about a health state or process that could possibly require attention, intervention, or management.
- A Health Concern is a health related matter that is of interest, importance or worry to someone, who may be the patient, patient's family or patient's health care provider.
- Health concerns are derived from a variety of sources within an EHR (such as Problem List, Family History, Social History, Social Worker Note, etc.). Health concerns can be medical, surgical, nursing, allied health or patient-reported concerns.
- Problem Concerns are a subset of Health Concerns that have risen to the level of importance that they typically would belong on a classic “Problem List”, such as “Diabetes Mellitus” or “Family History of Melanoma” or “Tobacco abuse”. These are of broad interest to multiple members of the care team.
- Examples of other Health Concerns that might not typically be considered a Problem Concern include “Risk of Hyperkalemia” for a patient taking an ACE inhibitor medication, or “Transportation difficulties” for someone who doesn't drive and has trouble getting to appointments, or “Under-insured” for someone who doesn't have sufficient insurance to properly cover their medical needs such as medications. These are typically most important to just a limited number of care team members.

Source: HL7 CDA R2.1 IG: Consolidated CDA Templates for Clinical Note (US Realm), DSTU R2—Vol. 2: Templates Page 303, August 2015

Plan of Treatment Template Definition – HL7

Plan of Treatment Template Definition (from HL7 Clinical Data Architecture R2.1)

- This section contains data that define pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only.
- This section may also contain information about ongoing care of the patient, clinical reminders, patient's values, beliefs, preferences, care expectations, and overarching care goals.
- The plan may also indicate that patient education will be provided.

Source: HL7 CDA R2.1 IG: Consolidated CDA Templates for Clinical Note (US Realm), DSTU R2—Vol. 2: Templates Page 358, August 2015

What Does A Typical Visit Look Like?

	1. Member Presents at Primary Care or Mental Health Practice	2. Member Completes Comprehensive Core Standardized Assessment (1x per year)	3. Core Team member(s) obtains/ discovers Patient's Goals	4. Core Team develops Shared Care Plan to guide ongoing integrated care	5. Care Manager locates Community Supports and initiates closed loop referral	6. Core Team meets periodically to review progress, adjust Plan, and synch. records
Member	→					
Care Team	• PCP • MH Provider	• PCP • MH Provider	• PCP • MH Provider	• PCP • MH Provider • SUD Provider • Care Manager	• Care Manager • Navigator • Community Supports	• PCP • MH Provider • SUD Provider • Care Manager
Information	*Authorization to Release Information*	*CCSA*	*Patient Goals*	*Shared Care Plan*	*Referral to Supports*	*Shared Care Plan*
Technology	• EHR	• EHR • Paper/PDF • Quality Reporting Application	• EHR • Paper/PDF	• Shared Care Plan	• Direct Secure Messaging • Community Supports Registry	• Direct Secure Messaging • Shared Care Plan