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JEN CLANCY CONSULTING

Behavioral Health Integration Complex Care Initiative

BHICCI Data Plan

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Data Plan

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Introduction

In designing the 202 Medicaid Waiver, the Department of California Health Services (DHCS) noted: "Transforming the current health and behavioral health systems in California into a high performing, well-coordinated system requires a shift in the focus of data collection for compliance to using data for quality improvement and evaluation. Current measurement practices do not produce sufficient data to assess and track overall population health and medical and behavioral health care system performance, which is essential for achieving the Triple Aim. Data also are not adequate to support decision-making by policy makers, public and private purchasers, providers, and other stakeholders. Developing a core measures set for integrated behavioral health will enable a common way of tracking medical and behavioral health performance in California. The performance measures are used to assess access, timeliness, quality, and coordination of care, and compare performance across payors and providers working with the target population."[1]

Data Requirements for Health Care System Improvement

A core principle of the Behavioral Health Integration Complex Care Initiative (BHICCI) is the recognition that population health and clinical data are the foundation of an integrated and effective health care system and are used to:

1. Identify and stratify base and target populations.
2. Facilitate patient engagement.
3. Assess patient and provider experience.
4. Conduct quality improvement activities.
5. Assist managers and other clinical leaders in providing clinical oversight (e.g. assure program effectiveness and report benefits to regulators and key stakeholders, monitor service utilization and costs).
6. Evaluate efficacy and impact of the BHICCI.

Data Requirements for Clinical Improvement

Real-time data is also critical to provide effective care at the point of service. Use of data in this way is relatively new to health providers and data-driven processes are used to:

1. Track clinic and provider panels and coordinate patient engagement.
2. Conduct medication reconciliation.
3. Coordinate referrals.
4. Manage care transitions.
5. Share information between providers.
6. Facilitate measurement-based clinical practices.
7. Inform care planning.
8. Provide patient education and empower self-management.

These many layers of data use require careful planning and coordination. On one hand, it is important to make sure the right data is at the right place at the right time or else the data becomes meaningless, and on the other hand clinicians and leaders risk experiencing "data overload" if too much data is pushed out in an uncoordinated manner.

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[1] Retrieved from http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/MHSUDS_TF_Summary.pdf

Part 1: Identifying and Stratifying the Target Population

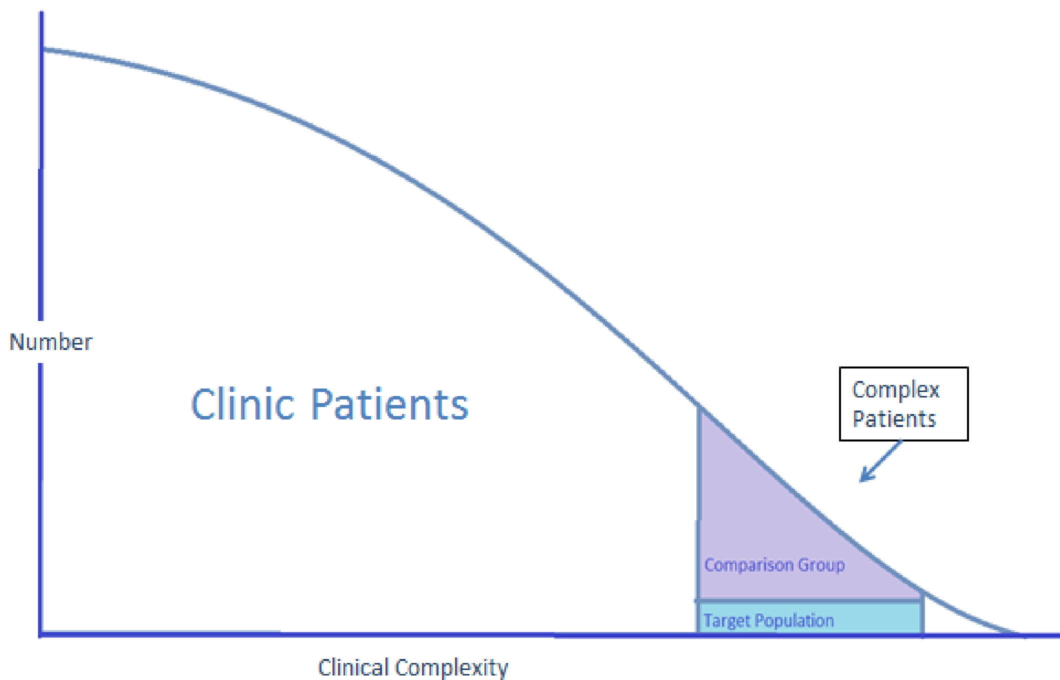
Key Terms: Base Population, Resource Utilization, Risk Stratification, and Target Population Identification.

The chart below describes the BHICCI process for identifying high needs patients that will be served with a complex care management intervention. The entire group of patients in a practice (or enrollees of a health plan) is called the Base Population. The bell curve illustrates the distribution of patients based on their annual costs (Resource Utilization). Typically, smaller groups of patients have low and high costs, while the bulk of the patients fall somewhere in the middle.

Risk Stratification tools, such as the Johns Hopkins Adjusted Care Groups (ACG) System, are used to identify those who would benefit most from a complex care management intervention. The ACG System can help by drawing on cost, diagnostic, procedure, and drug data to measure the *morbidity burden* of a patient population based on disease patterns, age, and gender.

In the example below, a group of patients with high morbidity risk have been identified. Some of those patients have been enrolled in the complex care management program (Target Population) and the second group, which will also be studied, will get usual care (Comparison Group).

Figure: Understanding Your Population



Part 2: Staffing

Every HCO participating in the BHICCI has identified the teams that will participate in their BHICCI project, including new hires. Key new positions include behavioral health professionals working in primary care clinics, primary care providers working in behavioral health organizations, and care managers working in both settings. An important question to answer is: *How many patients can be served by one full-time equivalent (FTE) staff person in each of these roles?* Knowing the answer to this question will be invaluable in right-sizing staffing levels and preventing burnout of staff.

The BHICCI Gap Analysis Tool is a simple Excel-based tool to help teams answer this question for the following roles:

- Behavioral Health Professionals in Primary Care
- Care Managers in Primary Care or Specialty Behavioral Health
- Psychiatric Consultants and Prescribers
- Primary Care Providers in Specialty Behavioral Health

The following figures illustrate how the tool is organized.

Figure 1: Gap Analysis Tool Data Entry Screen

ABC Primary Care Clinic

Behavioral Health Professional Gap Analysis Tool

	Youth	Adults	Total
1. Total Number of Clinic Patients	8,000	7,000	15,000
2. PCP Panel Size	1,400	1,400	1,400
3. BH Professional Direct Service Hours per Week per FTE	36	36	36
	Youth	Adults	Total
4. Behavioral Health Need Estimates	19.7%	51.2%	34%
Total Needing Mental Health or Substance Use Disorder Treatment	1,576	3,584	5,160
Patient Level of Behavioral Health Need	Youth % TTL	Adult % TTL	
5. % of Total with NO Service from Behavioral Health Professional	25%	25%	
6. % of Treated with Serious/Severe Need	25%	33%	

Figure 2: Step-By-Step Instructions

Total		Instructions
15,000	*(Data Input)*	Enter the number of clinic patients here
1,400	*(Data Input)*	What is the standard for your clinic?
36	*(Data Input)*	This is for direct patient time

Part 3: Tracking Clinical Outcomes

Key Terms: Population Health, Measurement-Based Practice, Treat-to-Target

This section contains guidance on the collection of clinical condition data. Clinical condition data is comprised of two groups: behavioral health data (typically obtained via the use of standardized scales) and physical condition data (clinical examinations, tests, and laboratory findings). The primary use of this data is to achieve the goal of population-based health (PBH) which entails achieving a clinical goal for a targeted group with an identified problem or condition. The data is utilized at multiple levels including individual use at the patient-level and pooled for use at caseload, panel, clinic, or network-levels.

Core to the achievement of health is the concept of measurement–based practice (MBP), also referred to as treat-to-target (T2T), or the use of structured clinical data to guide clinical care planning and decision-making. MBP is perhaps one of the greatest opportunities for innovation – especially on the side of behavioral health services. Given the importance of population-based care techniques, providers should carefully consider what conditions to track, what data to collect, and what tools to utilize. In general, the following considerations apply to both behavioral health and physical conditions:

- What are the prominent health conditions and health disparities among populations served?
- What data is already being collected (or what tools are already utilized) by HCOs?

Be careful not to "bite off more than organizations can chew" – it is better to start small and build on success than to have an overwhelming project with mediocre outcomes.

Behavioral Health Condition Stabilization and Improvement

As mentioned above, the primary care integration of behavioral health conditions is perhaps one of the greatest opportunities for innovation in the BHICCI project.

A site must select at least one initial behavioral health (BH) measure to begin the process of performing PBH services in early 2016. The initial measure must be either PHQ-9 or another tool selected using the guidance below. If the initial tool is not the PHQ-9, HCOs must select the PHQ-9 as a second BH measure. All HCOs are required to begin using a second BH measure by September 1, 2016.

1. First consider what measures are already collected. Are they on the Approved BH Measures list (see Table 1)? If not, is there another reason this data is collected? Do these measures fit well with the PBH tool considerations and the T2T criteria (see page 7)?
2. If BH data is not already collected, preference should be given to measures included in Table 1. These tools are either well-known as lending themselves to PBH practices, or were evaluated and approved by the BHICCI team as a promising practice tool.

Table 1: Approved Behavioral Health Measures for Treat-to-Target Services

Measure	Screening Recommendation	Routine Monitoring Recommendation
PHQ-9 (Required for Adults)	Administer PHQ-9 at enrollment; if score is ≥ 10, use for routine monitoring. If PHQ-2 is negative, or total PHQ-9 score is < 10, rescreen in 6 months, or earlier if clinically indicated.	If initial score is ≥ 10, measure monthly.
GAD-7	Administer GAD-7 at enrollment; if score is ≥ 10, use for routine monitoring. If total score is < 10, rescreen in 6 months, or earlier if clinically indicated.	If initial score is ≥ 10, measure monthly.
ANSA	Administer ANSA at enrollment; if score is a 2 or 3, use for routine monitoring. If score is 0 or 1, rescreen in 3 months.	If initial score is a 2 or 3, measure monthly.
SUA	Administer SUA at enrollment; if screen is positive, and the score in either the alcohol or drug blocks of questions is ≥ 5, or any single response endorses a "3 = often" or "4 = always," use for routine monitoring. If screen is negative, rescreen in 6 months, or earlier if clinically indicated.	If initial screen is positive, and the score in either the alcohol or drug blocks of questions is ≥ 5, or any single response endorses a "3 = often" or "4 = always," measure monthly.
SDQ (Pediatric)	Administer SDQ at enrollment; measure monthly regardless of score.	Measure monthly.
PSC-17 (Pediatric)	Administer PSC-17 at enrollment; if score is ≥ 15, use for routine monitoring. If score is < 15, reassess in 6 months, or earlier if clinically indicated or if one of the subscales is elevated.	If initial score is ≥ 15, measure monthly.

3. If an organization would like to propose a BH data collection tool for PBH and T2T that is not one of the approved measures, they should consider the tool selection criteria at right. The Practice Coach will forward the proposed tool to the BHICCI clinical advisors for broader team consideration. Over time the list of approved measures may be expanded.
4. Substance Use Disorder (SUD) concerns are often eclipsed by other mental health (MH) concerns. UCSD and Jen Clancy Consulting developed a custom SUD measure.
5. Organizations may consider other health behavior/health psychology concerns (e.g. medication adherence, or lifestyle) that are independent of a MH or SUD condition or diagnosis. However, these may be better foci as a second or third focus.
6. Kid's tools are problematic as few tools are available for tracking/population health; all proposals to use a child measure tool will be evaluated individually. Organizations that serve predominantly teens and older can utilize the PHQ-9 or other "adult" measures. Those serving younger kids (0 – 12) should not. Though there are few T2T tools available it is important to select a tool that meets as many of the criteria as possible.

Treat-to-Target Tool Selection Criteria

a) The tool must measure a clinically relevant symptom, function, or behavioral domain.

b) The tool must use a scoring scale that supports the ability to do sequential measurement, and have a track record of reliability and validity.

c) The tool must help the client and clinician determine whether the client is making progress.

d) The tool must be short and preferably self-reported by consumer/client when possible.

Medical Condition Stabilization and Improvement

In addition to BH conditions, sites will measure and track physical health conditions using hemoglobin A1c (HbA1c), blood pressure, and body mass index (BMI). While most primary care sites are familiar and comfortable working with these labs and vitals, these will likely be new measures for BH provider locations. However, the health disparities associated with BH patients are significant enough to require focus on some of the most common medical conditions.

Table 2: **Approved Medical Health Measures for Treat-to Target Services**

Measure	Screening Recommendation	Routine Monitoring Recommendation
HbA1c **(Required for patients with DM II or those at increased risk of DM II)**	Screen for DM II annually (laboratory HbA1c only). Prediabetes: HbA1c 5.7-6.4 DM: HbA1c $\geq$ 6.5 If prediabetes, rescreen in 1 year.	Monitor known DM II every 6 months if last HbA1c < 7, or every 3 months for last HbA1c $\geq$ 7 (POC HbA1c okay).
BP **(Required for All)**	Measure BP at enrollment and on a routine basis. Hypertension (for < 60 years of age): SBP $\geq$ 140 or DBP $\geq$ 90 Hypertension (for $\geq$ 60 years of age): SBP $\geq$ 150 or DBP $\geq$ 90	Measure at each visit. If patient has the diagnosis of hypertension, BP should be measured *at least* quarterly.
BMI **(Required for All)**	Measure BMI at enrollment and on a routine basis.	Measure at each visit, or *at least* quarterly.

Part 4: Process and System Performance Measures

In addition to the collection of clinical data for BH and physical health conditions, process and system performance data is collected through a variety of mechanisms and organized into three groups of data: 1) implementation and design, 2) health care team and patient experience, and 3) evaluation. This data is used to understand the challenges and successes associated with health care practice transformation, respond to health care team and patient experience and satisfaction, and assess the intervention's effectiveness in facilitating practice changes and improving health outcomes. Specific process and system performance measures are described in Table 3.

Table 3: Process and System Performance Measures

Measure	Frequency of Collection
Team Experience	Team members who spend at least 30% of their time on BHICCI complete the survey the second Tuesday of each month. Survey data is used to inform a monthly team-led reflection and goal-setting session. All team members are invited to attend and have their voices heard. Notes and S.M.A.R.T. goals are submitted after each session via an online form.
Patient Experience	BHICCI enrollees complete the survey after each visit, or as appropriate. Survey data is used to inform a monthly team-led reflection and goal-setting session. All team members are invited to attend and have their voices heard. Notes and S.M.A.R.T. goals are submitted after each session via an online form.
PROMIS Global Health	Administer at patient enrollment with quarterly reassessment. Reports on patient-level responses are produced for sites the second or third week of each month and made available through UCSD's portal.
Site Self-Assessment	Evaluation staff coordinates with practice coaches and healthcare organizations to collect the self-assessment at three six-month intervals beginning in May 2016. Subsequent self-assessments are completed in November 2016 and May 2017.
UCSD Site Visits	Evaluation staff conduct three sets of site visits, which include interviews with BHICCI teams and clinic staff, in August 2016, March 2017, and August 2017.

Part 5: Tracking Utilization & Cost

IEHP claims data for the target population at each HCO will enable the study of whether clinical interventions are affecting utilization and cost. Specifically, IEHP will study four metrics:

1. **Medical Inpatient Admissions:** The number of unique medical hospital admissions per month of those within the target population (one individual client admitted twice would be counted twice).
2. **Psychiatric Inpatient Admissions:** The number of unique psychiatric hospital admissions per month of those within the target population (one individual client admitted twice would be counted twice).
3. **Emergency Department Visits:** The number of unique ED admissions per month of those within the target population (one individual client admitted twice would be counted twice).
4. **Total Cost of Care:** The total claims based on all services billed to IEHP. This will include inpatient and outpatient medical and pharmacy claims, and mild-to-moderate outpatient behavioral health claims. This will not include costs related to inpatient psychiatric services, services to those with serious mental illness, or services for SUD.

These data will be made available to each team monthly in a format that illustrates change over time.