Implementation of CCBHC Outcome Measures and Population Health Management in Missouri

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MO Coalition for Community Behavioral Healthcare

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Tri-County Mental Health Services
Navigating the Control Panel

Your Participation

The GoToWebinar Control Panel allows attendees to interact with their session. Submit questions and comments via the Questions panel.

Note: Today’s presentation is being recorded and will be made available within 48 hours.
Missouri’s Journey

- Review of CCBHC Performance Measures
- Missouri’s Approach to the Measures
- Integration of Data Systems with New Platform
- Population Health Management
- CCBHC Provider Perspective
Missouri’s Journey

CCBHC Performance Measures
### CCBHC Pilot State: MISSOURI

#### TABLE 5: PROJECTED NUMBER OF INDIVIDUALS TO BE SERVED BY CCBHCS

<table>
<thead>
<tr>
<th>State</th>
<th>State population (in millions)</th>
<th>CCBHCs</th>
<th>CCBHC service locations</th>
<th>DY1 – Total to receive CCBHC services (all pay sources)</th>
<th>DY1 – Projected CCBHC Consumers who are Medicaid Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota</td>
<td>5.52</td>
<td>6</td>
<td>22</td>
<td>17,600</td>
<td>15,000</td>
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<tr>
<td>Missouri</td>
<td>6.09</td>
<td>15</td>
<td>201</td>
<td>127,083</td>
<td>87,284</td>
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<tr>
<td>Nevada</td>
<td>2.94</td>
<td>4</td>
<td>5</td>
<td>7,305</td>
<td>5,844</td>
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<td>New Jersey</td>
<td>8.94</td>
<td>7</td>
<td>20</td>
<td>79,782</td>
<td>50,882</td>
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<tr>
<td>New York</td>
<td>19.75</td>
<td>13</td>
<td>77</td>
<td>40,000</td>
<td>32,000</td>
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<tr>
<td>Oklahoma</td>
<td>3.92</td>
<td>3</td>
<td>19</td>
<td>23,076</td>
<td>11,077</td>
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<tr>
<td>Oregon</td>
<td>4.09</td>
<td>12</td>
<td>21</td>
<td>61,700</td>
<td>50,000</td>
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<tr>
<td>Pennsylvania</td>
<td>12.80</td>
<td>7</td>
<td>7</td>
<td>24,800</td>
<td>17,800</td>
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<tr>
<td><strong>Total:</strong></td>
<td><strong>64.05</strong></td>
<td><strong>67</strong></td>
<td><strong>372</strong></td>
<td><strong>381,346</strong></td>
<td><strong>269,887</strong></td>
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</table>

> 90 out of 115 counties covered by CCBHC
## CCBHC Performance Measures

<table>
<thead>
<tr>
<th>Clinic-Lead Measures</th>
<th>State-Lead Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Time to Initial Evaluation</td>
<td>1) Housing Status</td>
</tr>
<tr>
<td>2) Adult BMI Screening/Follow Up</td>
<td>2) Patient Experience of Care Survey (adult)</td>
</tr>
<tr>
<td>3) Youth Weight Assessment/ Counseling</td>
<td>3) Youth/Family Experience of Care Survey</td>
</tr>
<tr>
<td>4) Tobacco Use Screening/Cessation</td>
<td>4) Follow-up after ED visit for MI</td>
</tr>
<tr>
<td>5) Alcohol Use Screening/Counseling</td>
<td>5) Follow-up after ED visit for AOD</td>
</tr>
<tr>
<td>6) Youth MDD: Suicide Risk Assessment</td>
<td>6) MI Hospitalization Follow-up (adult)</td>
</tr>
<tr>
<td>7) Adult MDD: Suicide Risk Assessment</td>
<td>7) MI Hospitalization Follow-up (youth)</td>
</tr>
<tr>
<td>8) Screening for Depression/Follow Up</td>
<td>8) All Cause Readmission Rate</td>
</tr>
<tr>
<td>9) Depression Remission at 12 months</td>
<td>9) Diabetes Screening</td>
</tr>
<tr>
<td>10) Adherence to Antipsychotic Medication</td>
<td></td>
</tr>
<tr>
<td>11) Follow-up for Children ADHD Medication</td>
<td></td>
</tr>
<tr>
<td>12) Antidepressant Medication Management</td>
<td></td>
</tr>
<tr>
<td>13) Initiation/Engagement of AOD Treatment</td>
<td></td>
</tr>
</tbody>
</table>
CCBHC Performance Measures

For Missouri, that is the perfect split on measures:

• No CCBHC-lead measures could be reported by state
• No State-lead measures could be reported by CCBHCs
• Some edits to EHRs required to capture new data elements
  o e.g. if follow-up plan only documented in a note, now an explicit code
• For statewide metrics, changes to perception of care survey process
  o N=300 youth, 300 adult, per CCBHC
  o Otherwise state-lead metrics within existing datasets
  o Already had access to state Medicaid claims
  o Gap is Medicare claims but do have crossover (Medicaid copayment) claims
• CCBHC to report summary rates and stratifications on “OMB template”
• State completes state-lead tabs on template
• Completed workbooks to feds by 1 year from end of demonstration year
CCBHC Performance Measures

- Statewide workgroup with all 15 CCBHCs represented
- Bi-monthly became monthly
- Reviewing all specifications, particularly CCBHC-lead
- No additional metrics (for now)
- Kept to SAMHSA published specifications except for editing 4 service codes from one value set (for SRA-A)
- Various TA emails to feds from group
- Shifted to review of initial baseline metrics for QBP
Missouri Quality Bonus Payment

• Must meet goals for all 6 required Metrics

• Decided against MO specific metrics

• Goals set by average FY16 baseline:
  o Must meet either statewide average or (if below average)
  o Can exceed CCBHC specific baseline rate
  o Denominator <30 treated as statistically insignificant

• QBP is a flat x% of PPS payment totals, x set by budget
Missouri’s Journey

New Statewide Care Management & Population Health Platform
Previous Workflow 😞

- CIMOR: Access service and program data
- DMH sends hospitalization report/ED alerting
- Tracking populations
- Access to claims data
- Access to clinical data
- Data Entry to generate reports
- Receive monthly reports* from reporting tool
- Master Client Spreadsheet
- Medicaid EHR
- Medicaid Eligibility
- Health Information Exchange
- Provider Electronic Health Record
- Reporting Tool
- Dated reports … have I or someone on the care team already intervened?
- Performance can determine payment to agency
Raining Spreadsheets

The frustration of trying to manage populations and creating workflows with spreadsheets.

• You want me to log into another system?
• “Check your email.”
• Has the spreadsheet been sorted by caseload?
• How do I add filters and sort to find what I need?
“Shopping List”

- Access to data in near real-time (daily)
- Minimize and/or eliminate double entry of clinical data
- Easily assign and manage caseloads
- Allow for flexible reporting from the aggregate data set at the Coalition and site level
- Create risk stratification and apply rules logic to the data set
- Enable population health management
- **One Stop Shop** | Aggregate and display meaningful data in one system (claims data, hospital and ER notifications, clinical data and assessments)
How can we integrate our data?

- DMH sends hospitalization report/ED alerting
- Tracking populations
- Access to claims data
- Access to clinical data
- Data Entry to generate reports
- Receive monthly reports* from reporting tool

Data Silos:
- Master Client Spreadsheet
- Medicaid EHR
- Medicaid Eligibility
- Health Information Exchange
- Provider Electronic Health Record
- Reporting Tool

Dated reports ... have I or someone on the care team already intervened?

*Performance can determine payment to agency
Find a good PARTNER
NOT another VENDOR

• Go on dates to find your match
• Be honest and transparent about your needs and wants (past, present and future)
• Out of the box won’t work
• CAUTION: Sweet Talk/Buzz Words
• Get engaged before getting married (take time to pilot)
Dated reports…have I or someone on the care team already intervened?

- CareManager/Pop Health tool refreshes daily.
- Care Team has access and work is reflected real time.

Current Workflow 😊

Provider Electronic Health Record

CareManager & Population Health System

- Daily alerts of hospital and ER encounters
- Access to claims data
- Access to clinical data (from EHR)
- Medicaid eligibility
- DIY Reporting
- Outcome Measures
- State Reporting Requirements
MISSOURI'S SYSTEM OF CARE COORDINATION

January 2018 | 35 providers | 800+ end users
Population Health Management

**Aggregate View**

- Adult Body Mass Index (BMI)
  - 79%
  - Goal: 70%

**Individual View**

- Asthma Medication Adherence
- Blood Pressure Control for Diabetes
- Blood Pressure Control for Hypertension
- Body Mass Index Control
- Hemoglobin HbA1c Control for Diabetes
- LDL Control for Cardiovascular Disease
- LDL Control for Diabetes
- Metabolic Screening Complete
- Tobacco Use Control

Drill down to the specific clients needing intervention

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Case Manager</th>
<th>A1c Result</th>
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<tbody>
<tr>
<td>234234</td>
<td>Arenciba, Victor</td>
<td>M</td>
<td>57</td>
<td>Gibson, Janet</td>
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<tr>
<td>101</td>
<td>Brown, Todd</td>
<td>M</td>
<td>64</td>
<td>Gibson, Janet</td>
<td>-</td>
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<tr>
<td>456</td>
<td>Walken, Tonya</td>
<td>F</td>
<td>19</td>
<td>Green, Sue</td>
<td>13</td>
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<tr>
<td>6576</td>
<td>Jones, Betty</td>
<td>F</td>
<td>65</td>
<td>Gibson, Janet</td>
<td>10</td>
</tr>
</tbody>
</table>

Visually presenting the whole picture of an individual with metrics that matter.

Integrate, Analyze, Visualize
### Missouri Risk Stratification Model

#### Health Risk Profile

**Demographics**
- **NAME**: Blaine L Bamboocon
- **DCN #**: 5378434
- **NURSE CARE MANAGER ASSIGNMENT**: Cecilia Rahardjo
- **DATE OF BIRTH / AGE**: 06/06/1981 36 years Adult
- **GENDER**: Male
- **RACE**: Caucasian

**Program Enrollment**
- Primary Care Health Home - enrolled 1/3/2017

**Health Plan**
- BCBS KC - enrolled 01/03/2017

**Category Details**

<table>
<thead>
<tr>
<th>Metabolic Screening</th>
<th>Physical Health Diagnosis</th>
<th>Medication Use</th>
<th>ER &amp; Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.5</td>
<td>3</td>
<td>2.2</td>
<td>3</td>
</tr>
</tbody>
</table>

**TOTAL RISK SCORE**
- **MODERATE-HIGH RISK**

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

**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

**Health Risk Profile (HRP)**

| Client Profile | • Demographics  
|               | • Program Enrollment  
|               | • Health Plan  
| Risk Factors  | • Metabolic Screening Profile  
|               | • Physical Health Diagnosis  
|               | • Behavioral Health Diagnosis  
|               | • Substance Use Diagnosis  
|               | • Developmental Disability  
|               | • Other Chronic Conditions  
|               | • Medication Use  
|               | • ER & Hospitalizations  

**Risk Stratification**
- **Low Risk**: < 7.5
- **Moderate Risk**: 7.5 – 11.5
- **Mod-High Risk**: 11.6 – 15
- **High Risk**: > 15
Missouri’s Journey

Population Health Management
Population Health Management

A Roadmap for Provider-Based Automation in a New Era of Healthcare

Institute for Health Technology Transformation (iHT²)

Alide Chase, MS; Connie White Delaney, PhD, RN, FAAN, FACMI; Don Fetterolf, MD, MBA; Robert Fortini; Paul Grundy, MD, MPH; Richard Hodach, MD, PhD, MPH; Michael B. Matthews; Margaret O’Kane; Andy Steele, MD, MPH, MSC
Provider Definition: “The population health improvement model highlights three components: the central care delivery and leadership roles of the primary care physician; the critical importance of patient activation, involvement and personal responsibility; and the patient focus and capacity expansion of care coordination provided through wellness, disease and chronic care management programs.”¹ (Care Continuum Alliance)

GOAL: “The goal of population health management (PHM) is to keep a patient population as healthy as possible, minimizing the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests, and procedures.”¹

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.
Roadmap for Success

1. Planning for Population Health Management
2. Data Collection, Storage and Management
3. Population Monitoring and Stratification
4. Patient Engagement
5. Team-Based Interventions
6. Measuring Outcomes

Population Health Management: A Roadmap for Provider-Based Automation in a New Era of Healthcare, Institute for Health Technology Transformation, Chase, Alide, et.al.
“Health information technology is absolutely “necessary but not sufficient” for creating practice-based population health management; committed executive and clinical leadership, care team development, and care coordination processes are also critical success factors.”

“Efficient, systematic data collection, storage and management drive automation, quality measurement, and performance analysis; and, comprehensive, timely, relevant information is essential to high-quality patient care.”

“To manage population health effectively, an organization must be able to track and monitor the health of individual patients. It must also stratify its population into subgroups that require particular services at specified intervals.”

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.
Population Health Management

Automation makes population health management feasible, scalable and sustainable.
Population health management will become a required **core competency** for provider organizations in a post-fee-for-service payment environment.
Missouri’s Journey

CCBHC Provider Perspective
Multiple Enumerated Visit Tracking
Multiple Enumerated Visit Tracking

Services (4)

<table>
<thead>
<tr>
<th>Service ID</th>
<th>Episode Number</th>
<th>Service Location</th>
<th>Service Date</th>
<th>Service Duration</th>
<th>Staff ID</th>
<th>Service Value</th>
<th>Program</th>
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<td>12048</td>
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<td></td>
<td>64754.004</td>
<td>13</td>
<td>Home</td>
<td>2018-04-16</td>
</tr>
</tbody>
</table>
High Utilizers PPS 1 Tracking

Client ID

- 372 Days, 1,836 Services
- 288 Days, 1,675 Services
- 823 Days, 1,670 Services
- 446 Days, 1,646 Services
- 808 Days, 1,601 Services
- 813 Days, 1,597 Services
- 507 Days, 1,490 Services
- 719 Days, 1,464 Services
- 717 Days, 1,311 Services
- 331 Days, 1,302 Services

Unique Services

Unique Days
Tracking Enumerated Visits Per Month
Tracking Productivity for Enumerated Visit | Count and Time
<table>
<thead>
<tr>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment</td>
</tr>
<tr>
<td>Depression Remission at Twelve Months</td>
</tr>
<tr>
<td>Measure: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)</td>
</tr>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
</tr>
<tr>
<td>Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CDF-BH)</td>
</tr>
<tr>
<td>Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>Preventive Care and Screening: Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
</tr>
<tr>
<td>Time to Initial Evaluation</td>
</tr>
<tr>
<td>Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)</td>
</tr>
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</table>

Showing 1 to 9 of 9 entries  9 rows selected
<table>
<thead>
<tr>
<th>Measure Results</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Initial Population</th>
<th>Exclusion</th>
<th>Exception</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan</td>
<td>19</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100%</td>
</tr>
<tr>
<td>Measure: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A)</td>
<td>19</td>
<td>19</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100%</td>
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<tr>
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<td>24</td>
<td>40</td>
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<td>0</td>
<td>60%</td>
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<tr>
<td>Time to Initial Evaluation</td>
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<td>76</td>
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<td>0</td>
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<td>58%</td>
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<td>Time to Initial Evaluation</td>
<td>8</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>73%</td>
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</table>
### Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

**CCBHC BMI SF**

#### Filter Options:
- **Initial Population**
- **Denominator**
- **Denominator Exceptions**
- **Denominator Exclusions**
- **Numerator**

**Show** 10 entries

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Sex</th>
<th>Age</th>
<th>Race Code</th>
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<tbody>
<tr>
<td>Alan</td>
<td>Bench</td>
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<td></td>
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<tr>
<td>David</td>
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<td>Elsa</td>
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<tr>
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</tr>
<tr>
<td>Lavon</td>
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<td></td>
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<tr>
<td>Mai</td>
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<td></td>
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<tr>
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</tr>
<tr>
<td>Tom</td>
<td>Warner</td>
<td>35</td>
<td></td>
<td>2076-8</td>
</tr>
</tbody>
</table>

Showing 1 to 10 of 11 entries
Thank You!

Rachelle Glavin | rglavin@mocoalition.org
Clive Woodward | cwoodward@mocoalition.org
Discussion/Questions
Get Help!

Peer Learning Network Participants

Listserv Inquiries

- Email: ccbhc_cop@nationalcouncilcommunities.org

CCBHC Resource Page (Launch Pad)

- https://www.nationalcouncildocs.net/ccbhc-learning-community
Get Help!

Master Class Community of Practice Participants

Office Hours: Wednesday, May 23 1-4pm, Sign-up here

Attend an Affinity Group Call

- Monday, June 4 at 3pm ET – Clinical & Data/Quality Affinity Call with Kate Davidson
- Tuesday, June 14 at 3:00pm ET – Operations and Financial with Kristin Woodlock
- June Clinical & Data/Quality Affinity Call with Dr. Joe Parks (time TBD)
Next Webinar

Topic: Celebrations & Sustainability

June 20, 2-3pm ET - Registration link
Thank you!

Please take a few moments to answer the brief survey that will pop up when the webinar is over.