Integrated Policy Initiative: Behavioral Health Measurement Project

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## Participating Stakeholders

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I. Introduction

The Integrated Behavioral Health Project (IBHP)\(^1\) funded the Integrated Policy Initiative Behavioral Health Measurement Project to assess the current status of process, quality and clinical outcome measurement and data systems that concern and support integrated behavioral health\(^2\) (IBH) care delivery. The project aimed to “take a snapshot” of the current state of the field and what is needed to advance the standardization of IBH measures and develop a roadmap for broader implementation of integrated health and behavioral health systems in community health clinic settings.

**Project Goals:**

- Document the practices and capacity for integrated behavioral health measurement and data systems within community clinics in California
- Produce recommendations to further efforts for standardizing and implementing integrated behavioral health measures in community clinic settings

**Approach:**

This project involved several steps for gathering and synthesizing information:

- Conducted targeted interviews of experts and key stakeholders (n=26) in California regarding the current state of IBH measurement and implementation in community clinics and health centers, including quality improvement and measurement initiatives underway.
- Conducted interviews with IBHP grantees to provide the view from the field/front line.
- Convened a statewide webinar to gather additional input and recommendations regarding directions the field can take to advance IBH data systems and measurement.

The following report synthesizes and presents the findings of these conversations, focusing especially on the current “state of the field,” challenges and barriers, and lessons learned that are important to consider in advancing the capacity for integrated behavioral health measurement.

II. Background

Traditionally, community health centers (CHCs) have served the national public safety net, providing multidisciplinary, integrated care to the poor and uninsured, including racial and ethnic minority groups. Currently there are over 1200 CHCs operating more than 8000 clinic

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\(^1\) The Integrated Behavioral Health Project (IBHP) was started in 2006 by the Tides Center and funded by The California Endowment to enhance access to and improve outcomes of behavioral health services in primary care clinics throughout California (www.ibhp.org).

\(^2\) Integrated behavioral health encompasses primary care, mental health, and substance use conditions and services.
sites across the United States, and these centers provide care to 20 million Americans. In many cases, the CHC is the medical home for underserved populations, providing, not only primary medical, dental, and behavioral health care, but social services, translation, health education, and transportation assistance as well. Because of this mission to provide the array of services to meet the needs of their communities, many CHCs are vanguards in the field of integrated behavioral health. In California, there is a strong legacy of integrated behavioral health in clinics and a commitment to improving bi-directional care for individuals across the continuum of behavioral health needs.

Since 2008, the Integration Policy Initiative (IPI), a collaborative project led by the California Institute for Mental Health (CiMH), the California Primary Care Association (CPCA) and the Integrated Behavioral Health Project (IBHP), has worked to advance integrated care and improve the health outcomes of people with mental illness by focusing on policy, financing, and service delivery issues. In 2009, IPI issued a report that described a “Vision, Principles, and a Collaborative Care Continuum,” and included recommendations for expanding integrated care for California’s safety net population. One of the outcomes of the IPI process that was documented in the report was an interest in moving towards greater standardization of behavioral health measurement to support integrated care and build the capacity of clinics to collect and use data. IPI recognized the need to examine the current capacity and challenges faced by the field as a first step in achieving measurement standardization and developing more functional data systems.

As integrated care approaches are implemented more broadly in primary care settings, the need for data systems to support and track both health and behavioral health data is essential. Electronic health information serves as a cornerstone for ongoing efforts to improve efficiency, effectiveness, and overall quality improvement in integrated behavioral health care. In California, counties are actively moving to adopt integration measurement activities supported through funding opportunities under various initiatives (e.g., the Mental Health Services Act (MHSA) and the California Mental Health Care Management Program (CalMEND)). Over the past decade, California foundations have invested significant resources in building the IT and measurement infrastructure of counties and clinics.

The recent passage of the Patient Protection and Affordable Care Act of 2010 (ACA) is accelerating a shift toward greater accountability and efficiency in the health care system using information technology and data. The vision for a reformed health care system includes a shift from fee-for-service to performance and incentive based reimbursement, which will require the use of data to demonstrate positive clinical outcomes. According to the Institute for Healthcare Improvement (IHI), improving the U.S. health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. The patient-centered medical home (PCMH), a concept included in the ACA, is considered one of the most promising service delivery models

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4 http://www.cimh.org/Initiatives/Primary-Care-BH-Integration.aspx
5 http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm
to achieve the “triple aim.” In addition, ACA includes provisions for MH/SU parity, which will be a key driver in reforming benefit structure, service provision--and measurement.

The National Committee for Quality Assurance (NCQA) has developed standards and guidelines for primary care clinics to achieve designation as a PCMH\(^6\). “Must pass” elements for PCMH recognition include: 1) written standards for patient access and communication; 2) patient tracking and registry; 3) care management; 4) patient self-management support; 5) test tracking; 6) referral tracking; and 7) clinical and service performance reporting and improvement. Meeting the “must pass” elements assumes that clinics have sufficient infrastructure to capture and report data. Even if clinics are not seeking PCMH accreditation, a key component of national health reform – the concept of the Accountable Care Organization (ACO) -- will require that clinics have the infrastructure and capacity to collect and report data to succeed in the reformed health care environment. In fact, the draft NCQA criteria for ACOs require reporting, assessment and accountability standards that assume use of health information technology.

To promote widespread adoption of health information technology, the Centers for Medicare and Medicaid Services (CMS) proposed a regulation that would provide incentive payments to health systems that demonstrate “meaningful use” of electronic health record (EHR) technology. Meaningful Use Standards would enhance the interoperability, functionality, utility, and security of health information technology. While behavioral health has been excluded from the Meaningful Use regulations and funding, advocacy efforts and future legislation is expected to correct this omission. With the inclusion of behavioral health into Meaningful Use, alignment and advocacy for relevant standards for IBH can be expected.

In summary, greater standardization of integrated behavioral health measurement and the use of health information technology is critical in the current health policy environment and needs to elevate as a priority for not only community health centers, but also local health plans, managed care organizations, state leaders, and various other stakeholders to be responsive to the health system changes on the horizon.

### III. Current State of the Field

The following section presents the current “state of the field” of behavioral health measurement, drawing from a sample of community clinic vanguards across California with a track record of early adoption in providing integrated behavioral health services. Specifically, we present information on: 1) factors that motivate a primary care clinic or clinic system to collect behavioral health data; 2) data collection strategies and instruments used; 3) data systems used to capture and manage data; and 4) clinical, administrative and financial applications of the data.

A very clear theme that emerged during the course of this project is the significant variability across community clinics on all aspects of behavioral health measurement. While most clinics understand the inherent value in collecting BH data, there is little consensus on what is most critical to measure and which instruments and methods of administration are most efficient.

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\(^6\) NCQA is currently revising PCMH standards to include behavioral health elements. At the time of this report, the revised standards were not yet available.
Differences in leadership, clinic priorities and overall staffing and financial resources also affect the degree to which BH data are collected and how robustly this effort is integrated into the overall IT or data systems of clinics. Finally, there is ample evidence to suggest that even clinics at the leading edge of BH measurement would benefit greatly from technical assistance and resources to advance how they can apply the data they are collecting to enhance administrative operations and inform clinical decision-making.

A. Motivation for Collecting Behavioral Health Data Primary Care

Motivating factors influencing a clinic to collect BH data fall under two broad categories: 1) financial incentives and 2) quality improvement efforts. With the changes health reform will bring, financing and quality are becoming more connected as clinics look for ways to remain competitive and increase their market share of newly insured individuals in 2014. Dedication to quality improvement and positive health outcomes are ways that clinics can be viewed as the provider of choice in a market where patients have greater choice about where to get their health care.

Financial Incentives

Grant and contract requirements. Most clinics stated that grant and contract requirements were significant drivers of what BH data are collected. Clinics that participate in pilot demonstrations or receive grant funding to implement new programs are typically required to collect certain data elements defined and required by these programs. With scarce resources, clinics are pressured to prioritize projects, and priorities tend to be those with money and resources attached. Grant funding can also justify resources dedicated to data collection and analysis – functions that are not typically well funded within the safety net system in the absence of grant funded projects.

Cost Efficiencies. Clinics are motivated to collect certain data elements to reduce billing errors and improve overall financial efficiency of the system. Larger clinic systems or closed payer systems (e.g., CMSP) are motivated to look for high cost patient populations to identify strategies for intervention to keep costs down. In looking for ways to address inefficient patterns of care and contain costs, many systems collect demographic, diagnostic, utilization data and other data elements for modeling purposes. Data collection targeted at maximizing resources to manage the cost trajectory is typically used by much larger systems that have the resource and analytic capacity for this level of investment.

Federal incentives to improve data collection and quality. Financial incentives at the Federal level, such as Meaningful Use standards and movement toward “pay for performance” pilot demonstrations, are motivating clinics to enhance their capacity to track patient outcome data. While national Meaningful Use criteria currently do not include behavioral health providers or BH data measures, this is likely to change and clinics that are already committed to integrated service delivery are incorporating BH related factors into their systems. The Federal government has provided additional incentives through ARRA funding targeted specifically for expansion in Health IT and EHR implementation.
Making the “business case” for programs or positions. Given the financial demands and priorities associated with clinic administration, some clinics have collected data specifically to establish the “business case” or financial viability of a given behavioral health program, provider, or non-billable staff position. In one example, a clinic system that was once reluctant to hire a psychiatrist in-house, reports they “couldn’t operate without one” now that they have data demonstrating that the demand and utilization more than justifies the expenditure on salary. Clinics have also been motivated to collect data on medical provider satisfaction, no-show rates, provider productivity and BH outcomes to demonstrate the broader value of having behavioral health specialists as part of the team approach to care. Non-billable services and providers (i.e., case managers) are particularly vulnerable within a clinic, especially in difficult economic conditions. Program directors are motivated to have data available to demonstrate the contribution of these services and providers to make the case to clinic administrators to maintain the level of service provided to patients and communities served.

Quality Improvement

Participation in collaboratives. Community clinics and health centers have a tradition of providing comprehensive, culturally competent, patient-directed health care services to medically underserved and vulnerable populations. The community clinic patient population is often low-income, uninsured or underinsured, with complex health and psychosocial needs. As such, they have been at the forefront of participation in chronic disease collaboratives (e.g., diabetes, depression), as well as HRSA sponsored efforts to address health disparities. In addition to the motivation to improve health outcomes for the population served and reduce disparities, clinics gain visibility through participation in quality improvement programs and collaboratives. Greater visibility and a positive reputation serve as motivating factors for clinics as they prepare for a more competitive health care delivery system environment.

Accountability for outcomes. Accountability for patient outcomes drives provider motivation for data collection. As providers feel greater accountability (and incentives) for successful management of chronic conditions, there is greater ownership and investment in tracking progress, no-show rates, treatment compliance and outcomes. Clinical treatment priorities also drive motivation for data collection and tracking. Providers participating in collaboratives, where outcome data for patient panels are public and can be compared, are highly motivated to collect information that demonstrates success.

Improving clinical assessment and care management. Providers are looking for more systematic methods for screening, diagnosing and tracking progress on behavioral health measures. Providers that are committed to improving care quality are motivated to use objective measures to screen the patient population for unmet behavioral health needs as well as to track progress over time. Accessibility to these data enhances ongoing care management.

B. Currently Used Measures and Data Collection Strategies

As is the case with motivation to collect behavioral health data, clinics also vary widely in terms of the data that are actually measured and the instruments and strategies used for collection.
**Depression is the most common condition screened for, measured and tracked.** Depression is by far the most commonly addressed behavioral health condition in the primary care setting. There are brief, accessible screening instruments that can be administered by either the PCP or the medical assistant (MA) or self-administered while filling out paperwork in the waiting room, which has increased the identification of depression. There is greater provider confidence in diagnosing and successfully managing depression than most other behavioral health conditions, and there is significant research to support that successful treatment of depression has a positive impact on other chronic medical conditions, such as diabetes and cardiovascular disease.

Despite the increase in awareness of depression management in the primary care setting, there is great variability in screening and diagnostic tools, treatment and outcome tracking and measures used. Within the sample of clinics interviewed for this project, there were at least five different depression measures used (e.g., PHQ-2, PHQ-9, Duke, SF-12, MINI).

**Behavioral health measures are used with various patient populations.** While some clinics have adopted universal screens to identify various behavioral health issues in their entire patient population, limited treatment resources make this the exception rather than standard practice. Most clinics collect program specific BH data on a sub-population of their patient population receiving behavioral health services as part of a specific program or grant project (e.g., IMPACT, IBHP, CMS Integration Pilot) or they collect condition-specific behavioral health data, (e.g., depression scores for diabetics). There is no current standard that is widely adopted by community clinics to drive what elements are important to track and for which populations, so clinics are developing their own clinical protocols which are often driven by grant program participation.

Behavioral health process measures are being tracked in addition to outcome measures. Based on the range of motivations for collecting BH data mentioned previously, clinics are documenting a range of process measures related to behavioral health service delivery. Other BH service delivery data collected include: no-show rates, referrals to community-based and specialty services, provider productivity, treatment plan goals, pain contracts, and patient/provider satisfaction.

**C. Data Systems Used to Capture Behavioral Health Data**

Not surprisingly, with over 300 vendors currently developing and marketing software systems for electronic health records, clinics are using a variety of data capture strategies. The degree to which behavioral health data are incorporated into electronic health records, registries or other population health management systems also varies. Even within clinics that provide integrated services, data systems are often not integrated, with many behavioral health programs still relying on paper charts and separate records for mental health and/or substance use data elements. The current “state of the field” of behavioral health data systems is significantly behind medical data system infrastructure, and many BH providers are not even at the table when clinics initiate the long and arduous process of implementing a new data system or EHR.

**Software programs vary in focus and functionality.** Clinics interviewed for this project operated an array of information systems, which include: practice management systems
(focused on billing), fully implemented and operational EHR, disease specific registries (depression, diabetes), population health management systems (i2i Tracks), “home grown” programs that capture BH data in a separate Access database that is not integrated with other medical records, and paper charts for mental health and substance use information. Clinics indicated that there is currently no “state of the art” in terms of behavioral health data system management. Consequently, clinics are inclined to tailor their IT systems to meet the needs of their administrative and clinical needs.

Stakeholders reported that there is no one software system that can perform practice management, individual record tracking, and population health management functions. As a result, clinics have cobbled together multiple systems based on limited resources and knowledge of how to maximize the utility of any given system. When asked about their choice of data system, most clinics could only draw from their implementation experience and focused on challenges and barriers faced with usability.

**Currently no one vendor offers a program integrating health and behavioral health information/data.** Of the seven clinics interviewed, there were four distinct EHR programs in operation:

- NextGen
- GE Centricity
- eClinicalWorks
- OCHIN (EpicCare)

In addition, several clinics implemented i2i Tracks as a chronic disease/population health management system. **None of the vendors represented offered an “off the shelf” system that integrated health and behavioral health data. Because customization is time consuming and costly, many clinics that have electronic health record capacity are not using these systems to capture behavioral health data.**

**D. Applications of the data**

The variation in how clinics apply the behavioral health data they collect is consistent with the variability in motivation for collecting these data in first place. The primary applications of the data include: disease management, quality assurance, and quality improvement. While the clinics are making efforts to use the data they gather to enhance clinical decision-making and improve operational efficiencies, there are opportunities for clinics to receive additional guidance and technical assistance on how to maximize their data collection efforts.

Clinics are collecting behavioral health data and applying it to their clinics and clinic systems in the following ways:

- Using universal screens to determine and track incidence of depression
- Using depression scores to assess care effectiveness & validate treatment approach
- Using proactive disease management strategies to trigger BH services, health education, and case management referrals
- Tracking no-shows to target outreach and primary care physician (PCP) referral rates to BH services as part of PCP annual performance review
• Identifying most expensive patients to design special programs/interventions
• Communicating with patients about changes in their condition

IV. Barriers and Challenges Associated with Integrated Behavioral Health Data Systems and Measurement

During interviews, stakeholders were asked to identify challenges associated with advancing behavioral health data systems and measurement. The primary barriers and challenges identified were associated with implementing new data system technology, as well as issues associated specifically with achieving greater standardization in the field related to screening and diagnostics, clinical operations, and outcomes.

A. Barriers and Challenges: New Data System Implementation

Financial

Stakeholders with experience implementing new data systems (i.e., EHR, registries, and population health management systems) emphasized that securing the finances to purchase the software is only the beginning of the story. The additional costs associated with implementing new technology is challenging for clinics with limited resources to implement data systems. Financial barriers associated with implementing new data systems include:

• Limited funding for planning, implementation and ongoing TA and modifications
• Financial pressures make it difficult to hire IT staff to do data analysis
• Productivity slows during implementation of new technologies which can serve as barrier to administrator buy-in
• Post-implementation modifications to software can be costly and time consuming
• Data often need to be combined from multiple systems (e.g., EHR, practice management, i2i Tracks) and most clinics lack resources to do this on a routine basis

Culture Change, Buy-In, and Expertise Working with New Technologies

Another set of challenges to successful data system implementation concerns an organization’s capacity to engender buy-in among staff to develop new skills, and change clinical and operational practices to achieve quality improvement and accountability. Issues identified include:

• Behavioral Health staff are often not part of the planning process for implementing new IT and data systems, which limits a vision for integrated health and behavioral health measurement, data sharing, and service coordination
• Providers lack skill and comfort working with new technologies
• Clinics have experience collecting data, but often lack analytic capacity to use full functionality of systems that are in place
• Over reliance on EHR can isolate providers and reduce in-person communication across primary care and behavioral health providers
• Generating timely and relevant data reports for clinics is complicated
• Building screening and data collection into the clinical routine and operational flow of health and behavioral health providers
• Providers’ concerns that over-reliance on computers will result in “less eye contact” with patients or less in-person communication with colleagues and care teams
• Provider resistance to using data systems due to fear of accountability

Scope and Functionality of the System

Stakeholders reported that there currently is no single off-the-shelf product or system that supports integrated care and addresses three core functions: 1) tracking individual health records, 2) clinical reporting or registries for population health, and 3) billing and administrative functions. Many data management system products currently available focus on billing, not quality improvement or behavioral health (including non-billable services). In addition, there is a lack of knowledge and understanding in the field regarding the purpose and capacity of the various data management systems (e.g., EHRs vs. registries vs. population health management systems), which affects how effectively individual providers and clinics use these systems. Issues identified include:

• EHRs are critical to improving efficiency with individual patient management, but they do not have population health management capability
• Most data management systems still focus on billing rather than quality improvement
• IT/Data Management systems do not include BH measures in off the shelf products – all must be customized, which requires additional resources
• Many important BH services are non-billable (e.g., case management, health education, warm hand-off) and not captured in most data systems.
• EHR developers respond to market demand in terms of product development. The demand for behavioral health data capacity in medical clinics has not been a priority, which has affected the availability of integrated behavioral health modules in EHRs and other data management tools
• System modifications can be problematic when a clinic is part of a collaborative (e.g., the Oregon Community Health Information Network (OCHIN)) because change requests from one region affect the other regions, requiring more coordination and consensus prior to making a change
• Vendor variation and proprietary software limits connections between different systems

B. Barriers and Challenges: Data Standardization

Lack of Practice Standards

Stakeholders identified a lack of widely adopted practice standards within the broader field of behavioral health as a fundamental challenge to developing and achieving standardized IBH measures. Although there are various efforts at the national, state, and local levels to improve the quality and effectiveness of behavioral health treatment, these efforts are not coordinated and lack consensus. As such, stakeholders interviewed noted that the field of IBH measurement is in its “infancy” and needs a unified vision and leadership to advance the process for determining what data are collected, what gets measured, and how data can be
relevant to both providers and clinics to improve the efficiency and effectiveness of care. Barriers to standardization include:

- Lack of consensus at the state and national levels on behavioral health practice standards for screening, diagnosing, and treatment, which leads to a lack of consensus regarding measures to use and outcomes to track
- Concern about the appropriateness of using outcomes tied to diagnosis as a standard for behavioral health measurement when a patient-centered approach to care focuses on symptom reduction, progress on goals, and improved stability and functioning
- Level of variation is significant across multiple levels: provider-to-provider in the same clinic, across clinics in a system, across a consortium, regions, state
- Lack of reliability and utility in diagnostic registries for mental health conditions due to stigma and variation in diagnoses across providers
- No standard to collect behavioral health data on universe of patients served by clinics; protocols that due exist focus on specific priority populations/conditions (e.g., diabetes, children, pregnant women, depression)
- Restrictive and variable definitions of serious mental illness lead to “upcoding” to assist people in getting county services
- Behavioral health interventions in primary care encompass health education and psychotherapy components, making it difficult to balance data sharing needs with privacy/confidentiality
- Strict and inflexible interpretations of HIPAA and 42-CFR regulations restrict data sharing within integrated care settings and across organizations

V. Summary of the State of the Field

Interviews with stakeholders revealed a significant investment in infrastructure and capacity building throughout California over the past decade, with a focus on advancing health IT and performance and outcome measurement. However, much of the activity related to developing standard measures, implementing data systems (electronic health records, registries, population health management), vendor selection, and preparing clinics and community health centers for Health Care Reform, focused on physical health, with very limited attention on behavioral health. It was not uncommon for clinics on the leading edge of providing integrated behavioral health services, not to have behavioral health providers represented in the planning stages of electronic health records, or IBH data measures included in electronic data systems. Behavioral health measurement and inclusion in electronic data systems is at the beginning stages, and the mental health and substance use fields lag behind primary care in terms of developing practice standards, using objective measures, implementing new technologies, and moving toward greater accountability for treatment outcomes.

The 2009 IPI report documented several data and measurement recommendations based on the assumption that the field of integrated behavioral health is actively moving toward greater standardization. However, the current measurement project identified significant challenges that need to be addressed before the field can move toward standardization, including:

- Lack of widely adopted practice standards
- No clear leader at the state level initiating the work (must be augmented from outside)
• Wide variation in data systems, data utilization, and measurement practices across clinics
• Lack of strategic coordination across pilots, initiatives and other IT/measurement related efforts underway

Another issue that emerged was that stakeholders did not necessarily agree that there is a need for standardized measures. Stakeholders raised concerns that movement toward greater standardization would compromise “local” tailoring of patient care. Some argued that the clinics and practitioners have greater buy-in for data collection when it is tailored to what is most relevant to their patient population and administrative needs, and that uniform data sets are restrictive, not directly applicable to all clinics, and often “lower the bar” of what gets collected.

Stakeholders also noted potential resistance to standardization due to the burden of data collection and the possibility of being required to collect data without ever having access to the results. In the absence of a feedback loop for quality improvement and performance improvement, contract and regulatory requirements can create excessive burden with little value to the clinics and providers supplying the data. If the data collected have no relevance to patient care, practitioners have limited investment and data quality deteriorates.

Finally, the cultural tension between primary care and behavioral health continues to be a challenge to advancing IBH standardization and measurement. Some behavioral health stakeholders expressed a recommendation to move away from the “diagnosis driven model” that dominates the primary care field, to one that emphasizes wellness and prevention and better aligns with the recovery model used in specialty mental health. On a more positive note, stakeholders saw the increasing use of the term “Electronic ‘Health’ Records” rather than “Electronic ‘Medical’ Records” as a step in the right direction to better alignment across fields by using terminology that is more inclusive of behavioral health.

VI. Opportunities and Recommendations to Advance IBH Data Systems and Measurement

Stakeholders were asked to identify opportunities and make recommendations to advance the development of IBH data systems and measurement. While the current economic crisis facing California was acknowledged as a significant challenge to promoting a vision for advancing the field of IBH data and measurement, stakeholders agreed about the value in investing in IT infrastructure and measurement for IBH service delivery, and shifting toward data driven administrative, financial, and clinical decision making to improve care. Moreover, the ACA was seen as an unprecedented opportunity to improve and expand access to and the quality of integrated services in the healthcare system more generally.

Stakeholders also noted that past and current IBH efforts by Federal agencies (e.g., the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources Service Administration (HRSA), and the Agency for Healthcare Research and Quality (AHRQ)), accreditation bodies (e.g., CARF and NCQA), as well in California (e.g., IBHP, CMSP, CalMend) offer significant opportunities and resources to advance the field of IBH data and measurement.
However, the group was less clear about how best to move the process forward given the lack of leadership with a vested interest in promoting the issue. The recent experience of the 1115 Waiver process, which increased the interface among key leaders and stakeholders across California Departments of Health Care Services, Mental Health, Alcohol and Drug Programs, and Public Health, was cited as a potential process from which to learn and leverage.

Stakeholders also recognized that foundations can play an important role facilitating the next phase of advancing the field of IBH data and measurement by funding stakeholder convenings, and developing and disseminating new information and knowledge in the rapidly changing landscape of health policy and health care.

The following summarizes the recommendations of the stakeholder group for the State and Counties, as well as CHCs and behavioral health organizations.

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<td>1. Convene and fund knowledgeable leaders from the physical, mental and substance use health care systems serving California’s Safety Net Population to:</td>
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<td>a. Identify, document and assess data currently collected across funding sources and systems (MH/SU/PC) to determine data elements that are useful, not useful and/or missing and make recommendations regarding elimination of mandatory data elements that are not useful and/or redundantly reported.</td>
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<td>b. Create a process for developing IBH practice standards.</td>
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<td>c. Prioritize IBH data and measures for standardization.</td>
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<td>d. Build consensus for adoption, implementation and validation of data and measures.</td>
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<td>e. Identify priority topics for technical assistance and provider training.</td>
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<td>2. Build on existing infrastructure or stakeholder processes (e.g., 1115 Waiver work groups, Standardized Measures Group, CPCA Mental Health Task Force, CalMend, Accelerating Quality Improvement through Collaboration (AQIC) super region structure, and Building Clinic Capacity for Quality (BCCQ)) to specifically incorporate a behavioral health focus into measurement, technology, and technical assistance efforts.</td>
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<td>3. Ensure that California IBH practice standards and data measurement efforts leverage work currently underway at the national level (e.g., National Council for Community Behavioral Health, Center for Health Care Strategies, NCQA, Substance Abuse and Mental Health Services Administration).</td>
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<td>4. Advocate for mental health and substance use measures to be incorporated into the major components of the ACA, i.e., service delivery models (e.g., PCMH), health information technology, and financial incentives (e.g., Meaningful Use Standards).</td>
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<td>5. Encourage county systems to prioritize providing technical assistance and training to county Substance Use contractors to facilitate the development of administrative structures to support billing, data collection, and quality measurement functions to meet the requirements that will be expected in 2014.</td>
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<td>6. Develop a statewide learning community and technical assistance infrastructure to support clinics in understanding the capabilities of different types of data systems and to maximize data collected for quality assurance and quality improvement.</td>
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<td>7. Ensure that data collected from multiple sites (e.g., California Health and Human Services Agency (CHHS), Clinic Consortia, CMSP) is disseminated back to clinics, counties, and their contractors to:</td>
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a. Enhance buy-in at the clinic/provider level for collecting good quality data.  
b. Promote quality improvement.  
c. Facilitate analyses of regional and population comparisons.  
d. Develop interventions for specific populations (e.g., high users of services) identified through the data.

8. Examine and build on state level data sets (e.g., ADP CalOMS and DMH CSI) to initiate discussion to better understand current data requirements and identify common outcome measures used across behavioral health related systems.

9. Clarify HIPAA regulations across public systems and contractors to eliminate barriers and promote data sharing across primary care, mental health, and substance use systems and providers.

10. Develop and make available a standard template of essential data elements for integrated behavioral health that can be used by clinics, counties, and behavioral health contractors.

11. Foster continued collaboration between clinics and county mental health recognizing that optimal care coordination across provider organizations requires business agreements, IT infrastructure, data sharing, and opportunities for regular communication.

### CHC and BH Organization Recommendations

1. Incorporate measures that reflect and support all aspects of patient-centered care, including:  
   a. Administrative and accountability (e.g., contract management, financial, service utilization)  
   b. Comprehensive patient demographics  
   c. Clinical (e.g., screening, diagnostics, encounter effectiveness, health & behavioral health treatment outcomes)  
   d. Care management and coordination (e.g., no show rates, referrals)  
   e. Patient and provider satisfaction

2. Improve bi-directional data sharing and use for clinical decision-making across medical and behavioral health providers.

3. Promote population health management, in addition to individual outcomes, to improve QI practices.

4. Include BH staff in the planning and implementation phases of data systems.

5. Collaborate and pool market power of CHCs and BH organizations to influence technology vendors to develop and customize software to support IBH.

6. Expand funding opportunities to cover needed technical assistance, training and resources for implementation of new data systems, in addition to start-up funding

7. Educate frontline practitioners regarding the broader purpose of data collection and the connection to patient outcomes and provider/system performance to:  
   a. Improve the quality of data collected  
   b. Improve provider buy-in and commitment  
   c. Establish the relevance of ongoing data collection and measurement to clinical practice.

8. Provide technical assistance and support to clinics and providers on how to maximize the utility of existing and new data systems so that data can be successfully extracted and used for clinical decision-making,
III. Planning and Preparing for New IT Infrastructure

- Moving to EHR and implementing new technology requires transformation—not just change. Clinics need to evaluate their capacity for systems change and build in reflection time for providers to achieve successful culture change.
- Given the rate of growth in the technological sector, it is important for clinics to think a decade down the line in planning for IT expansion.
- To have an integrated health care delivery system, behavioral health providers/leadership must be at the planning table when implementing new data systems and electronic health records.
- An EHR system is a useful strategy to enhance care coordination between medical/BH providers when departments are separate. Shared access to patient information in an integrated health record can facilitate communication about the patient.
- Patient-centered care needs to put the patient’s needs first. The treatment outcomes that are tracked over time should connect to what troubles the patient most, in addition to provider (PC/BH) and organizational priorities.
- Data system choices need to balance clinic priorities: 1) a system to capture clinical data to improve care quality and document treatment outcomes; and 2) an efficient system for billing. Practice management systems need to interface with EHR to bring clinical and administrative priorities together.
- Be proactive about discussing integrated service delivery and behavioral health during planning discussions for new technologies. Software vendors rarely discuss BH modules, and BH is not a factor in marketing IT/software products. Behavioral health is not currently a driving force in software system development because the percentage of visits is so low compared to primary care, the demand for measurement and tracking is not significant enough to drive product supply.
- Clinics need both EHR and a bridge interface to extract information from the system to examine data from the individual level to the population level. i2i Tracks is currently one of the best tools for getting clinical data out of EHR system that can be used by a clinic in the aggregate.
- Population health management is critically important and in alignment with a public health philosophy. Electronic health records provide individual clinical data, but population health management systems allow a clinic or clinic system to look at the health of the entire patient population. An analogy is an “arborist” looks
at the health of an individual tree while a “forester” looks at the health of an entire region. Responsible healthcare needs to use both lenses.

- CHCs need to consider external vs. internal hosting of their data systems. Smaller, rural clinics do not have capacity to manage and host their own server. External hosting can provide efficiencies and data protection but there is less autonomy for change and additional hosting costs.
- Clinics need to think about “disaster recovery.” If there is no paper chart back up and the system goes down, operational flow and productivity is compromised. Preparing for a paperless environment includes protocols for service delivery during times when a clinic has technical difficulties.
- Without sufficient funding, clinics are at risk of “skipping critical steps” in data system implementation like disaster recovery planning, allocating sufficient time/resources to extract data from paper chart to enter into EHR, adequate staff involvement, training, and customizations necessary to incorporate behavioral health.

### Cost Considerations

- Costs associated with implementing new data systems: resource time dedicated to research, planning, and decision-making (which may include site visits to other clinic systems), software purchases, licensing fees, costs per/user, annual maintenance, costs for additional modules and modifications, technical assistance from consultants, staff training, and productivity losses during implementation.
- EHR and i2i tracks need to be customized to be useful for BH – customizing after the fact is expensive and BH providers need to weigh in on what types of queries would be useful in EHR so they are set up in advance.
- Population health management systems such as i2i Tracks have substantially lower costs to implement than EHR. They are user friendly for developing specific queries and internal reports, but do not replace an EHR.
- EHR implementation can be considered an FQHC scope change (ex: $107 to $140 per patient with EHR implementation). Costs are front loaded, but with a scope change, clinics can recoup some of the technology investment over time.
- Clinic systems need to be prepared for the fact that implementing EHR requires years of planning and considerable financial investments (upfront and ongoing) before it is fully functional.
- EHR is not set up for FQHC reporting requirements -- there is an opportunity for the field of FQHCs to come together to negotiate with vendors on developing products that include elements that meet the reporting requirements common to FQHCs. Pooling the market power of FQHCs, as opposed to working as individual clinics, may lower the costs of software purchases.

### Implementing New Technology

- Operational policies and protocols need to be in place before implementing them in an electronic format. Moving to electronic data systems highlights all of the clinical inconsistencies across providers. Implementing a new data system assumes a level of operational consistency across providers that may not be the case.
- Clinics will have multiple considerations for data extraction when moving to EHR from paper charts:
  1. Who extracts the data? (i.e., medical providers, MA, external party)
  2. Which elements get extracted and how far back do you go in the chart?
  3. Is this a paid or volunteer task?

Ultimately the medical provider is legally responsible for accuracy and completeness of vital elements to be extracted, but they are the most expensive staff to use in this capacity.

- Incremental implementation of new technologies is often the best choice for clinics from both a cost and systems change perspective. Before launching into EHR clinic-wide, a clinic may start with a registry or i2i Tracks module for a small population (e.g., diabetes, women’s health, depression) to ease the transition to an electronic environment.
- Medical and behavioral health providers need reinforcement and ongoing training on defining standard indicators of improvement, using objective measures, data entry and reporting. Screening and diagnostic instruments, treatment protocols and data systems are continuously evolving and providers should expect change as the norm.

For more information or questions about this brief, contact Karen Linkins at karen@desertvistaconsulting.com. Additional information about the Integrated Behavioral Health Project website: www.ibhp.org.