Take Your CCBHC Planning to the Next Level by Measuring Impact and Accessing Data

October 12, 2022

National Association of State Mental Health Program Directors
National Council for Mental Wellbeing
Logistics & Housekeeping

• Call in on your telephone, or use your computer audio option
• If you are on the phone, enter your Audio PIN

Type questions into the Q&A tab, located on your Zoom toolbar. We’ll answer as many questions as we can at the end of the presentation.
Welcome

Brian Hepburn
Executive Director, NASMHPD

Rebecca Farley David
Senior Advisor, National Council

To make mental wellbeing, including recovery from substance use challenges, a reality for everyone.
Today’s Presenters

Rachelle Glavin
VP Clinical Operations, Missouri Behavioral Healthcare Council

Valerie Huhn
Director, Missouri Department of Mental Health

Brent McGinty
CEO/President, Missouri Behavioral Healthcare Council

Joe Parks
Medical Director, National Council
What is a Certified Community Behavioral Health Clinic?

A CCBHC meets defined criteria for comprehensive service delivery and receives enhanced funding to support the costs of expanding access to care.

CCBHC Criteria
- Organizational Authority
- Staffing
- Access to Care
- Scope of Services
- Care Coordination
- Quality Reporting

CCBHC Payment
- Cost-related Medicaid reimbursement rate (demonstration/SPA participants)
- Grant funds: $2 million/year for 2 years (expansion grantees)

For more: https://www.thenationalcouncil.org/program/ccbhc-success-center/ccbhc-overview/
Status of Participation in the CCBHC Model

States where clinics have received expansion grants
States selected for the CCBHC demonstration
Current (or working toward) independent statewide implementation
No CCBHCs

There are 500+ CCBHCs in the U.S., across 46 states, plus Washington, D.C. and Puerto Rico

To make mental wellbeing, including recovery from substance use challenges, a reality for everyone.
# SAMHSA CCBHC Expansion Grants vs. Medicaid CCBHC Demonstration

<table>
<thead>
<tr>
<th>Medicaid CCBHC Demonstration</th>
<th>SAMHSA CCBHC Expansion Grants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open to 10 additional states every 2 years</td>
<td>Open to individual clinics in ALL states</td>
</tr>
<tr>
<td>Administered by state Medicaid and Behavioral Health authorities within guidelines set by SAMHSA/CMS</td>
<td>Administered by SAMHSA</td>
</tr>
<tr>
<td>States determine certification criteria using SAMHSA guidance as a baseline</td>
<td>Grantees must meet SAMHSA baseline CCBHC certification criteria</td>
</tr>
<tr>
<td>CCBHCs are certified by their states</td>
<td>CCBHCs are funded by SAMHSA; do not receive state certification</td>
</tr>
<tr>
<td>CCBHCs receive special Medicaid payment methodology (known as PPS)</td>
<td>CCBHCs receive up to $4M; continue to bill Medicaid and other payers per usual</td>
</tr>
<tr>
<td>Quality reporting includes 9 clinic-led and 12 state-led measures</td>
<td>Clinics report on clinic-led measures from the CCBHC demonstration</td>
</tr>
</tbody>
</table>
Opportunities for enhancing data systems through the CCBHC model

For states that are not currently in the CCBHC demonstration:
- Demonstration expansion allows 10 more states to join every 2 years, beginning in July 2024
- Interested states apply for planning grants and conduct a planning process
- SAMHSA Notice of Funding Opportunity (NOFO) expected this month (Oct. 2022)
- In 2016, planning grant funds could be used to “develop or enhance data collection and reporting capacity” – details of the 2022 NOFO are TBA
- Other ongoing expenditures can be built into CCBHCs’ cost reports/rates

For current demonstration states:
- Planning grant funding is not available, but states can implement enhanced data processes/platforms at any point
- For activities that require use of new platforms or staff, clinics can incorporate expenses in their cost report during the next rate rebase
CCBHC presents an opportunity to reimagine service delivery

• Engaging in a wide range of services adapted to clients’ and communities’ needs

• Coordinating and engaging with partners in innovative ways
  • New partnerships for care delivery, including services and outreach delivered in new settings (e.g., schools, hospitals)
  • Electronic communication among partners

• Moving beyond care coordination to care management and population health
  • Understanding service utilization across health and social service systems
  • Risk stratification, registries, decision support tools
  • Addressing social determinants of health

• Tracking standardized measures within & across states; supporting clinical performance improvement; enabling evaluation of program outcomes
Data and connectivity are the foundation for these efforts

- **For CCBHCs:** Real-time data can be used for care coordination, risk-stratified approaches to population health management, continuous quality improvement efforts, and demonstrating value to third-party payers when entering into value-based payment arrangements.

- **For States:** Data can be used for assessing CCBHCs’ impact, monitoring quality, and ensuring accountability (all critical for building buy-in across state agencies and legislatures).
Uses of Shared Data to Support State Operations

- Collecting and reporting CCBHC required performance measures
- Monitoring compliance with CCBHC certification requirements
- Systemwide care coordination
- Managing transitions of care
- Supporting 988 crisis systems
- Cross provider benchmarking to improve performance
- Rapid response to governor and legislator inquiries
- Service system planning
Financing to Align Interests

• Budget for the shared data capacity you need – software, training, staff
• Divide budget needed by your estimated # of PPS payments annually = shared data PPS add-on $
• Add CCBHC certification or contract requirement to participate in a statewide population management data system for accountability and quality improvement
• Each CCBHC must pay the shared data PPS add-on $ to the entity selected by the state to host and operate the state-wide population management data system.
• Options for the managing entity:
  • State CMHC Association
  • State University
  • Other?
Missouri CCBHC Case Study

Building a data-driven culture in a world of CCBHCs and value-based care
Certified Community Behavioral Health Clinics (CCBHCs)

- **Excellence in Mental Health Act** created a federal demonstration for CCBHCs

- Bipartisan legislation from U.S. Senators Debbie Stabenow (D-MI) and Roy Blunt (R-MO) in 2014

> The time has come for a **bold new approach.**
> —President John F Kennedy

> Nothing will be more innovative than treating behavioral health like all other health.
> —Senator Roy Blunt
Furthermore, several key themes emerged from this study that are priority issues for state chief administrators and their staff, including data governance, leading culture change, creating an agile workforce, and developing sustainable funding models for new initiatives.
CCBH

Collaboration, Implementation & Development

» CCBHC Leadership Team DMH, DSS, MBHC, CCBHC providers

» DMH & MBHC Liaison Meeting DMH, MBHC, all providers

» Practice Coaching Missouri provider/state experts

» CCBHC Learning Collaborative DMH, MBHC, CCBHC providers

» Quality Improvement Collaborative
### Missouri CCBHC Growth

<table>
<thead>
<tr>
<th>State</th>
<th>Population (in millions)</th>
<th>CCBHC Organizations</th>
<th>CCBHC Service Locations</th>
<th>Year 1 Total to receive CCBHC services (all pay source)</th>
<th>Year 1 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>
</tr>
<tr>
<td>MISSOURI</td>
<td>6.09</td>
<td>15</td>
<td>201</td>
<td>127,083</td>
<td>87,284</td>
</tr>
<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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<tr>
<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>
</tr>
<tr>
<td>OREGON</td>
<td>4.09</td>
<td>12</td>
<td>21</td>
<td>61,700</td>
<td>50,000</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>12.80</td>
<td>7</td>
<td>7</td>
<td>27,800</td>
<td>17,800</td>
</tr>
<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>
</tr>
</tbody>
</table>

Missouri CCBHC Service Area Map
## CCBHC Outcome Measures & Value-Based Payments

<table>
<thead>
<tr>
<th><strong>Clinic-Led Measures</strong></th>
<th><strong>State-Led Measures</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to Initial Evaluation</td>
<td>Housing Status</td>
</tr>
<tr>
<td>Adult BMI Screening/Follow Up</td>
<td>Patient Experience of Care Survey (adult)</td>
</tr>
<tr>
<td>Youth Weight Assessment/ Counseling</td>
<td>Youth/Family Experience of Care Survey</td>
</tr>
<tr>
<td>Tobacco Use Screening/Cessation</td>
<td>Follow-up after ED visit for MI</td>
</tr>
<tr>
<td>Alcohol Use Screening/Counseling</td>
<td>Follow-up after ED visit for AOD</td>
</tr>
<tr>
<td><strong>Youth MDD: Suicide Risk Assessment</strong></td>
<td><strong>MI Hospitalization Follow-up (adult)</strong> $</td>
</tr>
<tr>
<td><strong>Adult MDD: Suicide Risk Assessment</strong> $</td>
<td><strong>MI Hospitalization Follow-up (youth)</strong> $</td>
</tr>
<tr>
<td>Screening for Depression/Follow Up</td>
<td>All Cause Readmission Rate</td>
</tr>
<tr>
<td>Depression Remission at 12 months</td>
<td>Diabetes Screening</td>
</tr>
</tbody>
</table>

$ = VBP measures

CCBHCs must meet all 9 measure goals, statewide benchmark, and/or show improvement over previous FY

- Adherence to Antipsychotic Medication $
- Follow-up for Children ADHD Medication
- Antidepressant Medication Management
- **Initiation/Engagement of AOD Treatment** $
Missouri's Impact Report | Year 5

Improving Outcomes & Access to Care

35%
Increase in patient access to care
Overall increase in patients served from baseline (2017) to Year 5 (2022)

3,185
Veterans & active military served by CCBHCs
Overall increase in veterans and active military served from baseline to Year 5

Reducing Hospital & ED Utilization
CCBHCs have shown a reduction in the number of ED and hospital encounters (per 1,000 member months)

16%
Decrease in ED visits from baseline (2016) to 2021

27%
Decrease in hospitalizations from baseline (2016) to 2021
Certified Community Behavioral Health Clinics > Missouri’s Impact Report | Year 5

Workforce Recruitment

CCBHs have seen growth in their care team positions from baseline (2017) to Year 4 (2021).

Cost Savings

- CCBHC pre and post period hospital costs
  - Pre: $110,031,013.58
  - Post: $94,604,792.00
- Costs per person pre and post
  - Pre: $3,449.90
  - Post: $2,966.23

Decrease from pre to post period hospital costs totaling $15.4 million in savings.

$483.67 savings per person

This report was prepared by the Missouri Behavioral Health Council using data reported by the Missouri Department of Mental Health and CCBHCs as of August 2022. Jefferson City, Missouri | www.mobhc.org
The Data Journey
Evaluation of the workflow to gather information. Conclusion: It’s a hot mess – we need a one stop shop.

How can we eliminate the silos and integrate our data?

“Case Managers spend roughly 40% of their time searching for patient data”

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.
Please! No more spreadsheets.

» Has the spreadsheet been sorted by caseload?
» Is this spreadsheet the latest version? When was it last updated?
» You want me to log into another system?
» Check your email.
One Stop Shop

Aggregate and display meaningful data in one system for behavioral health providers to inform their day (claims data, hospital and ER notifications, clinical data, assessment scores, demographics)

› Access to data in near real-time (daily)
› Eliminate double entry of clinical data - interoperability with EHRs
› Custom reporting from the aggregate data set at the state and provider level
› Automated risk stratification methodology
› Display data in a meaningful way to enable population health in team workflows
CareManager & Population Health

CareManager was selected as Missouri’s new health technology tool for behavioral health providers to use in care management and population health.

- **34 providers**
- **900+ end users**
- **275,000 lives managed**

CareManager combines Medicaid claims data + DMH client detail + hospital and ER notification + clinical data from providers to:

- **alert** the care team of ER and hospital events
- **assess** populations for risk
- **monitor** health outcomes
- **manage** interventions to address gaps in care
Missouri’s Health Information

- Metabolic screening
- Status Reports
- Demographics
- SDoH
- Hospital follow up
- Functional assessment
- PHQ-9
- Suicide risk assessment

Data Integration

- Patient census
- Program assignment
- Demographics
- Medicaid claims
- Medicaid eligibility
- Hospital and ER notifications

CareManager

CareManager equips the Care Team on the ground to make informed, data-driven decisions with access to real-time, comprehensive health information.

Measures Reporting

Measures Reporting is integrated within CareManager and allows providers and the state to develop and standardize measures across the system for population health management.
Health Risk Profile

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

Risk Summary

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metabolic Screening</td>
<td>6.5</td>
</tr>
<tr>
<td>Physical Health Diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>Medication Use</td>
<td>2.2</td>
</tr>
<tr>
<td>ER &amp; Hospitalizations</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL RISK SCORE</strong></td>
<td>MODERATE-HIGH RISK</td>
</tr>
</tbody>
</table>

Primary Care Health Home - enrolled 1/3/2017

BCBS KC - enrolled 01/03/2017

Metabolic Screening
- Adult BMI 18.5 - 24.9 (Healthy Weight)
- BP > 140/<90 mmHg (High)
- No A1c or Blood Glucose, Unable to Calculate, or Opt Out in last 12 months
- No LDL, Unable to Calculate, or Opt Out in last 12 months
- HDL > 60 mg/dL (Normal)
- Triglycerides 150 ? 199 mg/dL (Borderline)
- No Total Cholesterol, Unable to Calculate, or Opt Out in last 12 months
- Tobacco Use

Housing, Employment Status

PHQ-9, Suicide Risk

Functional Assessment Scores

Client Profile
- Demographics
- Program Enrollment
- Health Plan

Risk Factors
- Metabolic Screening Profile
- Diagnosis:
  - Physical, Behavioral, Substance Use, Developmental Disability, Other Chronic Conditions
- Medication Use
- ER & Hospitalizations
- PHQ-9, Suicide Risk
- Functional Assessment Scores

Physical Health Diagnosis
- Thyroid Disorders (Thyroid, Acquired Hypo; Thyroid, Goiter, Nodular; Thyroid Disorder, Other)
- Blood Disorders (Anemia, NOS; Anemia, Other Deficiency; Anemia, Hemolytic, Hereditary; Sickle-cell Disease)
- Other Physical Health Diagnosis - Not Cancer

Medication Use
- Taking Aripiprazole (Abilify), Ziprasidone (Geodon), or first-generation antipsychotics

ER & Hospitalizations
- 1-2 ER Visits in last 6 months
- No Hospitalizations in last 6 months

**TOTAL RISK SCORE**
- Low Risk < 7.5
- Moderate Risk 7.5 – 11.5
- Mod-High Risk 11.6 – 15
- High Risk > 15
## Dashboard

### Alerts

- **ER Visits**
- **Hospitalizations**
- **Medicaid Eligibility**
- **Metabolic Screening Completion**

### Client List

<table>
<thead>
<tr>
<th>Name</th>
<th>Risk</th>
<th>DOB</th>
<th>Client ID</th>
<th>Chart</th>
<th>Chart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parsons, Jenny</td>
<td></td>
<td>10/24/1978</td>
<td>4501354</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Russell, Marcus</td>
<td></td>
<td>08/04/1959</td>
<td>3785772</td>
<td></td>
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</table>
## Claims

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Billing Provider</th>
<th>Rendering Provider</th>
<th>Place of Service</th>
<th>Claim Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/24/2017</td>
<td>MERCY CLINIC SPRINGFIELD COMMUNITIES</td>
<td></td>
<td>Urgent Care Facility</td>
<td>5555512021195</td>
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<tr>
<td>OFFICE/OUTPATIENT VISIT NEW</td>
<td>99203</td>
<td>07/24/2017</td>
<td>1</td>
<td></td>
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<tr>
<td>CHEST X-RAY 2WV FRONTAL and LATL</td>
<td>71020</td>
<td>07/19/2017</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ELECTROCARDIOGRAM COMPLETE</td>
<td>93000</td>
<td>06/28/2017</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Iron binding test</td>
<td>83550</td>
<td>06/25/2017</td>
<td>1</td>
<td></td>
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<tr>
<td>ASSAY OF FERRITIN</td>
<td>82278</td>
<td>06/26/2017</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>ASSAY OF NATRIURETIC PEPTIDE</td>
<td>83880</td>
<td>06/26/2017</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
## Population Health

### Common Selectors
- Populations
- Agency

### Payor Selectors
- Payer Name
- Medicaid/Medicare

### Reporting Period
- Reporting Period

### Executive Summary

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>Percentage</th>
<th>Results</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>MoCo 0036</td>
<td>Asthma Medication Adherence (Adult)</td>
<td>0%</td>
<td>0</td>
<td>115</td>
</tr>
<tr>
<td>MoCo 0059</td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>65%</td>
<td>2248</td>
<td>3458</td>
</tr>
<tr>
<td>MoCo 0059</td>
<td>Hemoglobin HbA1c Control for Diabetes (Adult)</td>
<td>59%</td>
<td>2031</td>
<td>3458</td>
</tr>
</tbody>
</table>

**Goal:**
- Asthma Medication Adherence (Adult): Goal 70%
- Blood Pressure Control for Diabetes (Adult): Goal 85%
- Hemoglobin HbA1c Control for Diabetes (Adult): Goal 65%
## Hemoglobin HbA1c Control for Diabetes (Adult) Measure Details

**Description**: 
% of patients 18-75 years of age with a diagnosis of diabetes (type 1 or type 2) who had an HbA1c < 8.0%

**Persons Flagged**: 
- Persons flagged have a documented HbA1c >= 8.0% OR have no HbA1c result reported in the previous 12 months

**Eligible Population**: 
Persons identified as having diabetes during the current or prior year through pharmacy data OR two face to face encounters in an outpatient or non-acute inpatient setting with a diagnosis of diabetes or one face to face encounter in an acute inpatient or ED setting during the current or prior year with a diagnosis of diabetes. Metformin is excluded from pharmacy data since it is used for numerous other conditions.

### Managed - (62)
- Client DCN ID
- Client DMH ID
- Last Name
- First Name
- Gender
- Age
- County of Residence
- Nurse Care Manager

### Intervention - (48)
- Lab Date
- A1c Result

<table>
<thead>
<tr>
<th>Lab Date</th>
<th>A1c Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018-09-12</td>
<td>8.7</td>
</tr>
<tr>
<td>2018-11-09</td>
<td>8.3</td>
</tr>
<tr>
<td>2018-04-05</td>
<td>10</td>
</tr>
<tr>
<td>2018-07-05</td>
<td>10</td>
</tr>
<tr>
<td>2018-12-28</td>
<td>11.6</td>
</tr>
<tr>
<td>2018-10-09</td>
<td>10.5</td>
</tr>
</tbody>
</table>
## Population Health

![Dashboard](image.png)

**Common Selectors**
- Populations
- Agency

**Payer Selectors**
- Payer Name
- Medicaid/Medicare

**Reporting Period**

**Measures**

### Missour Healthcare Measures - Adult

<table>
<thead>
<tr>
<th>Agency</th>
<th>Measure</th>
<th>Population</th>
<th>Managed</th>
<th>flagged</th>
<th>% Managed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapt of Missouri</td>
<td>Asthma Medication Adherence (Adult)</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>3.0%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>76</td>
<td>47</td>
<td>29</td>
<td>61.0%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Hypertension (Adult)</td>
<td>114</td>
<td>86</td>
<td>45</td>
<td>75.2%</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index Control (Adult)</td>
<td>168</td>
<td>61</td>
<td>107</td>
<td>36.3%</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c Control for Diabetes (Adult)</td>
<td>77</td>
<td>40</td>
<td>27</td>
<td>54.5%</td>
</tr>
<tr>
<td></td>
<td>LDL Control for Diabetes (Adult)</td>
<td>56</td>
<td>14</td>
<td>42</td>
<td>25.0%</td>
</tr>
<tr>
<td></td>
<td>Metabolic Screening Complete (Adult)</td>
<td>488</td>
<td>581</td>
<td>48</td>
<td>85.7%</td>
</tr>
<tr>
<td></td>
<td>Tobacco Use Control (Adult)</td>
<td>408</td>
<td>190</td>
<td>248</td>
<td>48.2%</td>
</tr>
<tr>
<td></td>
<td>Asthma Medication Adherence (Adult)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>55</td>
<td>21</td>
<td>20</td>
<td>74.5%</td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Hypertension (Adult)</td>
<td>76</td>
<td>30</td>
<td>20</td>
<td>73.2%</td>
</tr>
<tr>
<td></td>
<td>Body Mass Index Control (Adult)</td>
<td>200</td>
<td>37</td>
<td>12</td>
<td>13.0%</td>
</tr>
<tr>
<td></td>
<td>Hemoglobin A1c Control for Diabetes (Adult)</td>
<td>55</td>
<td>36</td>
<td>10</td>
<td>65.5%</td>
</tr>
</tbody>
</table>

*Export Data*
The new and improved workflow with integrated data that is near real-time and actionable.

Front Line Operations
Care Management/Coordination View

Quality Measures and Reporting
Population Health Data View

State Outcomes
Analytics and Compliance View

» Daily alerts of hospital and ER encounters
» Access to claims data + Medicaid eligibility
» Assess populations for risk
» Monitor health outcomes
» Manage interventions to address gaps in care
» DIY Reports
» State Reporting Requirements
Building a Data-Driven Culture
to thrive in a Value-Based World

- **CareManager**
  - Provider
  - Care Management
  - Risk Stratification
  - Custom Reporting

- **Population Health**
  - Provider, State, Association, Payors
  - Measures
  - Outcomes

- **Data Warehouse**
  - Provider Admin, State, Association, Payors
  - Evaluations
  - Advocacy
  - Social Factors of Health
Missouri’s Health Information

CareManager
Driving quality care in the field.

Measures Reporting
Measuring quality real-time.

CareManager combines Medicaid claims data + DMH client detail + hospital and ER notifications + clinical data from providers to:

- Alert the Care Team of ER and hospital events
- Assess populations for risk
- Monitor health outcomes
- Identify gaps in care

Intervention needed
Managed
Population

Populations can be further stratified by:

- Medicaid Coverage or MCO
- Program Enrollment
- CCBHO-specific or State Totals
- Team Role or Staff Name

Data Integration

34 organizations

Dept of Mental Health

MBHC CLIVE
Data Warehouse

IPAO / Payor Access
Primary Care / Community Health Centers
State Reporting
HIE / CareQuality
purpose

quality

efficiency

advocacy

data-driven
decisions

value-based
care &
payments

innovate &
address
healthcare
gaps

CLIVE data
warehouse
building a data-driven culture for value-based care
Data Elements

- Client
- Diagnosis
- Social Factors
- Allergies
- Labs
- Med Orders
- Vitals
- Services
- Programs
- Locations
- Providers
- Episodes
- Hospitalizations
- Assessments
- CCBHC State Reporting Requirements
- HCH State Reporting Requirements
- CBHL State Reporting Requirements
- ERE State Reporting Requirements
- DM State Reporting Requirements
- Block Grant Reporting Requirements
- Team Assignments

just to start
Dashboard Snapshot

Overview

Client Counts by Organization

- Preferred Family Healthcare
- Compass Health
- Burrell Behavioral Health
- Southeast Missouri Behavioral Health
- Heartland Center for Behavioral Change
- BJC Behavioral Health
- ReDiscover
- FCC Behavioral Health

Distinct Client Count: 287,295

Number of Vitals Readings: 349,001

Number of Encounters: 34,790,899

Number of Hallmark Events: 548,023

Number of Plans: 998,456

Number of Labs: 1,446,276

Number of Med orders: 19,459,806
START WHERE YOU ARE.
USE WHAT YOU HAVE.
DO WHAT YOU CAN.

- Arthur Ashe
Questions & discussion

Brian Hepburn, NASMHPD
brian.hepburn@nasmhpd.org

Rebecca Farley David, National Council
rebeccad@thenationalcouncil.org

Joe Parks, National Council
joep@thenationalcouncil.org

Valerie Huhn, MO Dept of Mental Health
Valerie.Huhn@dmh.mo.gov

Rachelle Glavin, MO Behavioral Healthcare Council
rglavin@mobhc.org

Brent McGinty, MO Behavioral Healthcare Council
bmcginty@mobhc.org