Technology Use in Maryland's Community Behavioral Health Sector

Environmental Scan and Needs Assessment | June 2017

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Executive Summary

Effective deployment of technology will play a growing role in health care. To help its members achieve economies of scale, simplify our collective learning curve, and improve performance in the community behavioral health sector, the Community Behavioral Health Association of Maryland seeks to play a more proactive role with members.

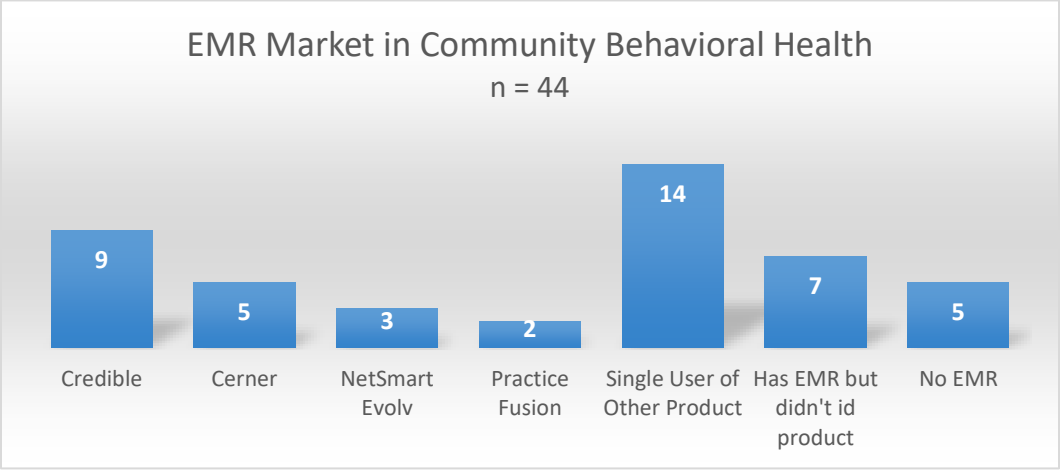
This document briefly summarizes existing health care technology systems in Maryland and the extent to which CBH members are using them. Information on CBH members has been gathered in onsite interviews with 37 members, as well as two online surveys:

- EMRs products and meaningful use: 38 organizations (November 2016);
- MACRA Needs Assessment: 10 organizations (March 2017).

This has provided a total universe of 44 organizations interviewed, although information is often incomplete.

Use of Electronic Medical Records

CBH has gathered a variety of information about the electronic medical records (EMRs) used by its members. Over 88% of CBH members use an EMR.



There is no market consolidation. Forty-four respondents use 20 different EMR vendors, including two who have built in-house electronic records. Fourteen members – over a third of respondents – use an EMR not used by any other member. A full list of vendors is included in Appendix A.

Another nine members use Credible, which appears to have growing momentum in market consolidation; all three members selecting new EMRs this year chose Credible. Meanwhile, Cerner/Anasazi is used by five members, and NetSmart's Evolv is used by the three Shepherd Pratt affiliates. Seven members indicated that they use an EMR but did not identify their products.

ONC Certification

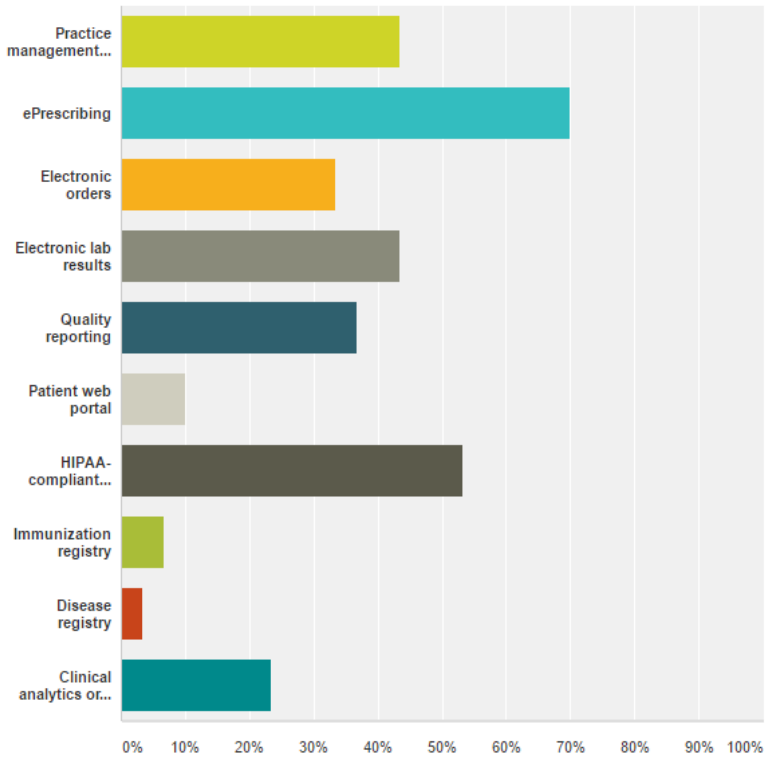
Survey respondents didn't identify their vendors or software products in sufficient detail to determine the extent to which members were using ONC-certified products. When we checked the federal list for certified health IT products,[1] it appears that the products being used by members are largely produced by vendors with certified products available.

However, at least one member reports using a Cerner product that is not ONC-certified, and others have noted the prohibitive cost of updates. The two members using their own, internally-designed EMRs and the seven members who failed to identify their vendor make up 20% of our respondents. Additional work should be done to identify these products so CBH has a clearer picture on the extent of ONC certification among its members.

> *"Our biggest challenge is the cost of upgrades to our EHR. Also a concern is whether upgrades will support interoperability if other providers do not have systems that can exchange data with ours."*

MACRA's Meaningful Use and Performance Measures

Our November 2016 survey asked members to identify the extent to which certain meaningful use criteria were in daily use in their practices.



Only two meaningful use practices – HIPAA-compliant secure document exchange and e-prescribing – were used daily by more than half of our respondents.

A follow-up survey in March 2017 with more detailed questions about MACRA had a low response rate, with only 10 respondents. While the low response rate makes it difficult to interpret, it appears that CBH members have largely not yet focused on the quality reporting elements of MACRA. MACRA's quality and cost measures were generally ranked as higher concerns that its advancing care information or improvement activities.

[1] Available at https://chpl.healthit.gov/#/search.

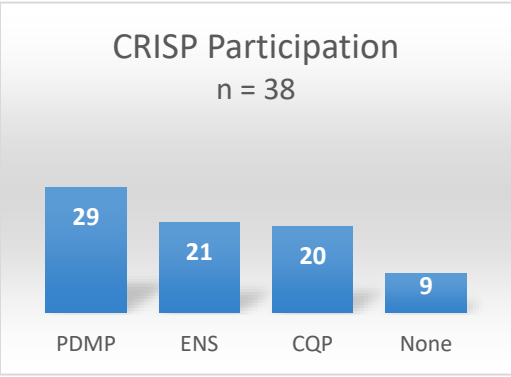
Eight organizations participating in the MACRA needs assessment identified a diversity of behavioral health measures currently being tracked:

Answer Choices	Responses
Adherence to Antipsychotic Medications For Individuals with Schizophrenia	25.00% 2
Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	50.00% 4
Anti-Depressant Medication Management	12.50% 1
Patients with Advance Care Plan	50.00% 4
Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	25.00% 2
Closing the Referral Loop: Receipt of Specialist Report	0.00% 0
Depression Remission at Six Months	0.00% 0
Depression Remission at Twelve Months	0.00% 0
Depression Utilization of the PHQ-9 Tool	25.00% 2
Documentation of Current Medications in the Medical Record	25.00% 2
Follow-Up After Hospitalization for Mental Illness (FUH)	25.00% 2
Elder Maltreatment Screen and Follow-Up Plan	50.00% 4
Please specify. Responses	50.00% 4

Participation with CRISP

The Chesapeake Regional Information System (CRISP) is a regional health information exchange (HIE) serving Maryland and the District of Columbia. CRISP has been formally designated as Maryland's statewide health information exchange by the Maryland Health Care Commission. CRISP houses several important data tools for CBH members. The overwhelming majority of CBH members are connected to CRISP, although additional work is necessary to refine participation.

The Prescription Drug Monitoring Program (PDMP) collects and securely stores information on drugs that contain controlled substances and are dispensed to patients in Maryland. Drug dispensers, including pharmacies and healthcare practitioners, electronically report the information that is stored in the PDMP database.



Access to prescription data is made available at no-cost to physicians, nurse practitioners, pharmacists and others that provide pharmaceutical care to their patients. By law, healthcare providers may only access information on patients under their care. Use of prescription information improves providers' ability to manage the benefits and risks of controlled substance medications and identify potentially harmful drug interactions.

Over 76% of CBH members participate in the PDMP for at least one location. However, not all members had all locations connected.

Of the 38 CBH members who participated in our member technology survey in November 2016, 76% were participating in the PDMP for at least one location. However, not all members had all locations connected to CRISP.

Encounter Notification Service (ENS) enables medical personnel to receive real-time alerts when a patient has a hospital encounter. Customizable by practice, the CRISP ENS will send a secure email message to providers for active patients in the practice. Practices may choose which alerts are most relevant to them, such as: hospital admission, hospital discharge, or emergency room visit. Coupled with the CRISP HIE portal, participating physicians will be able to access relevant clinical documents to better coordinate care for their patients. Providers may proactively coordinate patients' care and schedule any necessary follow-up treatment or visits; in conjunction with the CRISP Clinical Query Portal, review medical records from your patient's hospital stay; receive summary of care, chief complaint, and discharge disposition (if sent by hospital); facilitate additional Medicare reimbursements by allowing TCM (Transitional Care Management) codes to billed – i.e., seeing your patients within 7-14 days after a discharge; and provide readmission alerts. ENS notifications are delivered securely to providers via DIRECT email messaging.

CQM Aligned Population Health Reporting (CAliPHR) is a tool designed to give Eligible Providers (EPs) the ability to meet the clinical quality measurement requirements of federal and state incentive, as well as value-based programs. The tool allows providers to calculate and report clinical quality measures (CQMs), which are tools used to ensure that health care providers are delivering effective, safe, and timely care to patients. Clinical data will be transmitted from EP's EHR to CAliPHR on an ongoing basis, and securely stored for CQM calculation and reporting.

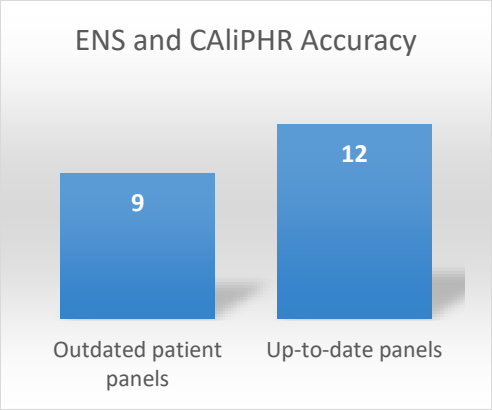
CAliPHR relies on incoming consolidated-clinical document architecture (C-CDA), or quality reporting document architecture category 1 (QRDA 1) feeds from providers that utilize the service. These feeds are generated and sent by health system's, or practice's electronic health records (EHR) and clinical information is stored in the tool's clinical data repository. The measure engine then utilizes this data to calculate various CQMs. A QRDA 3 file containing aggregated, de-identified patient data is generated for reporting purposes. EPs have access to a user portal that allows them to calculate and view their respective measure results, as well as patient level data.

Of the 21 organizations participating in ENS, 43% do not have up-to-date patient panels and are neither getting nor providing accurate data.

Participating in a CAliPHR pilot program offers several benefits to providers, including:

- CQMs give a snapshot of a provider's performance during a patient visit. This information is useful for making the necessary adjustments to improve the quality of care.
- Practices and providers will be able to report their CQMs for the Medicaid EHR program electronically.
- The cost of implementing the interface between a Medicaid practice and CRISP may be subsidized by grant funding.

- Providers can auto-subscribe to the Encounter Notification Service (ENS) in lieu of creating monthly patient panels manually.



Among CBH members connected to the PDMP, a subset of 21 organizations had signed up with the Encounter Notification Service (ENS) for at least one location. All but one of these had also signed up for the CAliPHR quality measurement tool. This means a slight majority of CBH members are taking advantage of these CRISP tools.

However, of the 21 organizations participating in ENS and CAliPHR to some degree, 43% are not maintaining accurate patient panels. This means that neither their ENS alerts nor their CAliPHR quality measures are accurate.

Clinical Analytics and Population Health Management

eMedicaid for Health Homes is an online portal that providers use to enroll participants and to report diagnoses, outcomes, and services delivered. Psychiatric Rehabilitation Programs (PRP) and Mobile Treatment (MT) providers will act as Health Homes for those with serious mental illness and serious emotional disturbance, while Opioid Treatment Programs (OTPs) will serve those with opioid substance use disorders. The reporting options vary depending on which provider type is using the system.

Providers use eMedicaid to add patients to their health home list, determine eligibility for health home services, and assign patients to a care manager and other team members. Data input into eMedicaid occurs manually. Providers must enter:

- Diagnostics;
- Height and weight (to calculate BMI); and
- Blood pressure.

CBH members express frustration and concern with e-Medicaid. It requires manual entry, which extends human error and administrative burden upon providers.

Pro-Act Analytics is a clinical analytics tools used by fourteen CBH members with health homes. CMT's ProAct Analytics provides abstraction, aggregation, analysis and interpretation of data, both prospectively and retrospectively, to aid clinical and financial risk analysis and management of a population. CMT integrates large volumes of disparate data (primarily behavioral pharmacy and services data, but including medical services and pharmacy data) and analyzes this convergence of information for the eligible population in respect to proportional financial risk, including adherence markers, gaps in care, substandard or inappropriate care, medical-behavioral co-morbid conditions that are associated with elevated cost burden, and chemical dependency or underlying addiction or substance dependency concerns that may be undermining overall health care and increasing costs.

ProAct provides secure, 24/7 access to prescriber and patient healthcare analytics by providing data on best practice for psychopharmacologic application relative to psychotropic and pain medicines called CMT's Quality Indicators™ (QIs) and Disease Management flags relative to gaps in care for chronic disease states most frequently associated with those suffering from mental illness. All data and data analytics are displayed for each patient in an Integrated Health Profile (IHP) for holistic health management. This data is used by care managers and care coordinators, provider relations departments, quality improvement staff and clinical and financial administrators to understand the patient/population needs and to direct intervention activity to obtain desired outcomes.

Performance Measures

Health care payers are moving toward value-based purchasing, in which a provider's performance on defined measures will determine their level of payment. Despite all the changes happening in health care, ***value-based payment is here to stay***, and CBH is undertaking efforts to help its members prepare.

To that end, CBH convened its members in March 2017 to review behavioral health performance measures in Medicare, as well as those contemplated in the duals ACO model and by the HSCRC's all-payer waiver. Appendix B crosswalks performance measures for behavioral health programs, including existing MACRA measures and those under development by BHA and for the Medicaid managed care program. The crosswalk is sourced from:

- In Medicare, providers' performance on measures this year will define their level of payment in 2019.[2]
- In 2019, Maryland is slated to roll out an Accountable Care Organization model for dual eligibles in four, high-density areas of the state, with broader roll-out possible in later years.[3] In low-density areas of the state, CRISP's CAliPHR tool will be used to measure provider performance.
- Maryland defined its performance expectations for Medicaid health plans, including behavioral health measures,[4] and
- the Behavioral Health Administration is in the process of creating a performance measure for providers by measuring the change in patients' DLA-20 functional assessment scores over time.

This creates a universe of 33 behavioral health performance measures upon which current or future payers may base their level of payment to community behavioral health providers.

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[2] Medicare performance measures can be found at https://qpp.cms.gov/measures/quality (accessed Mar. 22, 2017).

[3] Bob Atlas, EBG Advisors, "Maryland's Innovation Model for Medicare-Medicaid Dual Eligibles," at p. 18 (Mar. 22, 2017).

[4] DHMH, Medicaid Planning Administration, "New HealthChoice Evaluation Requirements 1115 Waiver Renewal," at pp. 8-18 (Mar. 27, 2017).

Appendices

Appendix A: List of EMR Vendors Used by CBH Members

EMR Vendor	Number of CBH Members	ONC Certified Products
Credible	9	Yes
Cerner	5	Yes
NetSmart Evolv	3	Yes
Practice Fusion	2	Yes
Alpha Flex	1	Yes
Angel Systems, Inc.	1	Yes
Askesis - Psych Consult	1	Yes
ClaimTrak	1	Yes
Core Solutions	1	Unclear
ECHO	1	Yes
EPIC	1	Yes
Psytech Solutions	1	Yes
Medical Master Mind	1	Yes
Patagonia	1	Yes
Streamline	1	Yes
Qualifacts CareLogic	1	Yes
Internally-Built EMR	2	No
Product Not Identified	7	Unclear

Appendix B: Performance Measures for Maryland Payers

Developed April 2017

		Performance Measures	MACRA High Priority	MACRA Lower Priority	Duals ACO	Medicaid MCOs	BHA	HSCRC - Hospital	TOTAL PAYERS
A		**Adherence & Management of Medication**							
	1	Documentation of Current Medications in the Medical Record	X		X				2
	2	Medication Reconciliation Post Discharge			X				1
	3	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	X			X		?	2-3
	4	Anti-Depressant Medication Management		X		X		?	2-3
	5	ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication		X		X			2
	TOTAL AREA WEIGHT:								**9**
B		**BH Screening and Referrals**							
	1	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	X						1
	2	Elder Maltreatment Screen and Follow-Up Plan	X						1
	3	Depression Utilization of the PHQ-9 Tool		X				?	1-2
	4	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan		X	X				2
	5	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		X	X				2
	6	Tobacco Use and Help with Quitting Among Adolescents		X					1
	7	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling		X		X			2
	8	Initiation and Engagement of SUD Treatment			X	X			2
	TOTAL AREA WEIGHT:								**12**
C		**Care Planning and Coordination**							
	1	Care Plan	X		X				2
	2	Closing the Referral Loop: Receipt of Specialist Report	X						1

	3	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	X						1
		Performance Measures	**MACRA High Priority**	**MACRA Lower Priority**	**Duals ACO**	**Medicaid MCOs**	**BHA**	**HSCRC - Hospital**	**TOTAL PAYERS**
	4	Follow-Up After Hospitalization for Mental Illness (FUH) **	X		X	X		?	3-4
	5	Timely Transmission of Transition Record			X				1
	TOTAL AREA WEIGHT:								**8**
D		**Response to Treatment**							
	1	Change in DLA-20 functional assesment score over time					X		1
	2	Depression Remission at Six Months	X					?	1-2
	3	Depression Remission at Twelve Months	X					?	1-2
	4	Drug overdose death				X			1
	5	CAHPS Health Plan - adult questionaire			X	X			2
	TOTAL AREA WEIGHT:								**6**
F		**Somatic health results**							
	1	Diabetes for SMI: HbA1c Testing			X	X		?	2-3
	2	Diabetes for SMI: Med Attn for Nephropathy			X			?	1-1
	3	Diabetes for SMI: Blood Pressure Control			X			?	1-2
	4	Diabetes for SMI: HbA1c Poor Control >9%			X			?	1-2
	5	Diabetes for SMI: HbA1c Control <8%			X			?	1-2
	6	Diabetes for SMI: Eye Exam			X	X			2
	7	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan		X	X				2
	8	HIV Viral Load			X	X			2
	9	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented		X					1
	TOTAL AREA WEIGHT:								**13**
G	**1**	**Plan All-Cause Readmission ****			X	X		X	3