BHT Learning Cohorts

March 28, 2019

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better health together

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Psychiatry & Behavioral Sciences

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Screening for Social Determinants of Health

Bruce Goldberg, MD
Anne King, MBA

Session Outline:

1. Session Goals
2. Context for Screening
3. Screening Tools & Implementation Considerations
4. Business Case for Screening
5. Patient-Centered Screening
6. Data “Systems”
7. Partnership Strategies
8. Closing Remarks

Session Goals:

- Understand the variety of screening tools in use around the country
- Explore opportunities to screen patients in a patient-centered way
- Consider the rationale for and ways to develop a screening strategy, partnerships and workflows for your organizations and populations

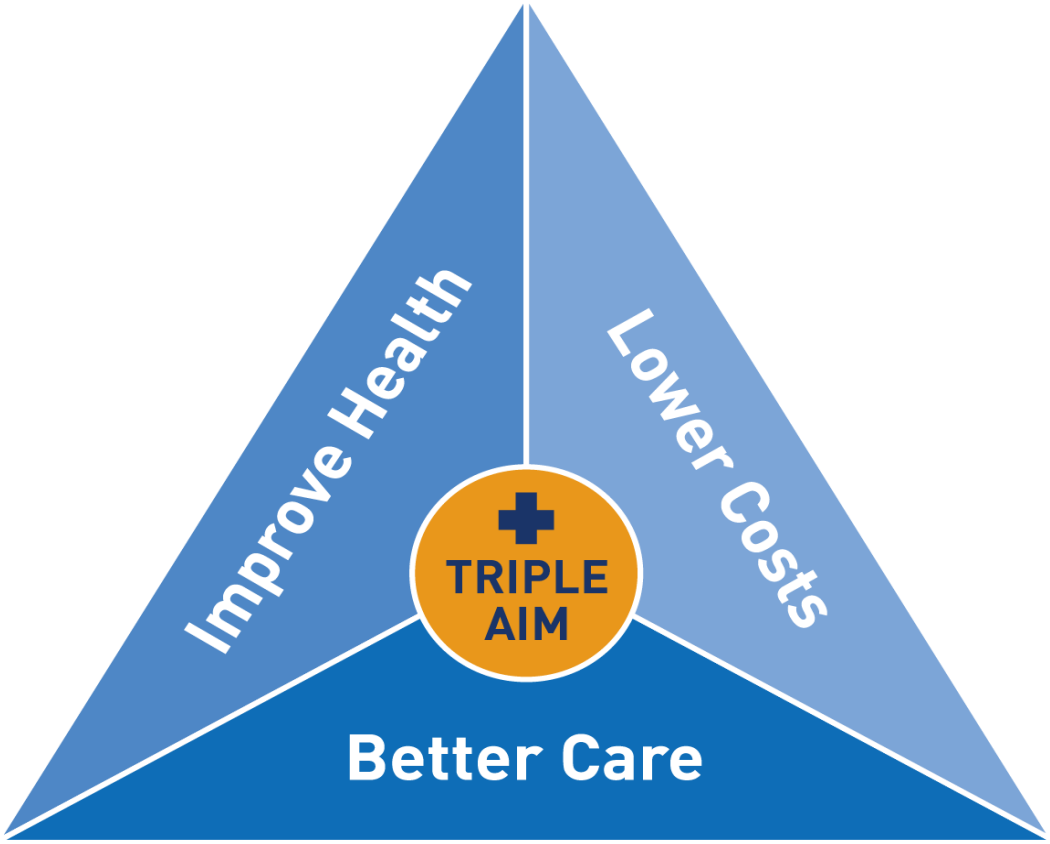
CONTEXT FOR SCREENING

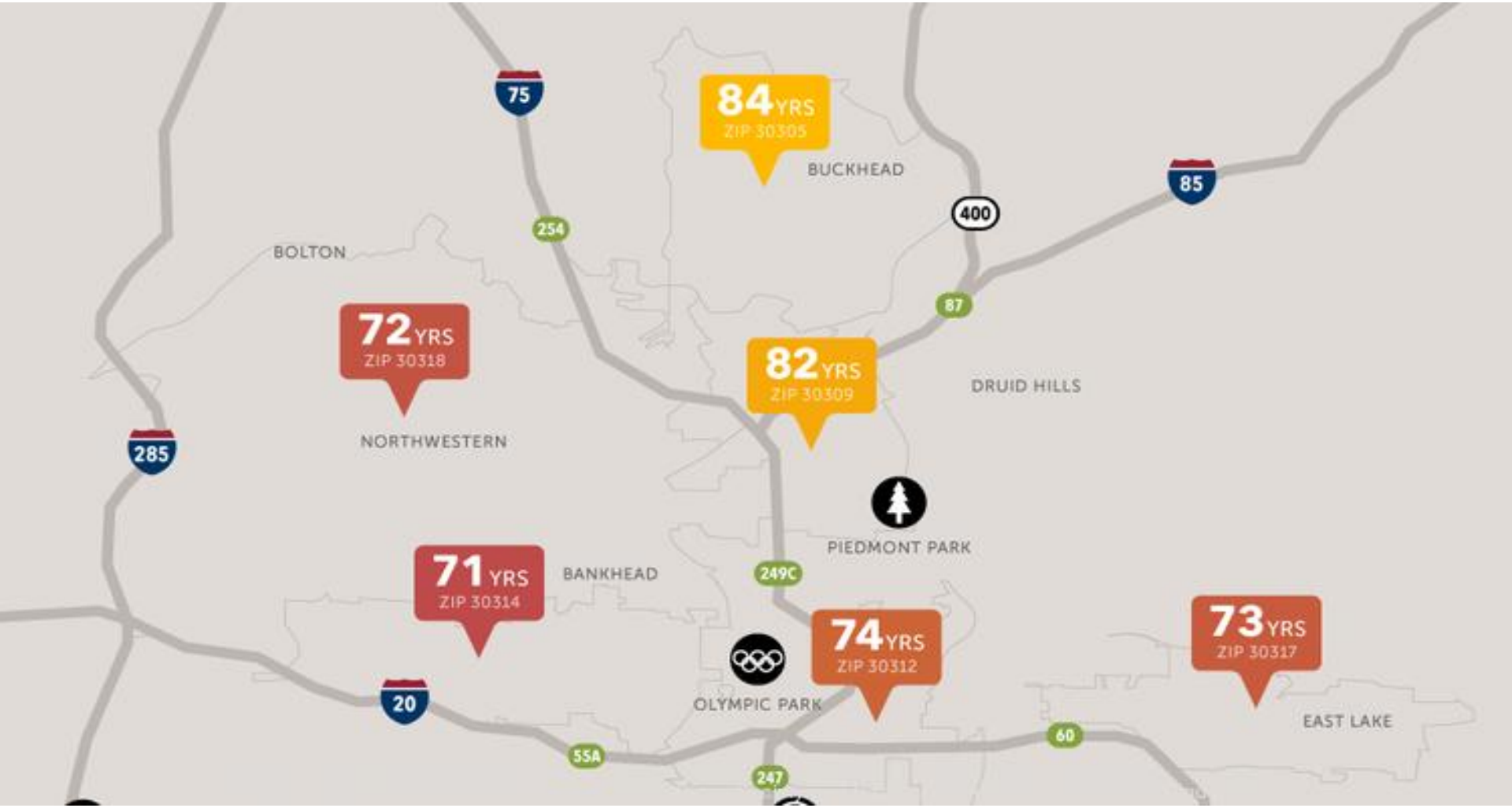
What are Social Determinants of Health?

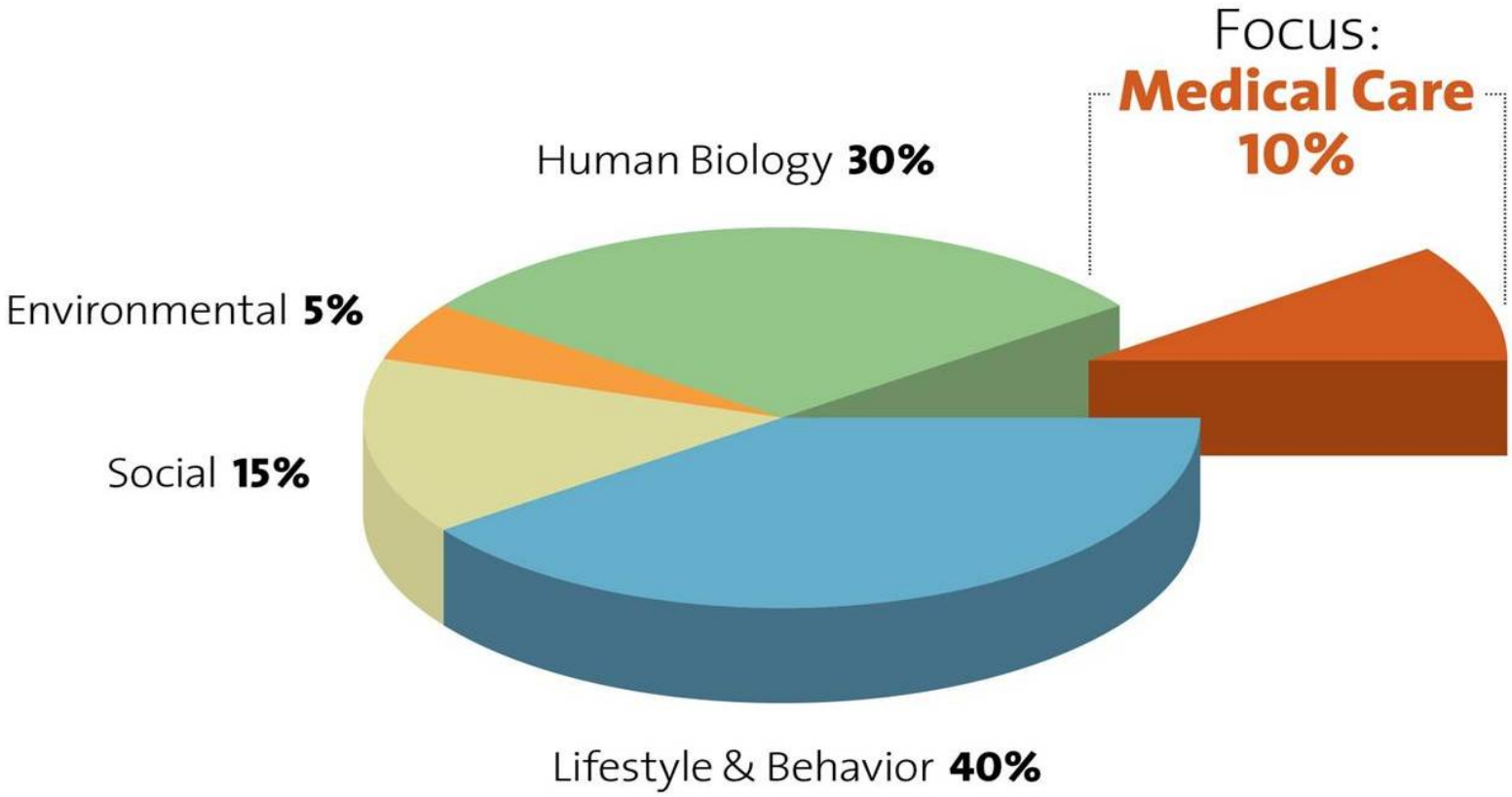
- “…the economic and social conditions that influence ... health" (Commission on Social Determinants of Health, 2008).

NATIONAL CONTEXT

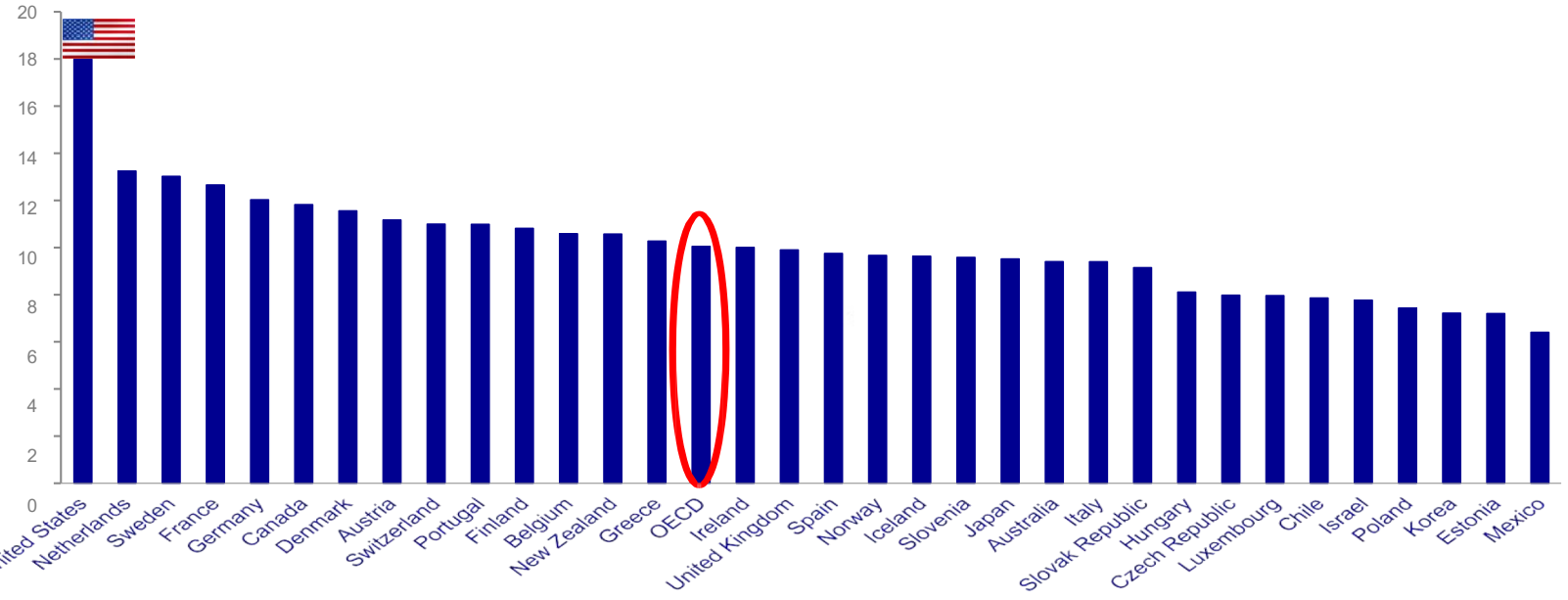
- Health care costs growing faster than other economic indicators
- Outcomes are varied and inconsistent
- National health reform efforts – SIM, Medicare, PCMH, CPC+
- A plethora of state health reform efforts
- Growing evidence of importance of social investments, care coordination, primary care





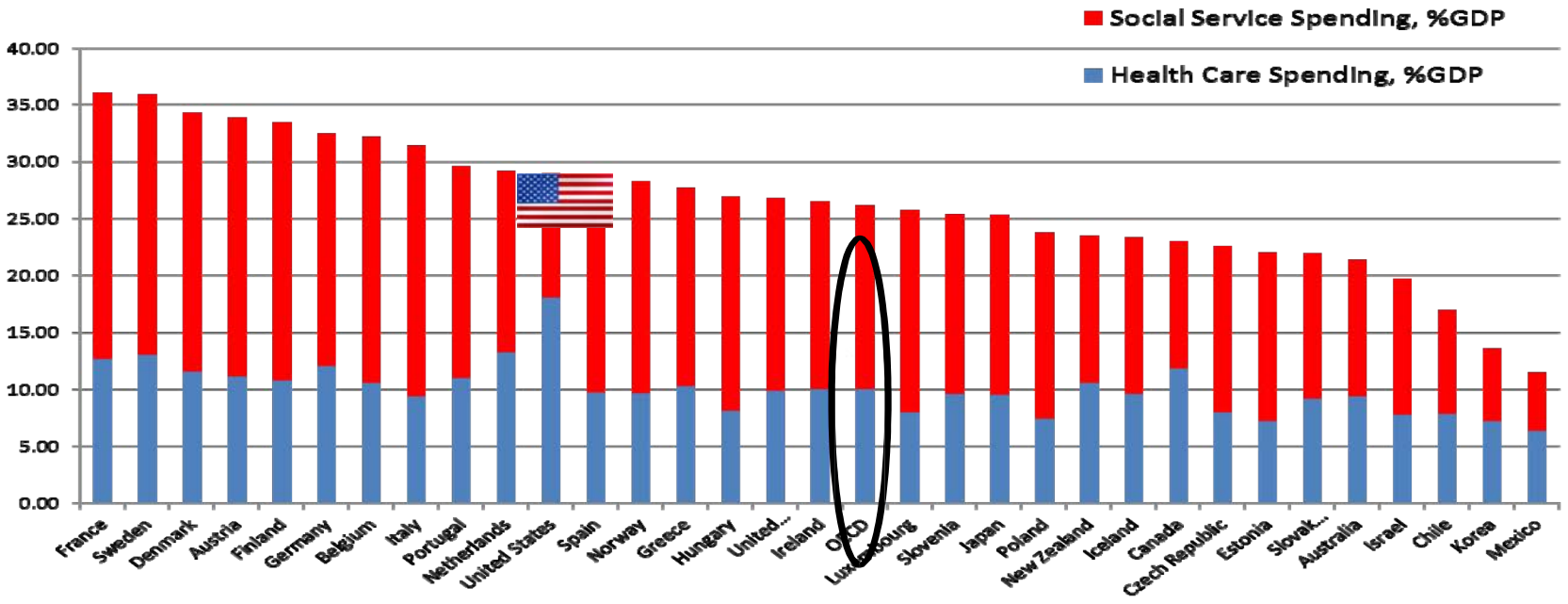


Health Expenditures as % of GDP, 2009



Elizabeth Bradley, PhD
Yale Global Health Leadership Institute

Total Investment in Health as % of GDP



Elizabeth Bradley, PhD
Yale Global Health Leadership Institute

Opportunity Costs!

- **1 ED Visit = 1 months rent**
- **2 hospitalizations = 1 year of child care**
- **20 MRIs = 1 social worker per year**
- **60 echocardiograms = 1 public school teacher per year**

SGIM Presidential Speech, Dr. Moran, 2015

HOW DO YOU INCREASE INVESTMENTS MADE INTO SOCIAL DETERMINANTS??

STATE EFFORTS TO IMPROVE HEALTH
&
INCREASE INVESTMENTS IN SOCIAL SPENDING

- Foster better value and efficiency in health delivery systems through payment reforms, value based purchasing and delivery system changes
- Invest some of those savings into social enterprises that improve health
- Increased partnerships across health and social service endeavors
- Creating coordinating/integrating organizations

The Alphabet Soup of Approaches

- ACO
- CCO
- ACC
- ACH
- CPC
- AHC
- RCCO
- MCO
- PCMH

SOCIAL DETERMINANTS OF HEALTH SCREENING TOOLS

Considerations for Selecting a Tool

- Population
- Which social needs
- Screening “dosage”
- Handling screening results
- Implementation considerations
- Other?

Population

- Adults, pediatrics, all patients, ?
- Subgroup, by:
  - Healthcare utilization
  - Insurance status
  - Chronic disease(s)
  - Co-existing conditions (e.g. mental illness, addiction)
  - Age subgroups (e.g. very old, very young)
  - Zip code
  - Other?

Which Social Needs? Screening Tools- Adults & Gen. Pop.

DOMAINS	AHC-Tool	HealthBegins	Health Leads	MLP IHELLP	NAM Domains	PRAPARE	WellRx	Your Current Life Situation
Education	■	■		■	■	■	■	
Financial strain	■	■			■			■
Food insecurity	■	■	■			■	■	■
Housing insecurity/ instability/homeless	■	■	■	■		■	■	■
Housing quality	■	■		■				■
Interpersonal violence	■	■		■	■	■	■	■
Social support	■	■	■		■	■		■
Stress	■	■			■	■		■
Transportation	■	■	■			■	■	■
Utilities	■		■			■	■	■

https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison

Which Social Needs? Screening Tools- Pediatrics

Domains	iHELP	SEEK	SWYC	We Care
Education	■			■
Financial strain	■			■
Food insecurity	■	■	■	■
Housing insecurity/ instability/homeless	■			■
Housing quality	■			
Interpersonal violence (IPV)	■	■	■	
Social support		■		
Stress		■		
Utilities				■

https://sirenetwork.ucsf.edu/tools-resources/mmi/screening-tools-comparison

Many of the questions are similar

Domain/topic	*PRAPARE*	*AHC*
Education	**10. What is the highest level of school that you have finished?** a. Less than a high school degree b. High school diploma or GED c. More than high school d. I choose not to answer this question	**(Optional) 33. What is the highest grade or year of school you completed?** □Never attended school or only attended kindergarten □Grades 1 through 8 (Elementary) □Grades 9 through 11 (Some high school) □Grade 12 or GED (High school graduate, diploma, or alternative credential) □College 1 year to 3 years (Some college, Associate's degree, trade, vocational, or technical school) □College 4 years or more (College graduate)
Housing	**7. What is your housing situation today?** e. I have housing f. I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a	**4. What is your living situation today?** □ I have a steady place to live □ I have a place to live today, but I am worried about losing it in the future □ I do not have a steady place to live

Patient Experience of Screening for SDOH

Research thus far:

- Little patient discomfort with SDOH screening (LaForge et al, 2018)

- Low patient refusal rates (LaForge et al, 2018; Giuse et al., 2017; Page-Reeves et al., 2016; Pinto et al., 2016)

Clinician Experience of Screening for SDOH

Source: https://www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/sdoh-survey-results.pdf

Who will do the screening?

- Registration
- Intake
- Care Management
- Care coordination
- Front desk
- CHW
- MA
- Behaviorist
- Counselor
- Nurse
- Physician
- Psychiatrist
- ???

“Dosage” of Screening

Timing

At…

- registration
- intake
- care coordination
- new diagnosis
- ?
- ?

Other Considerations

- How long does it take to do the screening?
- Can the patients screen themselves?
- Other?

Followup

What will you do for positive screens?

- Provide potential resources
- Counsel
- Refer
- ?

Who will do the follow up?

Why screen if you have no resources?

Accountable Health Communities Screening

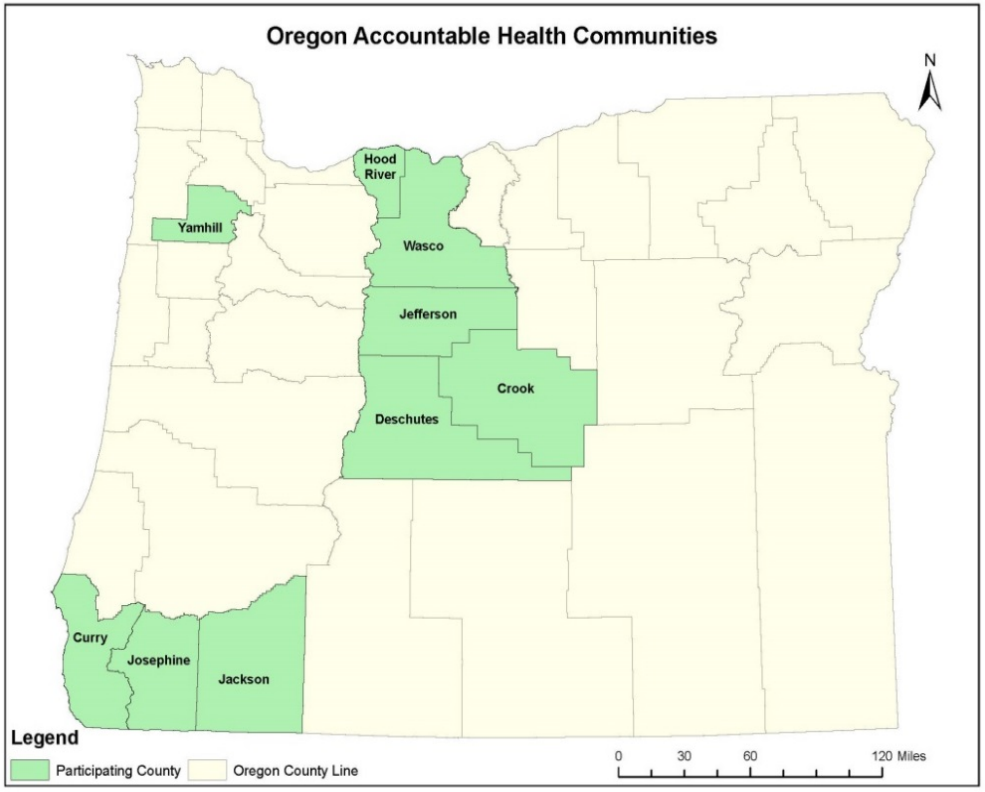
- Screening for 5 health-related social needs: housing, food, utilities, transportation and violence
- Connecting patients with social needs to community services
- Developing tailored referral and care plan for a subset of high risk patients

Screening & Navigation Settings

- **Screening:**
  - Primary Care (Family Medicine, Internal Medicine, Pediatrics)
  - Behavioral Health
  - Hospital
  - Public Health
  - Dental Providers
  - CCOs, Community Agencies

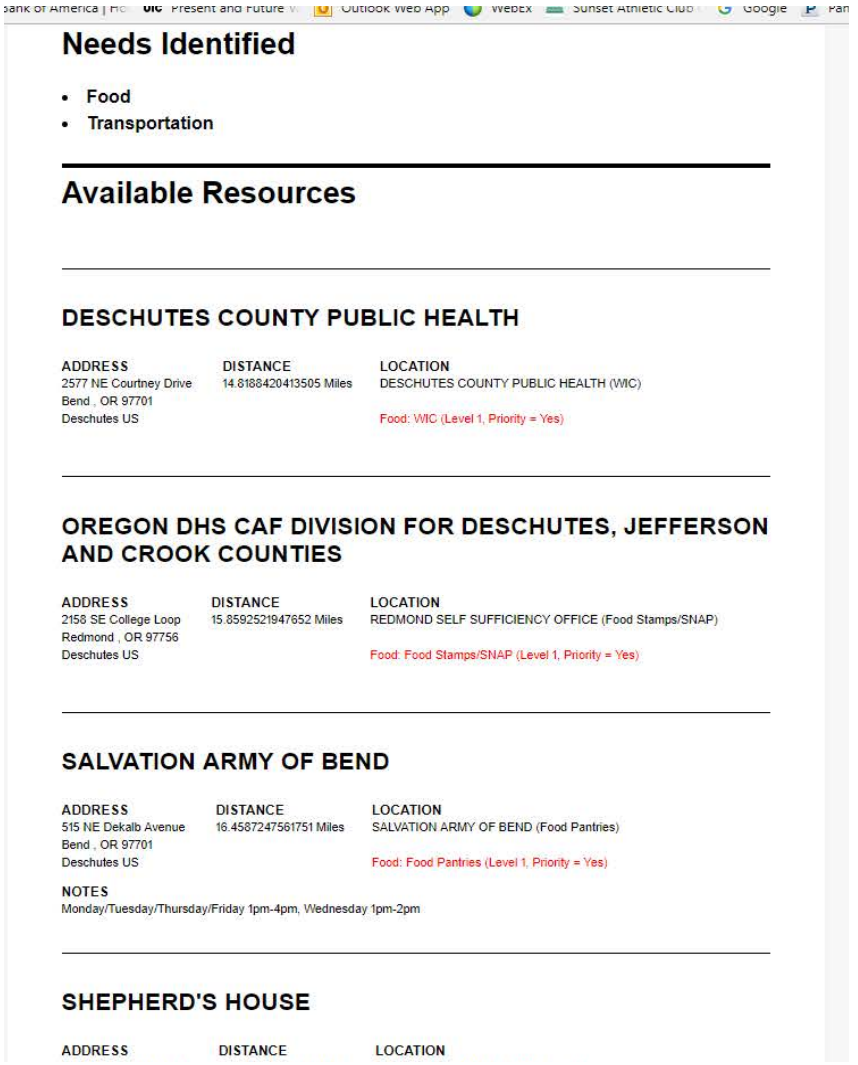
AHC Geography and Numbers

- Collaboration across 9 counties in partnership with 6 CCOs, IPAs, health systems, and over 50 clinical sites
- Screening 75,000 Medicaid and Medicare patients a year
- Navigating for 3,000 high risk patients annually



Community Resource Summary

- Tailored to identified social need
- Delivered at a clinical visit via a warm handoff



Needs Identified

- Food
- Transportation

Available Resources

DESCHUTES COUNTY PUBLIC HEALTH

ADDRESS	DISTANCE	LOCATION
2577 NE Courtney Drive Bend , OR 97701 Deschutes US	14.8188420413505 Miles	DESCHUTES COUNTY PUBLIC HEALTH (WIC) Food: WIC (Level 1, Priority = Yes)

OREGON DHS CAF DIVISION FOR DESCHUTES, JEFFERSON AND CROOK COUNTIES

ADDRESS	DISTANCE	LOCATION
2158 SE College Loop Redmond , OR 97756 Deschutes US	15.8592521947652 Miles	REDMOND SELF SUFFICIENCY OFFICE (Food Stamps/SNAP) Food: Food Stamps/SNAP (Level 1, Priority = Yes)

SALVATION ARMY OF BEND

ADDRESS	DISTANCE	LOCATION
515 NE Dekalb Avenue Bend , OR 97701 Deschutes US	16.4587247561751 Miles	SALVATION ARMY OF BEND (Food Pantries) Food: Food Pantries (Level 1, Priority = Yes)

NOTES
Monday/Tuesday/Thursday/Friday 1pm-4pm, Wednesday 1pm-2pm

SHEPHERD'S HOUSE

ADDRESS	DISTANCE	LOCATION

TABLE ACTIVITY

In your table groups:

- Share your name, organization and role
- Are you currently screening for social needs? If so, for what needs?
- If not, are you interested in doing so? If so,
  - What social needs would you want to screen for?
  - What do you think you need to get started?

BUSINESS CASE FOR SDOH SCREENING

First off…

- There's not enough high quality research on the health or cost impacts of screening for and addressing social determinants within a healthcare context.

- **For example…**
  - **Gottlieb, Wing and Alder, 2017 systematic review on effectiveness of interventions to connect social & medical care:**
    - » **Of 4,995 articles 67 studies met inclusion criteria.**
      - Of these 40 studies had non-experimental designs
      - Wide heterogeneity in outcome measures of the remaining 27
      - Bottom line– **more high quality research with common utilization outcomes is needed**

Wealth & Health

- **Wealth contributes to:**
  - **Higher life expectancy**
  - **Lower rates of chronic disease**
  - **Lower rates of unhealthy behaviors (e.g. poor diet, smoking, physical inactivity)**

Robert Wood Johnson Foundation How We Work Our Focus Areas About RWJF

SHARE

Wealth Matters for Health Equity

September 5, 2018 | Publisher: Robert Wood Johnson Foundation

Author(s): Braveman P, Acker J, Arkin E, Proctor D, Gillman A, McGeary KA, and Mallya G

Building wealth and income among people who have long lacked opportunity is essential—and possible—for improving health equity.

Substantial evidence links greater wealth with better health. Longitudinal studies have documented strong, pervasive links between income and multiple health indicators across the life span. Although the relationship between wealth and health has been

https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70442

Social Needs & Health

- **People with social needs:**
  - Obtain fewer preventive services
  - Use more emergency services
  - Have increased chronic health conditions
  - Have higher readmission rates
  - Have poorer health outcomes

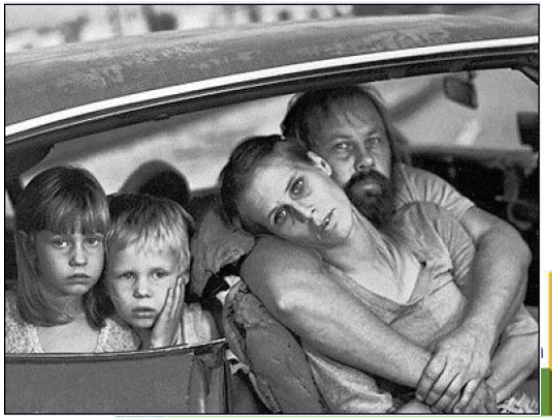
(McKelvey, 2017) (Meddings, 2017)

In Children…

More ACEs (e.g. homelessness, food insecurity, violence, divorce, etc.) = Worse Health Outcomes

- Chronic obstructive pulmonary disease
- Depression
- Fetal death
- Ischemic heart disease
- Liver disease
- Sexually transmitted diseases
- Illicit drug use
- Alcoholism and alcohol abuse
- Smoking
- Unintended pregnancies
- Early initiation of smoking

(Kaiser, 1998)



Problem/Opportunity

- Patients with social needs are faring worse in health outcomes and healthy behaviors than other patients.
- By addressing social needs we should be able to improve our patients' health outcomes.

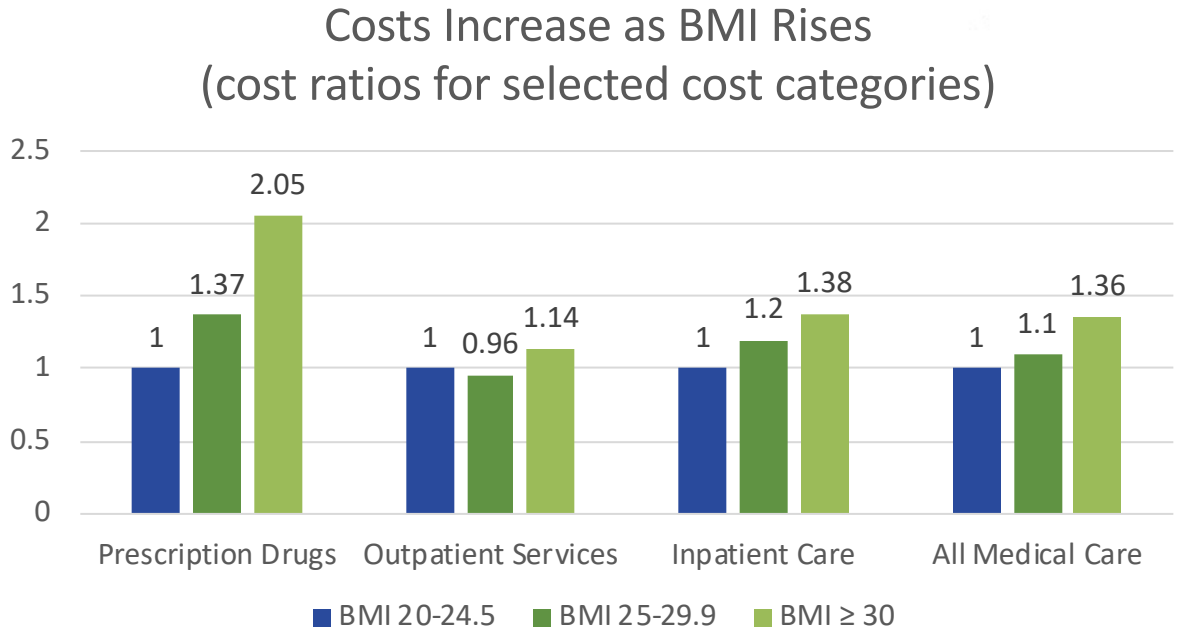
Housing & Healthcare Research- Benefits & Costs

1. Housing improvements (heating, ventilation) improved asthma symptom scores and reduced health care costs
2. Housing for low income elders with care coordination, advance planning, medication management reduced ED visits, unplanned hospitalizations and nursing home transfers
3. Housing for chronically homeless with severe alcohol problems decreased total health care spending 53% for housed vs. wait-listed controls
4. Supportive housing reduced overall health care expenditures, primarily through lower ED and inpatient care costs

1. Barton, 2007, Edwards, 2011, Garland, 2013; 2. Castle, 2014; 3. Larimer, 2009; 4. Wright, 2016, Gusmano, 2018, Counsell, 2008

Nutrition & Healthcare Research- Benefits & Costs

- Increased fruit and vegetable consumption reduced cancer incidence, but overall cost of health care the same (Gundgaard 2003)
- Higher BMI an important risk factor for chronic diseases (coronary heart disease, type 2 diabetes, hypertension, selected cancers, musculoskeletal disorders) Costs also rise as BMI rises (see below)(Pi-Sunyer, 1993)



Education & Healthcare Benefits & Costs

Early childhood education results in:
(as cited in Thornton, 2016)

- Increased safety belt use and reduced smoking and illicit substance use (Karoly, 2005)
- Reduced systems of depression, lower marijuana use, and increased physical activity (Campbell, 2012)
- Lower body mass index and fewer risk factors for cardiovascular and metabolic disease (Campbell, 2014)

Societal ROIs from early childhood education investments range from $3-$17 per dollar invested (Karoly, 2005.)

Risks

From Accountable Health Communities discussions:

- May uncover needs that can't be met
- Legal risk (e.g. safety needs)
- Cause problems for other sectors
- Cause challenges in busy clinical settings

PATIENT-CENTERED SCREENING

Patient-centered screening

- Patients own their story and their information
  - Allow patients to skip questions
  - Allow patients to stop answering questions at any time
  - Consider the screening environment

Patient-centered screening

- Patients own their story and their information
  - Obtain consent to screen
  - Explain why you are screening
  - Explain how the information will be used and shared

Patient-centered screening

- Trauma history
- Culture
- Prior experience with healthcare
- Economic, other disparities
- Comfort level with modality of screening (writing, verbal)

Cultural Identity Informs:

- Concepts of health, healing
- How illness, disease, and their causes are perceived
- The behaviors of patients who are seeking health care
- Attitudes toward health care providers
- Feelings of safety and inclusion when seeking care

Source of slide: PacificSource CCO

Patient-centered screening

- Language barriers
- Literacy level
- Educational disparities
- Comfort level with modality of screening (writing, verbal) and screening environment

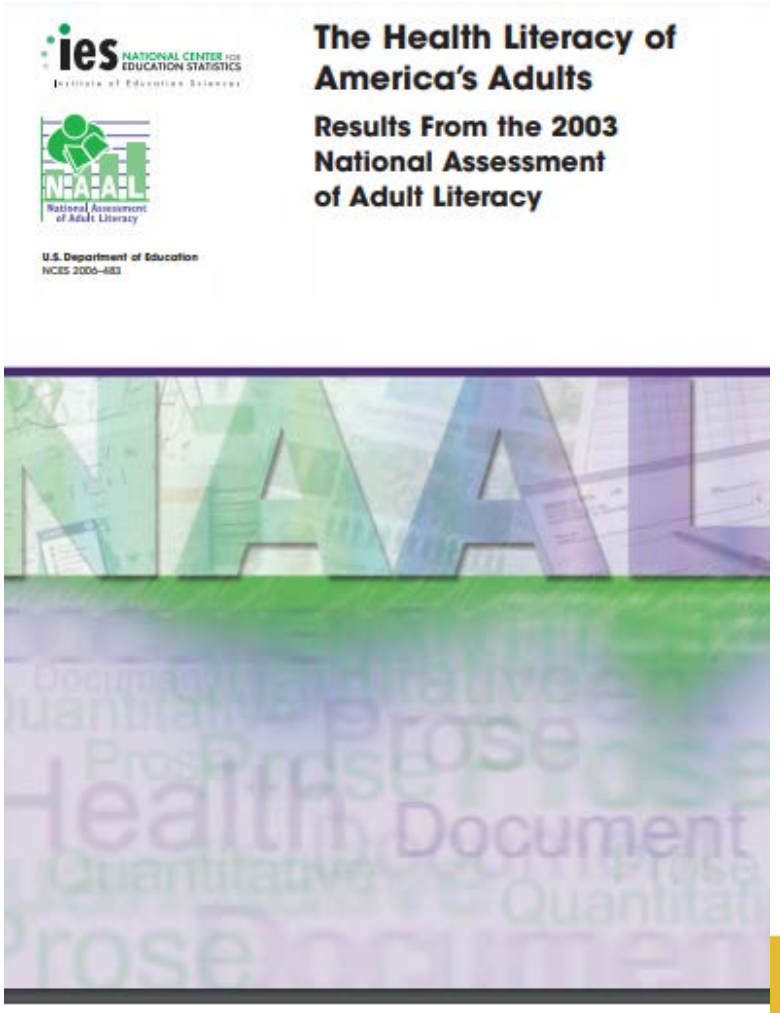
Health Literacy

- **Health literacy is the degree to which an individual has the capacity to:**
  - **Obtain, communicate, process, and understand basic health information**
  - **Act on information and make appropriate health decisions**
  - **Access/navigate the health (and other) systems**

Source: Centers for Disease Control and Prevention, PacificSource CCO

Who is impacted?

- **National Assessment of Adult Literacy (NAAL)**
  - Assessed both reading and math skills
  - Focused on health-related materials and tasks
  - 36% of adults where identified as having *serious* limitations in health literacy skills
  - It is estimated that just 12% of U.S. adults have the level of skills needed to manage the system



Source of slide: PacificSource CCO

Stigma

- Stigma associated with poverty, social needs
- Sensitive questions (e.g. safety)

DATA “SYSTEMS”

What are some data systems you could use for SDOH screening & referral?

- Paper
- Chart flag
- Room flag
- Stand alone system
- Patient portal
- EHR integration

Considerations

- Time
- Cost
- Administration modality- (flexibility may be key)
- Workflows needs
- Ability to share across the community

PARTNERSHIP STRATEGIES

Partnerships

- How do you make yourself aware of available resources?
- How do you make referrals?
- What is the best way to share information?

TABLE ACTIVITY

For clinical sites: What do you need to better assist patients in obtaining needed social supports?

For community partners: What can clinical partners do to help your clients obtain needed social supports?

CLOSING REMARKS

10 minute break

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Developing Sustainable Care Compacts in the Healthcare Neighborhood

Ron Stock, MD MA

March 28, 2019

Learning Objectives

- Understand what a care agreement (compact) is, and isn't
- Discuss barriers and facilitators to creating successful care compacts
- Discover tools to support successful care compacts
- Develop a plan to utilize a care compact

Care Compact/Collaborative Agreements Definition

Care coordination agreement, compact, service level agreement or standardized checklist for referrals all refer to an explicit understanding between providers that outline expectations around defining accountability for care management, the sharing of clinical information, access to care and areas of care coordination to facilitate a well orchestrated and seamless care experience for the patient. A care coordination agreement is not a legal document rather it offers standardized language to describe the referral process and outlines what each provider can provide in key areas.

-*Colorado Systems of Care/Patient Centered Medical Home Initiative, funded by the Colorado Health Foundation, 2010.* Available: http://www.cms.org/uploads/PCMH-Primary-Care-Specialty-Care-compact-(10-22-10).pdf

Care Compact Components

- **Sharing data: accurate and up-to-date clinical records**
- **Sharing data: practice-level quality and performance measures**
- **Requirements related to content, timing, and method of communication**
- **Defined responsibilities for patient care and communication throughout the referral process**
- **Defined responsibilities for clinical co-management of specific conditions**
- **Protocols for requesting and conducting referrals**

Link to the Triple Aim

- **Patient Experience: Fragmented care causes delays, miscommunication, gaps in care and, thus, is a major irritant to patients**
- **Cost: Fragmented care leads to unnecessary service especially related to ED and hospital visits**
- **Quality: Lack of a care compact can lead to the lack of coordination across providers on plans of care, which often contradicts and/or misaligns patient goals; this can result in patient safety issue(s)**

Why do “care compacts”?

- Patients assume a partnership between the primary care (or mental health) team and specialists;
- BH/MH care and Primary care have a robust role in managing the pathway to the system for the patient
- Preparing patients—Do they understand why? Do they agree? Are they educated about expectations?
- How much time does your practice spend reacting and chasing information rather than being proactive?
- P4A

Historical perspective

- **The Medical Neighborhood is a systems model that extends the team--based care paradigm and:**
  - Fosters shared accountability among providers
  - Improves quality
  - Reduces waste
  - Aligns incentives to encourage collaboration
  - Includes measures to evaluate the patients' experience of care
- **Real-life examples:**
  - 2001, Senior Health & Wellness Center

Partnering Provider's Experience with Care Compacts

Share!

Care Compact Strategy

- Develop team and clinical “champion”
- Decide who to develop compact with
  - What is the biggest issue for practices?
  - Data on population
  - Validate data and choices
- Outreach to the specialty practice/hospital/ community agency
- Develop compact
- Plan-Do-Study-Act

Exercise 1:
Developing the Clinic "Team" and Strategy

- Clinician “champion”
- The team
- How will decisions be made?
- Process?

Exercise 2: How do you decide who to develop a compact with?

- Seek care compact partners based on need for neighborhood alignment
- Decrease unnecessary costs/overutilization
  - Utilize existing data reports
- Partner with those whom communication has been poor in the past
- Engage providers and staff
- Identify a list of key specialists /PCPs that you want to invite into your medical neighborhood and send invitations to join

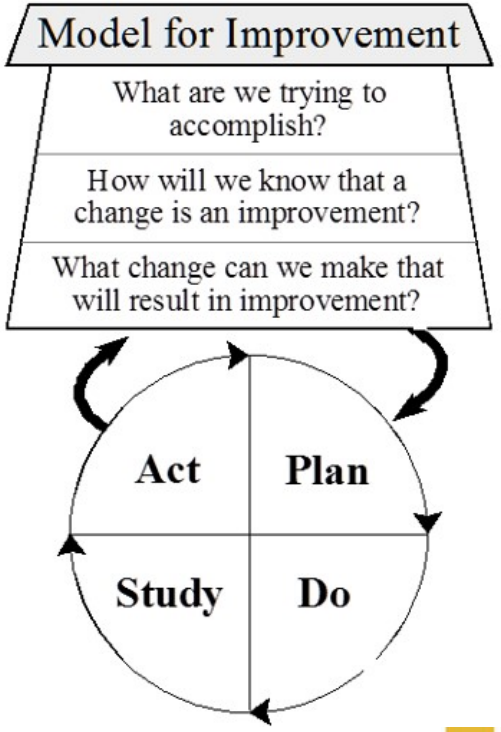
Exercise 3: The Compact

- **Questions to consider:**
  - Think about your various referring partnerships and identify what elements work well for your practice?
  - Are there areas within your referral relationship that you feel strongly about and/or are non--negotiable as you develop care coordination agreements with your colleagues?

- **Care compact examples**
  - Colorado Systems of Care/Patient Centered Medical Home Initiative
    - Available: http://www.cms.org/uploads/PCMH-Primary-Care-Specialty-Care-compact-(10-22-10).pdf
  - SAMSHA-HRSA
    - Available: https://www.integration.samhsa.gov/operations-administration/contracts-mous#bmb=1

QI Methodology: PDSA (Plan-Do-Study-act)

- **How will you know whether you've accomplished your aim?**
- **Collecting feedback from patients and specialty collaborators**
- **Develop and maintain relationships**



Group Q & A

Break for lunch

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Tools for Whole Person Care:
42 CFR Part 2
PreManage

Milena Stott, LICSW, CDP

42 CFR: Objectives For Today

- Overview of 42 CFR
- History and Intent
- 42 CFR Part 2 in Context of Integration
- Regulatory Requirements
- Consent / Release of Info

This session does not constitute legal advice. It will provide basic background information to help inform agency protocols and decisions!

Checkpoint #1

- **Any experts in the room?**
- **Any novices?**
- **Any particular concerns about CFR 42 and whole person care that would be good to discuss and share information about today?**

Intent Of 42 CFR Part 2

Protects confidentiality of:

- **Identity, diagnosis, and prognosis, *or***
- **Treatment of any patient records maintained in connection with the performance of any federally assisted program *or***
- **Activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research**

Why Was 42 CFR Part 2 Enacted? (1/2)

- Congress recognized stigma associated with substance use disorders
- Fear of prosecution stopped people from entering treatment
- 42 CFR Part 2 protects individual rights to privacy and confidentiality - a cornerstone of SUD treatment programs for many years

Why Was 42 CFR Part 2 Enacted? (2/2)

- **Prevents misuse of information about an individual's substance use disorder**
- **Protects individuals seeking and receiving SUD treatment from consequences of a privacy breach**
  - **Loss of employment, housing, child custody**
  - **Discrimination by healthcare providers and insurers**
  - **Arrest, prosecution, and incarceration**
  - **Denial of life or disability insurance**
  - **Possible impacts on health disparities**

What Is A Part 2 Program? Three Definitions

1. **Individual or entity**
   Other than general medical facility
   That holds itself out as providing/does provide SUD services & referral

2. **An identified unit**
   Within a general medical facility
   That holds itself out as providing/does provide SUD services & referrals

3. **Medical personnel or other staff**
   In a general medical care facility
   Whose primary function is:
   provision of SUD treatment or referral for treatment and who are identified as such

Examples Of Part 2 Programs

First definition

- Freestanding drug/alcohol treatment program
- Student assistance program in a school
- PCP who provides SUD services as principal practice

Second definition

- Detox unit
- Inpatient or outpatient drug/alcohol program within a general medical facility

Third definition

- Addiction specialist working in primary care

What Does "Holds Itself Out" Mean?

- **CFR 42 does not define**
- **SAMHSA FAQ examples**
  - **Advertising, notices in office**
  - **Information given to patients and families**

<u>Takeaway:</u> Any activity that would reasonably lead one to conclude SUD services are provided

What Is A "General Medical Facility?"

- **CFR 42 does not define**
- **SAMHSA FAQ examples:**
  - **Hospitals**
  - **Trauma Centers**
  - **Federally Qualified Health Centers**

When Is A Program "Federally Assisted?"

Receives federal funds in any form,

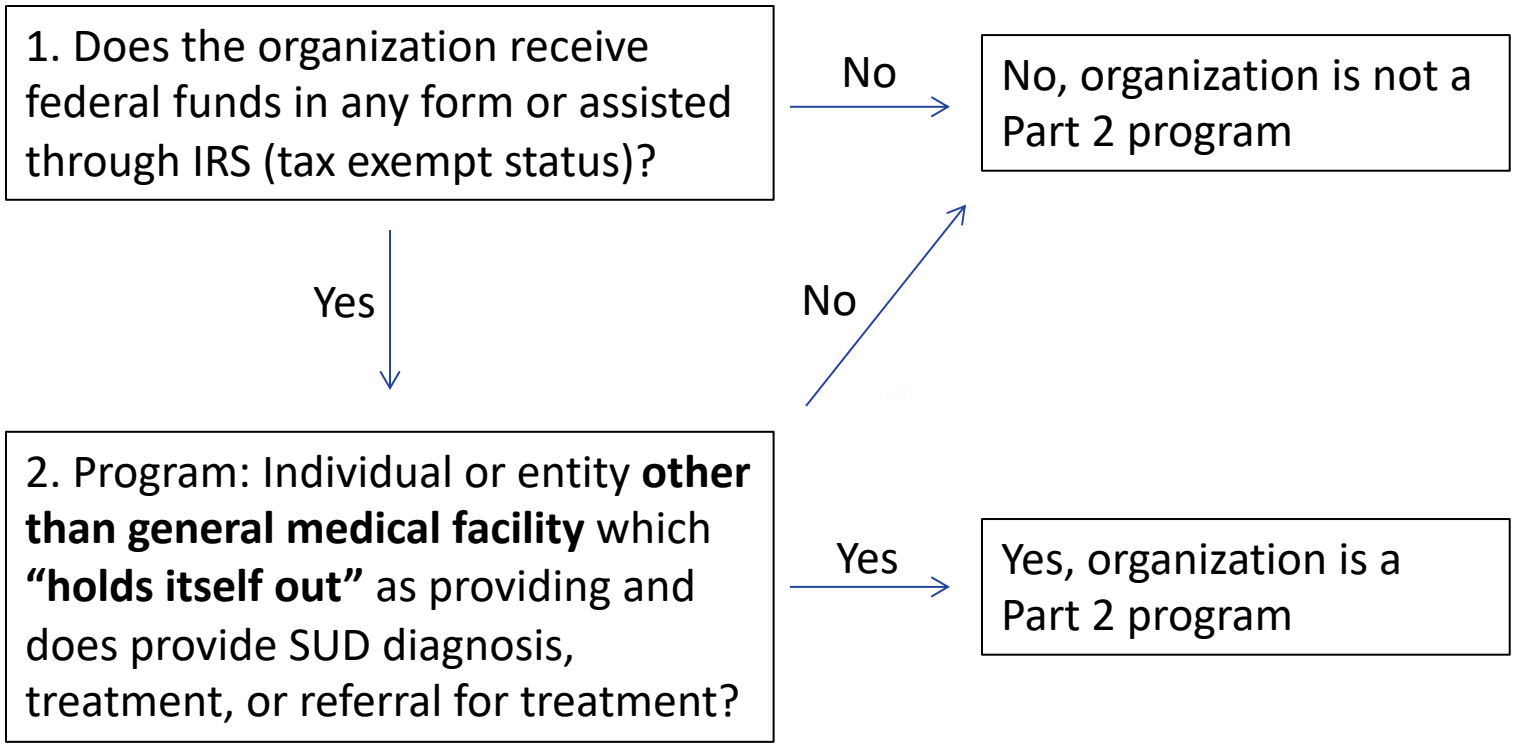
not necessarily for SUD services

Authorized, licensed, certified, registered by the federal government:

- **IRS tax-exempt status**
- **DEA registration to dispense controlled substances**
- **Receives Medicaid or Medicare reimbursement**

Who Is Subject To Part 2?

Federally Assisted + Program = Part 2 Program



42 CFR Part 2 In Whole Person Care

- **Significant changes in healthcare delivery since Part 2 enacted**
- **Whole person integrated care depends on information sharing on both treatment and care coordination**
  - **New IT infrastructures and platforms**
  - **New focus on performance measurement**

Challenges With 42 CFR Part 2:

Possible negative impacts for both provider and patient

- **Limits on data sharing**
- **Assuming financial risk more challenging**
- **Complicates management of high-risk, high-cost patients**
- **Providers accountable for health outcomes despite missing SUD information**

When Is Disclosure Allowed?

- **Disclosure of information that identifies patient directly or indirectly as having current or past SUD is generally prohibited**
- **Unless patient consents to disclosure through Release of Information (ROI)**

Key Point

- **When dealing with a general medical facility…**
  - **The "program" is the unit or medical personnel, NOT the whole general medical facility**

Definition Of Program Under Part 2

- **Case Scenario #1:**
  - Joe Smith enters ED visibly intoxicated following an accident
  - Dr. Jones calls staff from hospital's drug/alcohol unit to assess Joe Smith for alcoholism, but he leaves before assessment occurs

Is Dr. Jones a "program" under 42 CFR Part 2?

Case Scenario #1 Answer

- **No, Dr. Jones is not a "program."**
  - **Works in a general medical facility but not in an identified unit that holds itself out as providing drug/alcohol diagnosis, treatment, or referral for treatment**
  - **"Primary function" is ED provider - not the provision of drug/alcohol services**

Coverage Under 42 CFR Part 2

- **Case Scenario #2:**
  - Dr. Jones is a PCP in a federally assisted practice
  - Dr. Jones prescribes buprenorphine for OUD as his primary practice

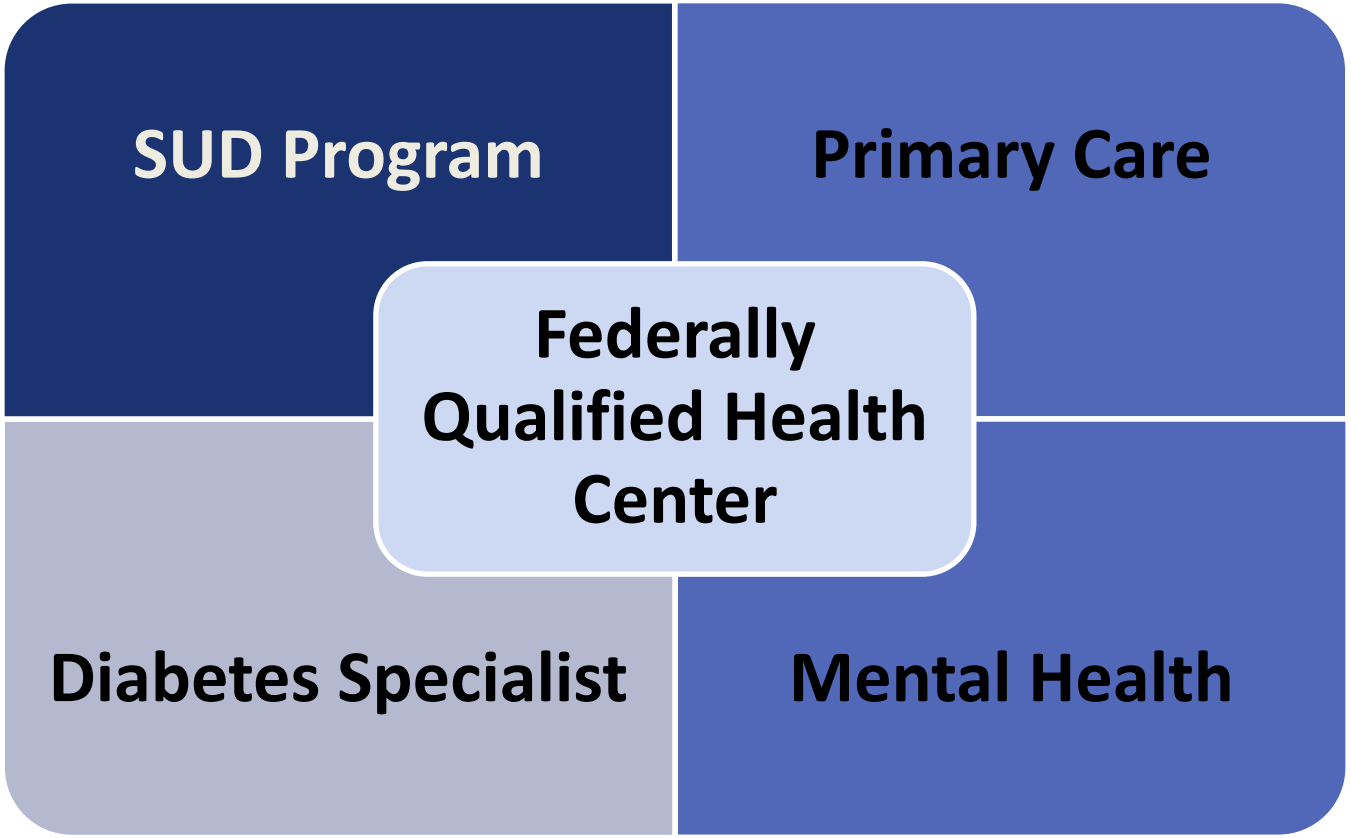
Is Dr. Jones covered by 42 CFR Part 2?

Case Scenario #2 Answer

- **Yes, Dr. Jones is a "program" under 42 CFR 2**
  - **His principal practice consists of providing drug/alcohol diagnosis, treatment, or referral for treatment**
  - **He holds himself out as providing those services**

Co-located And Integrated Services: How Do Privacy Laws Apply? (1/2)

- **Example: “‘Program’ within Larger Entity”**



Co-located And Integrated Services: How Do Privacy Laws Apply? (2/2)

- **Case Scenario #3:**
  - Quality CHC provides primary care and behavioral health services, including addiction treatment
  - Providers in some programs within Quality CHC conduct SBIRT

Would Quality CHC be covered by Part 2?

Case Scenario #3 Answer

- **It depends… on which providers, which units, at Quality are conducting SBIRT**
  - **When a unit or provider at the CHC is a Part 2 "program" providing SBIRT, the SBIRT services and all corresponding patient records are covered by Part 2**
  - **When a unit/provider at the CHC is not a Part 2 program but conducts SBIRT, the services and records are not covered by Part 2**

Co-Located And Integrated Services

- **How can a Part 2 program share information with co-located or integrated providers?**
  - **QSO Agreement (QSOA)**
  - **Written Consent**

Consent Requirements

- **Release of information (ROI) must include:**
  - Purpose of release
  - How much and what kind of information to disclose
  - Date or condition of expiration
  - To whom the patient is disclosing information
  - Can give verbal revocation
- **Handouts!**
  - Examples from Primary Care and BHA

Checkpoint #2

Any thoughts or comments on these particular ROI examples?

Any better ROI examples that you might share?

When Consent Isn't Required: Exceptions To Rule Prohibiting Disclosure

- Internal communications
- Medical emergency
- Qualified service organization agreement (QSOA)
- No patient-identifying information
- Crime on premises/against program personnel
- Research (consent through research ROI)
- Audit
- Court order
  - Example: Reporting child abuse/neglect

Working With Court-ordered Patients

- DOC and CPS – may be afraid to sign ROI
- May be ambivalent
- Coercive treatment
- Shared decision making
- MAT and reporting implication
- How do we support patients across scenarios with various providers and their training?

SAMHSA Online Resources

- Disclosure of Substance Use Disorder Patient Records: Does Part 2 Apply to Me?
  - https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf

  How healthcare providers can determine how Part 2 applies to them
- Disclosure of Substance Use Disorder Patient Records: How Do I Exchange Part 2 Data?
  - https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

  How 42 CFR Part 2 applies to the electronic exchange of healthcare records with a Part 2 Program
- Substance Abuse Confidentiality Regulations
  - https://www.samhsa.gov/about-us/who-we-are/laws-regulations/confidentiality-regulations-faqs

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Cross Setting Tools: Using PreManage

Milena Stott, LICSW, CDP

Premanage: Objectives For Today

- **Review basic features and functions**
- **Share BHT provider experience with PreManage**
- **User experience and workflows**

Why Talk About This?

- **Statewide ACH Accountability Metric**
  - **All Causes ED Visits per Member Month**
- **BHT P4A Measures**
  - **Care Compacts**
    - Referral Pathways & Info Exchange
  - **Complex Care Planning**
    - Workflows and Protocols
  - **(Future) HIE and HIT**
- **MCO Value Based Purchasing**
  - **Anticipate P4P Measures**

Checkpoint #1

- **Who is already using PreManage?**
- **Who has a plan to implement?**

Hope you'll all be willing to share good ideas and lessons learned a little later!

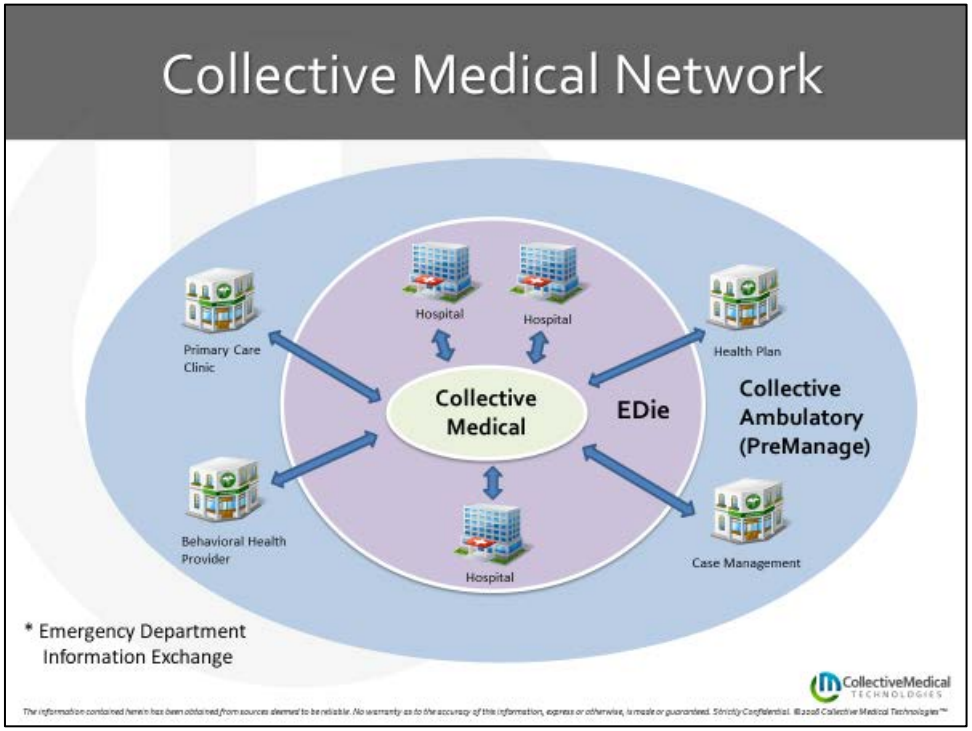
Context: Why Talk About This?

- Whole person health
- Value based purchasing
- Accountable care and defined payments
- Population health management
  - Risk stratification
  - Registries
  - Treatment to target

Information In PreManage

- Admission dx and chief complaint
- Demographics
- Care team
- Disposition
- ED visit history
- Custom reports on ED utilization

Collective Platform



Who Can Be On The Network?

- Hospitals
- Managed care organizations
- Providers – BH and primary care
- Risk-carrying organizations (ACOs, etc.)
- Long term care and post-acute care facilities

Passages Experience With EDIE/Premanage

- Why we implemented PreManage
- How our staff use ED data for our clients
- Workflow and follow-up for multiple ED visits
- Plan for the future

Checkpoint #2

Would anyone like to share their own experience with PreManage?

Opportunities With PreManage

- **Real time notification**
  - Allows for rapid response
- **Providers notified when patients in ED**
  - Full picture of patient's health and utilization
- **Patients and clients lost to follow-up**
  - Opportunity to engage or re-engage with new contact information
  - Opportunity to engage with PCP

Example Of A Rapid Response Strategy

- **Focus Group: *decreasing emergency department utilization management (EDUM)* among individuals with medical and behavioral health conditions presenting at EDs. Interventions are specifically aimed to improve rapid engagement in behavioral healthcare post ED-discharge and community stabilization.**

Risk Stratification: Matching Service Intensity To Level Of Need

- **Match client needs to levels of care and types of care**
- **Leverage reports to identify patients with increased risk who may require a higher level of care**
- **Identify patients with co-morbid conditions and/or exceptionally high ED utilization**
- **Care team section**
  - **Allows view of all providers and team members involved**
  - **Provides two years history of provider information**
  - **Can be organized and filtered by status and provider type**

Checkpoint #3

Delete if no questions to ask

Online Resources

- **WA Portal PreManage Toolkit for BHAs**
  - **https://waportal.org/resources/premanage-implementation-toolkit-guide-washington-state-behavioral-health-agencies**

OR

- **HealthInsight PreManage ToolKit**
  - **https://healthinsight.org/tools-and-resources/send/73-educational-resources/1450-premanage-implementation-toolkit-v2**

Checkpoint #4

- **Final questions, ideas or resources to share around work flow strategies?**
- **Next steps for your organization?**

Wrap Up

Thank You!

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