

# The Future of Behavioral Health Data

Presented by the Division of Behavioral Health

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# Why Do We Collect Data?

1. For State and Federal Reporting
  - Currently, data is gathered primarily for state and federal reporting obligations
  - Staffing is limited to leverage the data for much more
  - Minimal value to providers

# Why Do We Collect Data?

## 2. To Increase Value of Care

- High value to providers
- Requires that we have data that is both meaningful and consistent

### “Value” of Care Equation

1. **Services provided** – Timely access to clinical and medical services, service array, duration and density of services through Level of Care/Benefit Design Criteria and/or EBPs that focuses on population based service needs
2. **Cost of services** provided based on current service delivery processes by CPT/HCPCS code and staff type
3. **Outcomes achieved** (i.e., how do we demonstrate that people are getting “better” such as with the DLA-20 Activities of Daily Living)
4. **Value is determined** based on can you achieve the same or better outcomes with a change of services delivered or change in service process costs which makes the outcomes under the new clinical model a better value for the payer.

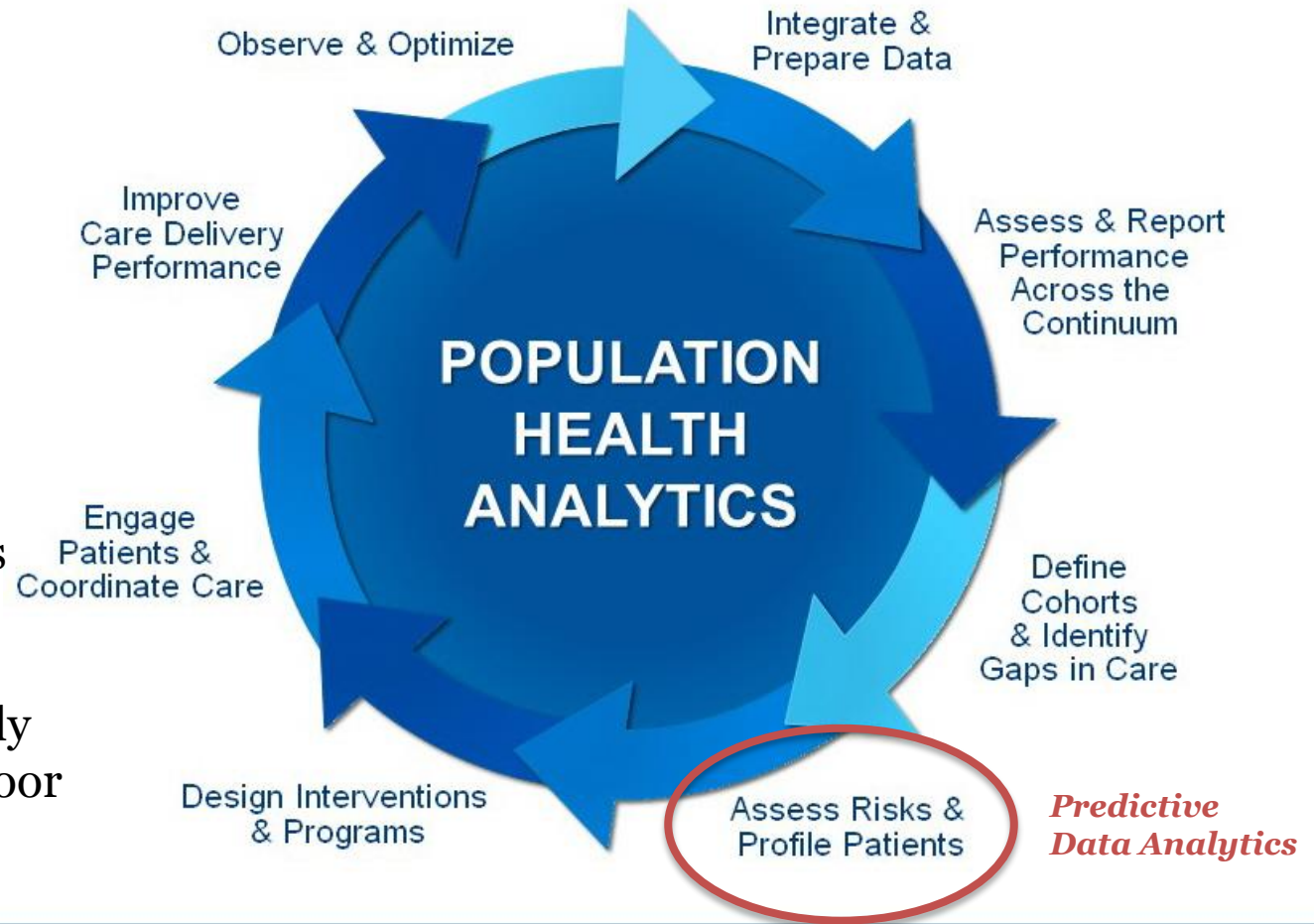


Presented By:  
David Lloyd, Founder

# Why Do We Collect Data?

## 3. To improve Population Health

- High value to providers
- Helps providers identify and prioritize individuals likely to experience poor outcomes

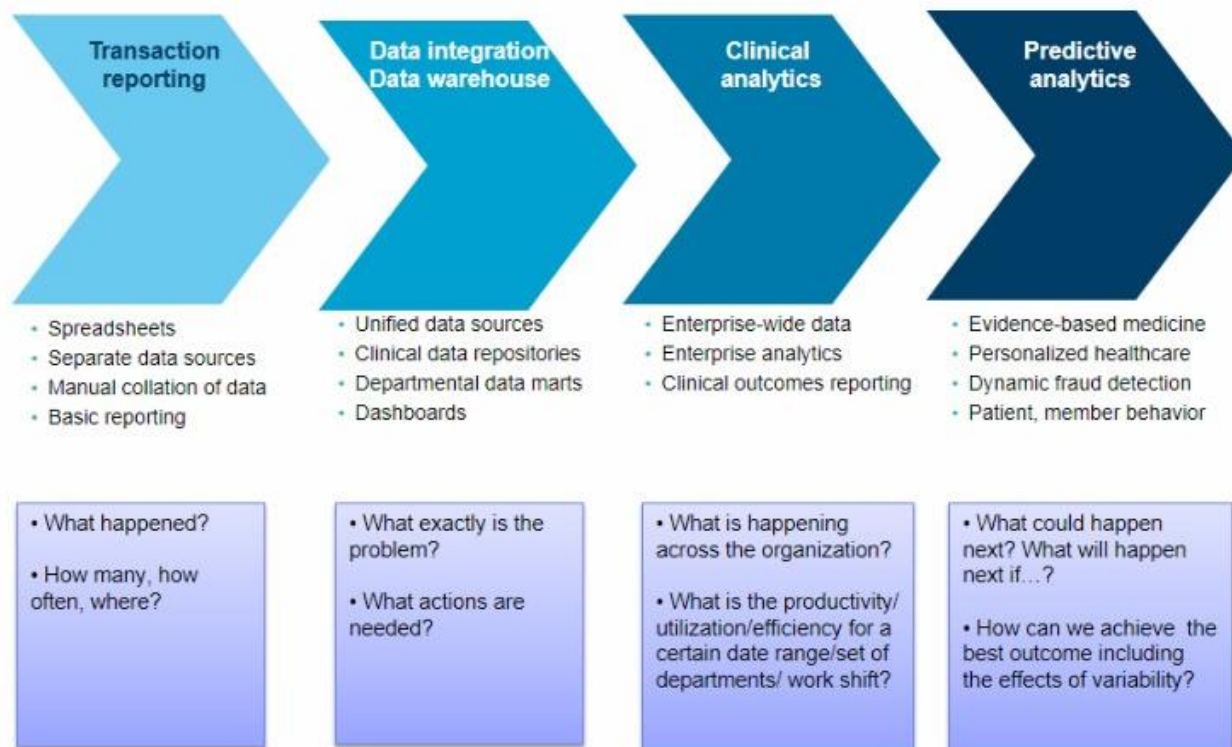


# Looking Ahead: We Must Improve Data Analytics Capacity

## The Analytics Continuum

*“In a time where data is needed to inform every step of transformation, building the analytic capacity of the system is critical.”*

Alaska Behavioral Health Systems Assessment



What steps will we take  
to get there?

# Step 1: Implement Modified Minimum Data Set

- Must meet state and federal reporting requirements, but can do that with a modified (trimmed down) version for the next 2-3 years
- Future changes expected with implementation of 1115 waiver and administrative service organization

Modified Minimum Data Set Options Considered

*Preferred Option*

	Field Counts						Change of Count	Percent Reduction
	Total	TEDS	Notes	CSR	AST	Extra		
Current 262	256	83	12	52	50	59	0	0
Scenario 156	156	92	12	52	0	0	-100	-39.1%
Scenario 144	144	92	0	52	0	0	-112	-43.8%
Scenario 104	104	92	12	0	0	0	-152	-59.4%
Scenario 92	92	92	0	0	0	0	-164	-64.1%

# Modified Minimum Data Set

## Key Elements

### Treatment Episode Data Set (TEDS)

- States are required to report treatment episode data to SAMHSA
- TEDS is a national source for client-level information on substance abuse and mental health services
- Used for performance management and national trends analysis

[http://www.dcf.state.fl.us/programs/samh/publications/UpdatedCombined\\_SA\\_MH-TEDS\\_Manual.pdf](http://www.dcf.state.fl.us/programs/samh/publications/UpdatedCombined_SA_MH-TEDS_Manual.pdf)

### Encounter Notes

- Episode is issue-driven and encompasses the full course of action related to that issue, from admission to discharge
- the occurrence that triggered the care; encounters provide information about the services provided to address the issues experienced by the individual.
- What treatment was rendered in light of the episode being attended to.
- Contain information, such as note type (progress note, Medicaid management, case management, crisis intervention summary, etc.), service rendered, program name, location of service, start date and duration of service, whether service is billable, primary, secondary, and tertiary diagnosis for service, rendering staff, supervising staff
- Many of these fields are (or can be) automated
- Valuable for understanding services provided and cost of care



# Modified Minimum Data Set

## Key Elements

### **Treatment Episode Data Set (TEDS)**

- States are required to report treatment episode data to SAMHSA
- “Episodes” are issue-specific and encompass the full course of care related to a given issue, from admission to discharge
- TEDS is a national source for client-level demographic, socioeconomic, and substance abuse, mental health characteristics for inds receiving publicly funded services
- Used for performance management and national trends analysis
- Learn more about TEDS here:

[http://www.dcf.state.fl.us/programs/samh/publications/UpdatedCombined\\_SA\\_MH-TEDS\\_Manual.pdf](http://www.dcf.state.fl.us/programs/samh/publications/UpdatedCombined_SA_MH-TEDS_Manual.pdf)

# Modified Minimum Data Set

## Key Elements (cont.)

### **Encounter Notes**

- Encounter notes provide information about about each service provided to address an episode of care
- Encounter notes contain information such as service rendered, location, start date and duration of service, whether service is billable, diagnosis being addressed, rendering and supervising staff
- Many of these fields are (or can be) automated
- Valuable for understanding services provided and cost of care, two key components of the value of care equation

# Modified Minimum Data Set

## Key Elements (cont.)

### Client Status Review (CSR)

- Client Status Review will continue to be required for the next 2-3 years
  - Necessary for point in time review requirement
  - The instrument will likely change with implementation of the 1115 waiver

### Alaska Screening Tool (AST)

- Alaska Screening Tool will no longer be part of the minimum dataset
  - However, providers must still complete a screening and assessment
  - The 1115 waiver will identify a standardized screening and assessment tool for system-wide use upon implementation

# Modified Minimum Data Set

## Key Elements (cont.)

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- Necessary for point in time review requirement and will continue to be required for the next 2 to 3 years
  - However, the instrument will likely change with implementation of the 1115 waiver

### **Alaska Screening Tool (AST)**

- Will no longer be part of the minimum dataset
  - However, providers must still complete a screening and assessment
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# Step 2: Standardization and Streamlining

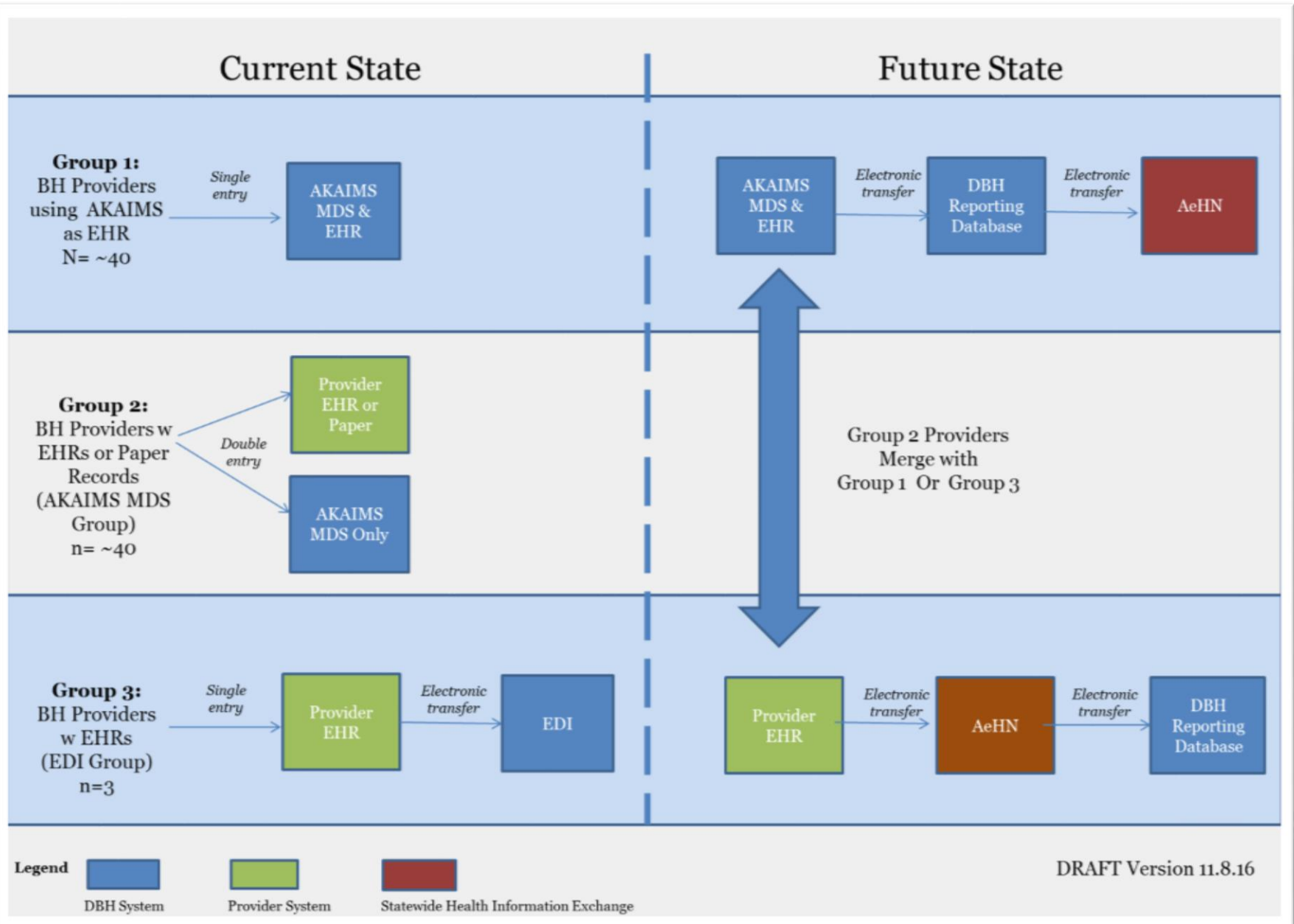
- DBH to secure contract support to assist with **standardization** and **streamlining**
  - From intake to screening to assessment to treatment to services to discharge and aftercare
    - David Lloyd referred to this a “Golden Thread Process”
  - Value to State: Improved quality of data is a prerequisite for meaningful analysis
  - Value to Providers: Reduced risk of error in billing practices, comparative data to inform clinical decisions

# Step 3: Leverage the Statewide Health Information Exchange

Partner with the Alaska eHealth Exchange (AeHN) to make data collection...

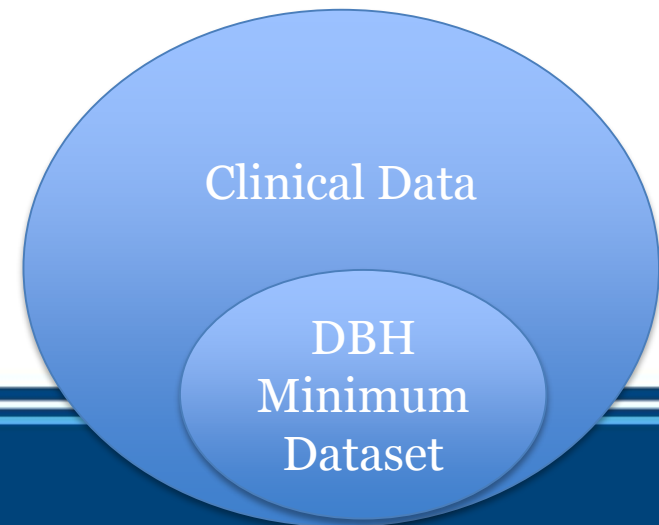
- **More efficient**
  - AeHN to transmit the minimum data set to DBH
- **And more timely**
  - The more recent the data, the more valuable!
  - Today, when we analyze Medicaid data, we are often looking two years back!
  - We want to start looking at now! And then pivot to anticipating the future...

# Envisioned Behavioral Health Data Flow



# Step 3: Leverage the Statewide Health Information Exchange (cont.)

- Fund interfaces with AKAIMS and behavioral health provider systems interfaces for those that wish to participate in the health information exchange
- Support sharing of clinical data across provider types
  - To improve care and create efficiencies through electronic data exchange





Questions?