azara 2025
USER CONFERENCE APR 29–MAY 1 | BOSTON, MA

Mending the Divide | Effective Data Strategies for Integrated Behavioral Health

Presented By

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Today’s Speakers

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Agenda

History & Understanding CCBHC, CMHC, FQHC

Compass Health Network’s Journey with DRVS

Using Azara DRVS for Behavioral Health

Wrap Up & Questions

History & Creating a Foundation

CCBHC, CMHC, FQHC

What's the Difference?

FQHC

Federally Qualified Health Center

- Provides comprehensive primary care, including dental & behavioral health.
- Serves underserved populations, including low-income, uninsured, and geographically isolated individuals.
- Must complete annual UDS reporting.

CMHC

Community Mental Health Center

- Offers mental health services in rural & underserved areas.
- Includes psychiatry, therapy, crisis care, & substance use treatment.
- Focuses on behavioral health, not primary medical care.
- No federal reporting requirements.

CCBHC

Certified Community Behavioral Health Center

- Federally certified to provide comprehensive behavioral health services.
- Includes mental health, SUD treatment, 24/7 crisis care, care coordination & recovery support.
- Must offer or partner to provide primary care.
- Annual federal reporting required.

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FQHC Timeline | A Brief History of Impact

1967

The first Community Health Centers (then called Neighborhood Health Centers) were established.

1977

CHC Program officially authorized under Section 330 of the U.S. Public Health Service Act.

1996

Omnibus Budget Reconciliation Act designates CHCs as Federally Qualified Health Centers (FQHCs), eligible for federal funding & cost-based Medicaid/Medicare reimbursement.

2009-Present

Federal Acts expand funding & support for FQHCs across the country.

Today

1,400+ FQHCs serve patients in every U.S. state, D.C., & territory.

CMHC Timeline | Expanding Access to BH Care

Created under the Community Mental Health Act of 1963, signed by President John F. Kennedy – his final piece of legislation.

Goal: Shift mental health care from large psychiatric hospitals to **community-based services**.

Provided **federal funding** to improve access & support local care models.

Emphasized care within **patients' own communities**, promoting recovery & reducing institutionalization.

Today, **1,000+ CMHCs** operate across the country, serving local behavioral health needs.

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CCBHC | History & Growth

2014

Protecting Access to Medicare Act (PAMA) established the **CCBHC Medicaid Demonstration (Section 223).**

2015

SAMHSA awarded planning grants to 24 states to prepare for CCBHC implementation.

2016

8 states launched the Demonstration: MN, MP, NV, NJ, NY, OK, OR, PA.

2019

First federal evaluation conducted; Missouri approved for the first CCBHC Medicaid State Plan Amendment.

Today

500+ CCBHCs serve communities across **46 states, D.C., Guam & Puerto Rico.**

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Behavioral Health Outcomes History

Historically inconsistent monitoring of behavioral health outcomes across states & systems.

Tracking often centered on **documentation compliance** (e.g., assessments, treatment plans, progress notes, discharge).

Outcomes were typically tied to **state initiatives** or **federal grant programs** (e.g., SAMHSA, NIMH).

CCBHC model introduced standardized outcomes measures, promoting consistency and incorporating value-based payment models.

As of **2023**, UDS reporting includes **behavioral health eligible visits** in core quality measures.

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Compass Health Network & DRVS

A Journey…

MISSION

Inspire Hope.
Promote Wellness.

VISION

Full, productive, healthy lives for everyone.

Compass Service Offerings

Behavioral Health

-Mental health; psychiatry, therapy, psychological testing, school-based & community-based case management

-Substance use disorder; outpatient counseling, intensive residential services, & an opioid treatment clinic

-Behavioral Health Crisis Centers (24/7/365 access)

-Psychiatric Inpatient Hospital (56 beds)

Primary Care

-Pediatric, family, internal and geriatric medicine

-Preventative health, immunizations, women's health & chronic disease management

Dental

-Preventative Care

-Surgeries including sedation

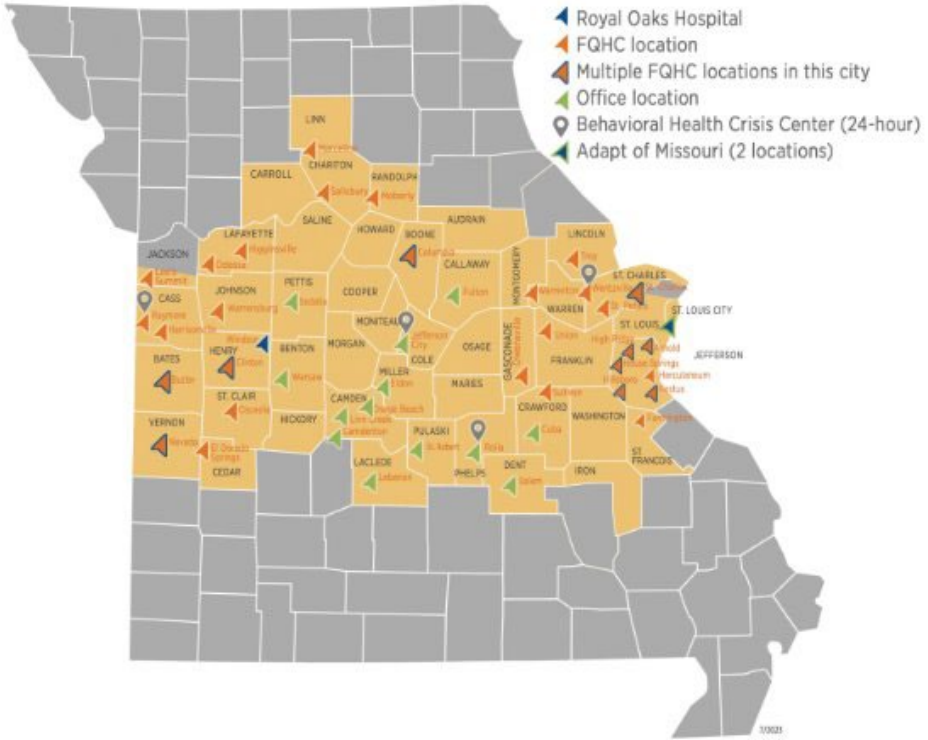
-Mobile dental units

Vision

-Optometry

Compass By The Numbers (2024)

- **$550+** Million Budget
- **5100+** Employees
- **125+** Locations
- **155,862** Total Patients Served
  - *FQHC specific:*
    - 115,113 patients
    - 658,423 visits
    - 65 FQHC sites
  - *CCBHC specific:*
    - 66,475 patients
    - 90 CCBHC sites



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Behavioral Health & DRVS Challenges

DRVS was originally built around primary care, dental and vision data – behavioral health teams are often new to this kind of population health tool.

Many BH providers have not had access to a tool like DRVS, making it a new concept for clinical staff.

Not all behavioral health locations fall under FQHC scope, creating limitations in data capture & reporting.

Workflows vary widely across BH sites, creating challenges for standardizing data entry & use of DRVS.

Couldn't simply connect the full EHR – needed creative, customized approaches for integration.

Inclusion of data from psychiatric hospitals & other non-CCBHC/FQHC entities added complexity.

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Compass 2024 | Data Integration Highlights

Consolidated from five EHRs down to two to streamline data systems.

Merged two organizations, each with their own DRVS instance – aligned under a unified strategy.

Built & optimized a data warehouse to normalize data across systems.

Shifted from Excel to DRVS dashboards for real-time, scalable reporting.

Refined EMPI* solution to ensure one unified patient chart across the organization.

Adjusted BH workflows to support UDS measure ingestion from the behavioral health EHR.

Connected BH EHR to DRVS, bringing behavioral health data into population health reporting.

* EMPI = Enterprise Master Person Index (links patient information from different healthcare information systems)

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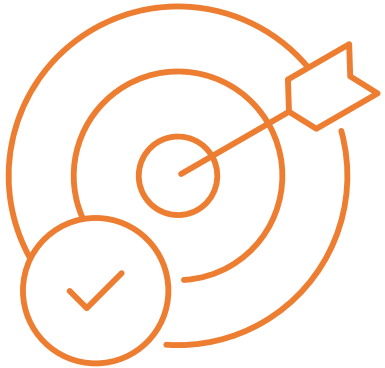
Behavioral Health in Focus

Current Goals & Priorities



Align with both CCBHC & UDS measure requirements.

Ensure all behavioral health patients have an assigned PCP.

Confirm patients have been seen within the past year to support care gap closure.

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Nursing Support in Preventive Care

Extending BH Team Roles

BH nursing staff now ask about cancer screenings during patient interactions.

Encourage follow-up care for screenings like cervical, breast & colorectal cancer.

Reinforces whole-person care across disciplines.

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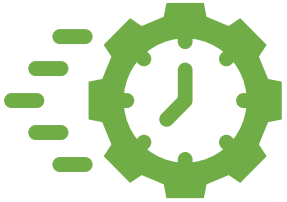
Streamlined Documentation Across EHRs

Reducing Duplication



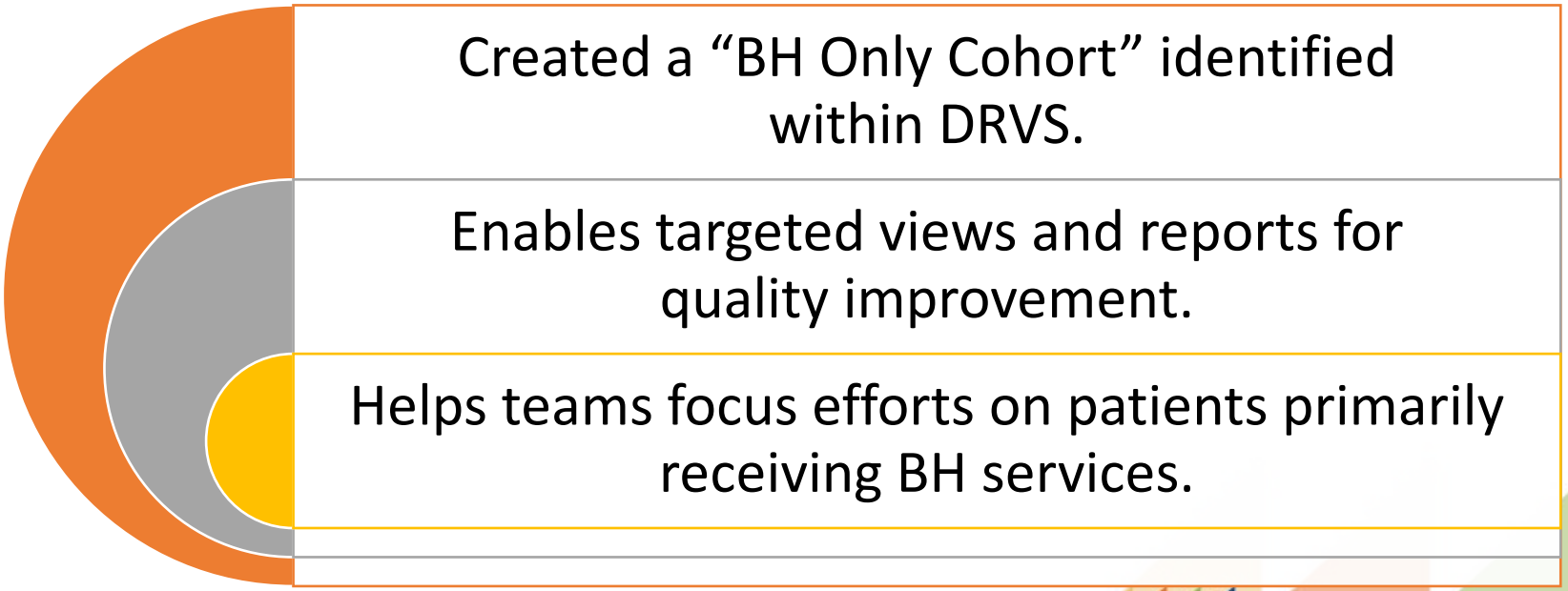
For patients who span multiple EHRs, no need to document twice.

Example: Cancer screening data flows into DRVS regardless of where it was documented.

Promotes efficiency & reduces staff burden.

Identifying Behavioral Health Patients in DRVS

BH-Only Population Tagging



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Unified Patient View in DRVS

Managing Multiple MRNs

Some patients have multiple MRNs due to multiple EHRs.

DRVS consolidates these into a single patient view for end users and quality staff.

Ensures accurate data, better reporting & coordinated care.

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CCBHC vs UDS Measures

Only 5 measures are similar!

Many BH services impact denominator for most UDS measures, but not the reverse.

CCBHC	UDS
•**Depression Remission at Six Months****	•BMI Screening and Follow-Up
•**Depression Screening and Follow-Up Plan**	•Breast Cancer Screening
•Unhealthy Alcohol Use: Screening and Brief Counseling	•Cervical Cancer Screening
•**Screening for Social Drivers of Health**	•***Screening for Social Drivers of Health***
•Time to Services**	•Child Weight Assessment/Nutrition Counseling/Physical Activity
•Adherence to Antipsychotic Medications for Individuals with Schizophrenia	•Childhood Immunization Status
•Antidepressant Medication Management	•Colorectal Cancer Screening
•Follow-Up After ED Visit for Alcohol and Other Drug Dependence	•Dental Sealants for Children ages 6-9
•Follow-Up After ED Visit for Mental Illness	•**Depression Remission at Twelve Months**
•Follow-Up After Hospitalization for Mental Illness	•**Depression Screening & Follow Up**
•Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder	•**Diabetes A1c or GMI>9 or Untested**
•**Diabetes A1c Control****	•HIV & Pregnant
•**Initiation and Engagement of Alcohol and Other Drug Dependence Treatment**	•HIV Linkage to Care
•Medication	•HIV Screening
•Patient Experience of Care Survey	•Hypertension Controlling High Blood Pressure
•Plan All-Cause Readmissions Rate	•**Initiation and Engagement of Substance Use Disorder Treatment****
•Use of Pharmacotherapy for Opioid Use Disorder	•IVD Aspirin Use
•Youth/Family Experience of Care Survey	•Statin Therapy
	•Tobacco Use Screening & Cessation
	•Screening for Social Drivers of Health – *available in Core DRVS*

Clinic & State Collected Measures | Reference

Clinic

- Time to Services
- Depression Remission at 6 mo.
- Preventive Care & Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- Screening for Social Drivers of Health (SDOH)
- Screening for Clinical Depression & Follow-Up Plan
- Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- Major Depressive Disorder: Suicide Risk Assessment
- Child & Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment
- Weight Assessment & Counseling for Nutrition & Physical Activity for Children/Adolescents
- Controlling High Blood Pressure

All available in DRVS except Time to Services

State

- Patient Experience of Care Survey
- Youth/Family Experience of Care Survey
- Antidepressant Mediation Management
- Use of Pharmacotherapy for Opioid Use Disorder
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia
- Plan All-Cause Readmissions Rate
- Follow-Up Care for Children Prescribed Attention-Deficit Hyperactivity Disorder (ADHD) Medication
- Hemoglobin A1c Control for Patients with Diabetes
- Initiation & Engagement of Alcohol & Other Drug Dependence Treatment
- Follow-Up After Emergency Department Visit for Mental Illness
- Follow-Up After Emergency Department Visit for Alcohol & Other Drug Dependence
- Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics
- Metabolic Monitoring for Children & Adolescents on Antipsychotics

[Quality Measures for Behavior Health Clinics - Technical Specifications and Resource Manual]

Behavioral Health Services Impact

MEASURE	RESULT	RESULT
Childhood Immunization Status (CMS 117v13)	28.5%	28.5%
Child Weight Assessment / Counseling for Nutrition / Physical Activity (CMS 155v13)	43.1%	64.6%
BMI Screening and Follow-Up 18+ Years (CMS 69v13)	74.8%	89.1%
Depression Remission at Twelve Months (CMS 159v13)	5.7%	10.7%
Screening for Depression and Follow-Up Plan (CMS 2v14)	73.5%	69.4%
Tobacco Use: Screening and Cessation (CMS 138v13)	58.1%	82.6%
Colorectal Cancer Screening (CMS 130v13)	39.0%	47.6%
Cervical Cancer Screening (CMS 124v13)	39.2%	51.7%
Breast Cancer Screening Ages 50-74 (CMS 125v13)	34.9%	45.7%
Hypertension Controlling High Blood Pressure (CMS165v13)	69.7%	70.1%
Diabetes A1c or GMI > 9 or Untested (CMS 122v13)	40.5%	39.5%
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (CMS 347v8)	82.9%	85.0%
Initiation of Substance Use Disorder Treatment (CMS137v13a)	27.9%	27.1%
Initiation and Engagement of Substance Use Disorder Treatment (CMS137v13b)	5.0%	5.7%
IVD Aspirin Use (CMS 164v7.2)	87.8%	88.9%
HIV and Pregnant	0.0%	0.0%
HIV Screening (CMS 349v7)	52.9%	70.9%
HIV Linkage to Care	20.0%	12.5%
Dental Sealants for Children between 6-9 Years (CMS 277v0)	81.1%	81.1%

Snapshot: 2025 UDS CQMs (as of March)
Comparing Performance Across Service Lines

Left Column:
- Includes **all service lines.**
- Reflects performance **with Behavioral Health included.**

Right Column:
- Excludes **Behavioral Health.**
- Isolates performance from **primary care, dental, and other services.**

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Behavioral Health | Future in DRVS

🚧 **Still in Motion:** Continued development and integration across teams.

🎓 **Staff Training:** Ongoing DRVS training for therapy, psychiatry, and support staff.

📏 **Measure Monitoring:** Department-specific tracking for services with clinical impact.

🗓️ **Patient Visit Planning (PVP):** Leverage for pre-scheduled services and team prep.

📋 **Care Management Passport (CMP):** Use for any patient to support whole-person care.

💊 **Controlled Substance Module:** Supports identification, monitoring, and follow-up for CS users.

🔍 **Workflow Review:** Analyze documentation patterns to spot gaps (missing consents or follow-ups).

✅ **Care Gap Closure:** Improved coordination for screenings, follow-ups, and chronic care.

The Sky is the Limit!!

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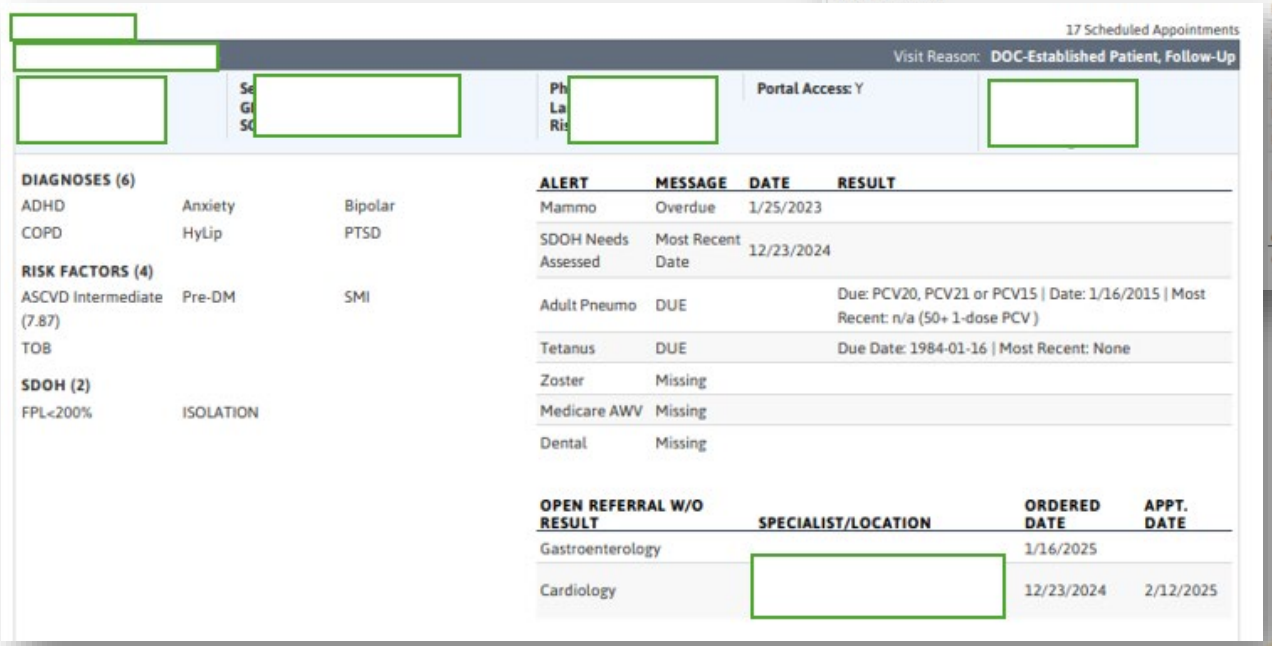
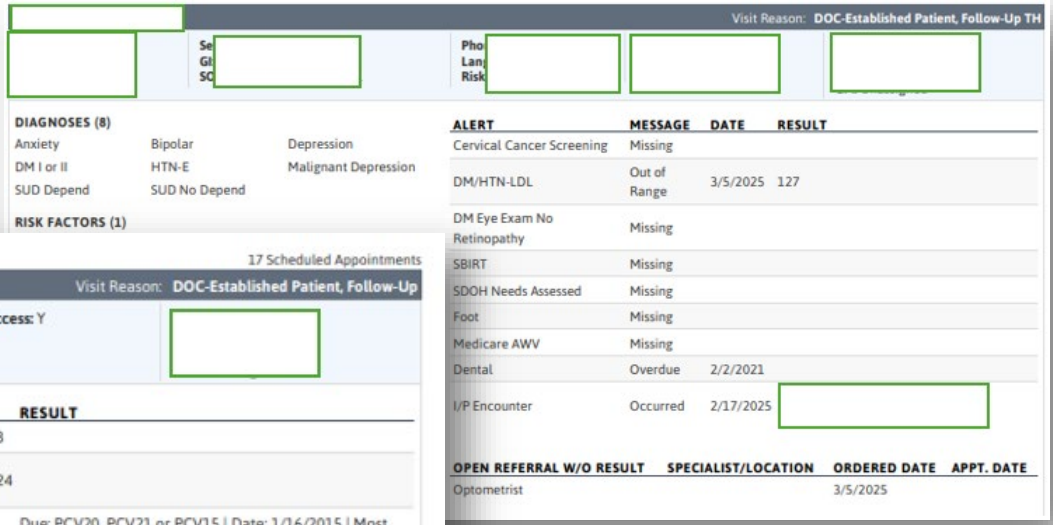
Pre-Visit Planning





Review current patient information beyond what is documented in the Behavioral Health EHR!

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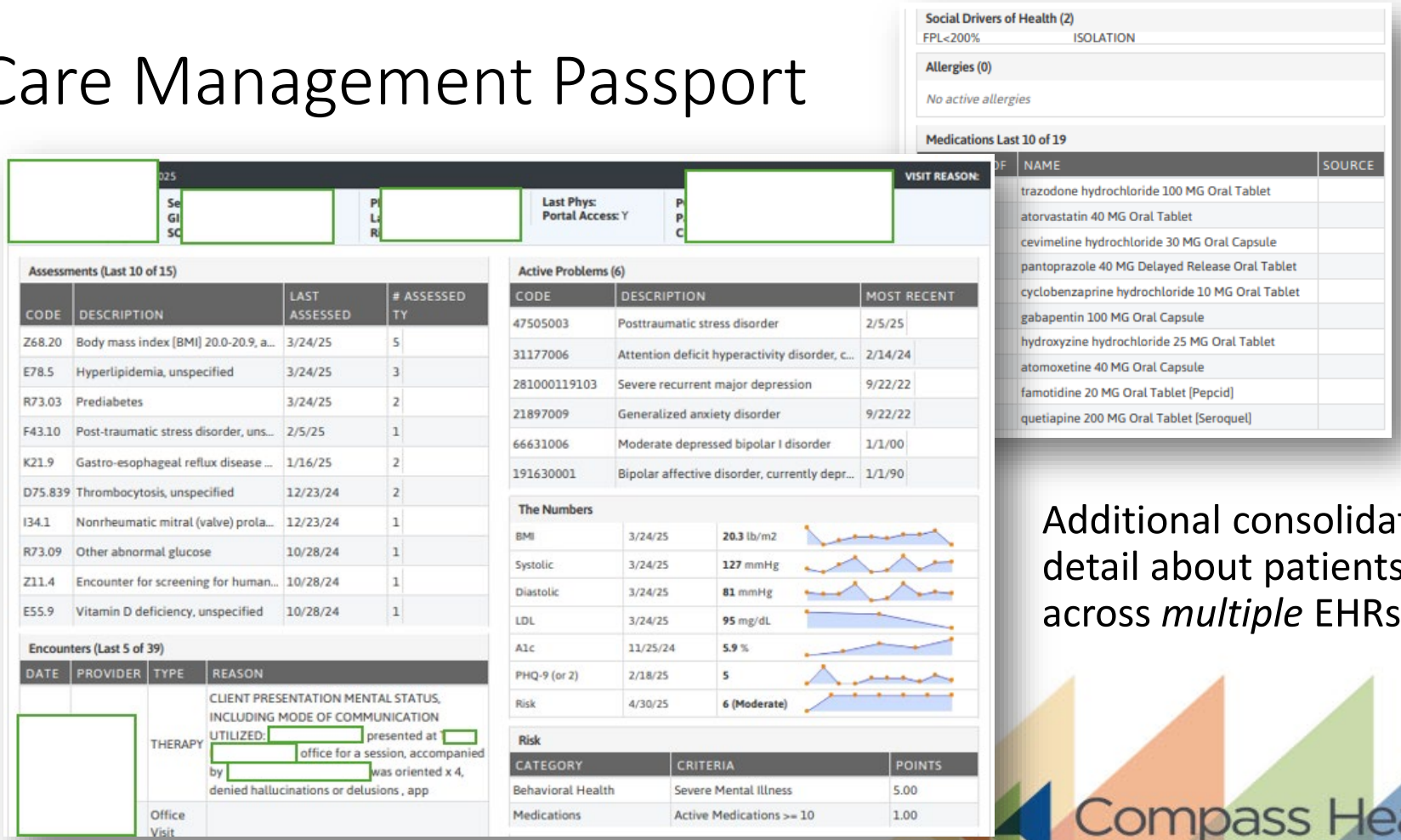
Care Management Passport



Social Drivers of Health (2)

FPL<200%	ISOLATION

Allergies (0)

No active allergies

Medications Last 10 of 19

NAME	SOURCE
trazodone hydrochloride 100 MG Oral Tablet	
atorvastatin 40 MG Oral Tablet	
cevimeline hydrochloride 30 MG Oral Capsule	
pantoprazole 40 MG Delayed Release Oral Tablet	
cyclobenzaprine hydrochloride 10 MG Oral Tablet	
gabapentin 100 MG Oral Capsule	
hydroxyzine hydrochloride 25 MG Oral Tablet	
atomoxetine 40 MG Oral Capsule	
famotidine 20 MG Oral Tablet [Pepcid]	
quetiapine 200 MG Oral Tablet [Seroquel]	

025 VISIT REASON:

Last Phys:
Portal Access: Y

Assessments (Last 10 of 15)

CODE	DESCRIPTION	LAST ASSESSED	# ASSESSED TY
Z68.20	Body mass index [BMI] 20.0-20.9, a...	3/24/25	5
E78.5	Hyperlipidemia, unspecified	3/24/25	3
R73.03	Prediabetes	3/24/25	2
F43.10	Post-traumatic stress disorder, uns...	2/5/25	1
K21.9	Gastro-esophageal reflux disease ...	1/16/25	2
D75.839	Thrombocytosis, unspecified	12/23/24	2
I34.1	Nonrheumatic mitral (valve) prola...	12/23/24	1
R73.09	Other abnormal glucose	10/28/24	1
Z11.4	Encounter for screening for human...	10/28/24	1
E55.9	Vitamin D deficiency, unspecified	10/28/24	1

Encounters (Last 5 of 39)

DATE	PROVIDER	TYPE	REASON
		THERAPY	CLIENT PRESENTATION MENTAL STATUS, INCLUDING MODE OF COMMUNICATION UTILIZED: presented at office for a session, accompanied by was oriented x 4, denied hallucinations or delusions , app
		Office Visit	

Active Problems (6)

CODE	DESCRIPTION	MOST RECENT
47505003	Posttraumatic stress disorder	2/5/25
31177006	Attention deficit hyperactivity disorder, c...	2/14/24
281000119103	Severe recurrent major depression	9/22/22
21897009	Generalized anxiety disorder	9/22/22
66631006	Moderate depressed bipolar I disorder	1/1/00
191630001	Bipolar affective disorder, currently depr...	1/1/90

The Numbers

BMI	3/24/25	**20.3** lb/m2
Systolic	3/24/25	**127** mmHg
Diastolic	3/24/25	**81** mmHg
LDL	3/24/25	**95** mg/dL
A1c	11/25/24	**5.9** %
PHQ-9 (or 2)	2/18/25	**5**
Risk	4/30/25	**6 (Moderate)**

Risk

CATEGORY	CRITERIA	POINTS
Behavioral Health	Severe Mental Illness	5.00
Medications	Active Medications >= 10	1.00

Additional consolidated detail about patients from across *multiple* EHRs.

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Behavioral Health in DRVS

Tools to Support Primary Care & Behavioral Health Integration

Building HIT Capacity to Meet CCBHC Requirements

Purpose of HIT in CCBHCs

- Empower person and family-centered recovery-oriented care.
- Improve coordination across physical, behavioral, & community services.
- Track outcomes, close care gaps, & enhance quality of care.

Core HIT Capabilities Required by SAMHSA

- EHRs with ONC certification.
- Clinical decision support, e-prescribing & API-enabled patient access.
- Secure information exchange for care transitions (e.g., ADT feeds).

HIT Must Support These CCBHC Functions

- 24/7 crisis access & service delivery continuity.
- Real-time data sharing with Designated Collaborating Organizations (DCOs).
- Routine triage, risk assessment, treatment planning, & documentation.
- Ongoing evaluation, data protection & system resilience (e.g., disaster recovery).

Getting Started

- Conduct a HIT readiness assessment.
- Identify current gaps & future needs.
- Engage clinical, IT, and administrative stakeholders early.

https://www.thenationalcouncil.org/resources/health-information-technology-hit-for-ccbhcs-toolkit/

Priority HIT Areas to Drive CCBHC Impact

1. **Care Delivery**
   a. Leverage decision support & templates to guide evidence-based care.
   b. Integrate measurement-informed care to track progress & adjust in real time.
2. **Care Coordination**
   a. Enable collaborative treatment planning & referral tracking.
   b. Utilize care dashboards & alerts for proactive, person-driven care.
3. **Health Information Exchange (HIE)**
   a. Share critical data across care settings to reduce duplication & improve safety.
   b. Use ADT feeds to manage transitions & flag follow-up needs.
4. **Population Health Management**
   a. Identify disparities and underserved populations.
   b. Use SDOH & outcomes data to inform strategy & outreach.
5. **Quality & Funder Reporting**
   a. Extract and report on required quality measures (eCQMs/CQMs).
   b. Support continuous quality improvement through real-time dashboards.

https://www.thenationalcouncil.org/resources/health-information-technology-hit-for-ccbhcs-toolkit/

Behavioral Health in DRVS for CCBHC

CCBHC MEASURES

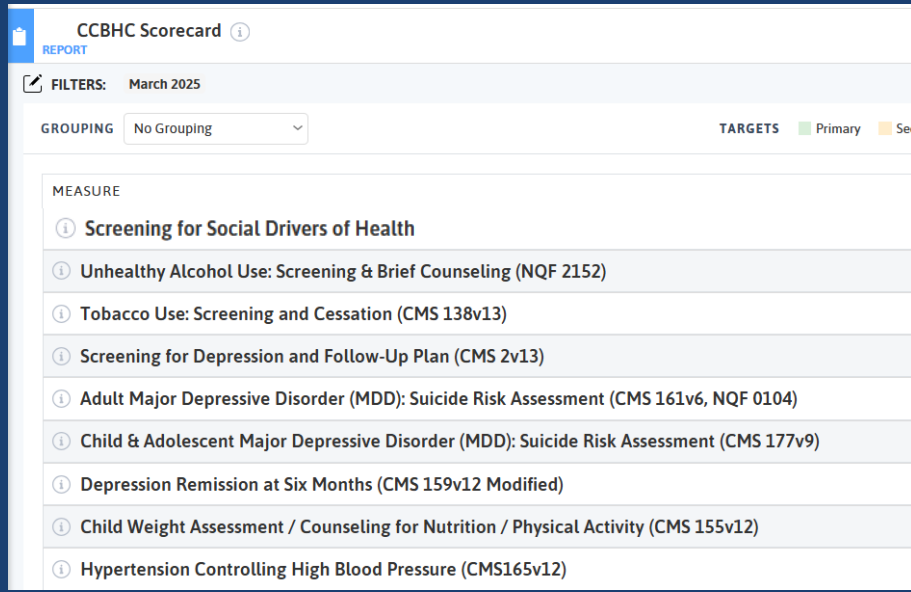
CCBHCs are required to report both state-collected and clinic-collected measures to SAMHSA.
DRVS supports, the **clinic-collected measures*.** It does not currently include the Time to Services (I-SERV measure).

CLINIC-COLLECTED MEASURES SUPPORTED IN DRVS

1. Screening for Social Drivers of Health -SDOH NEW
2. Unhealthy Alcohol Use: Screening & Brief Counseling (NQF 2152)
3. Tobacco Use Screening & Cessation (CMS138v12)
4. Screening for Clinical Depression and Follow-Up Plan (CMS2v12)
5. MDD Suicide Risk Assessment (CMS 161v6, NQF 0104)
6. Child & Adolescent Suicide Risk Assessment (CMS 177v9)
7. Depression Remission at Six Months (CMS 159v12 Modified)
8. Child Weight Assessment (CMS155v11)
9. HTN Controlling High BP (CMS 165v12)

CCBHC SCORECARD

The DRVS CCBHC clinic-collected measures can be viewed via the **CCBHC Scorecard****. With the Flexible Home Screen, users can set this scorecard as the default allowing you see the high-level measure results as soon as you log into DRVS.



CCBHC Population Identification - COHORTs

Location and Provider groupings can be used to identify your CCBHC only patients. This will allow you to report on just CCBHC patients and exclude those same patients from UDS reporting. In cases where this does not meet the practice needs, a custom dynamic cohort may be required to properly segment the CCBHC population.

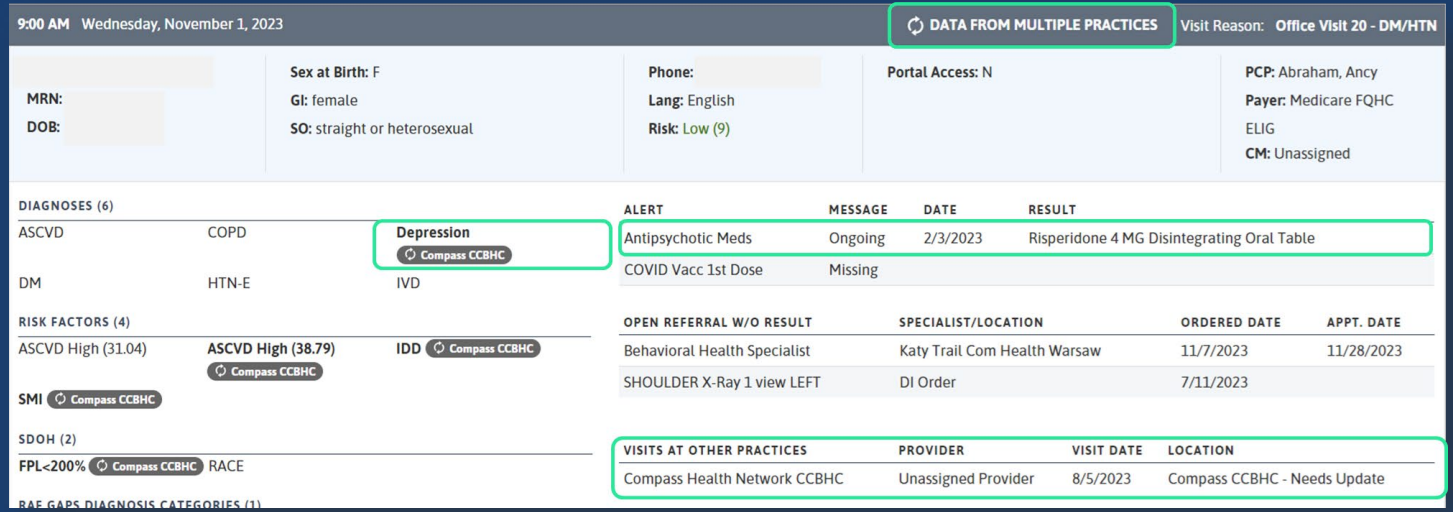
**CCBHC clinic-collected measures use the standard method for determining qualifying encounters as other standard CQMs in DRVS.*
***Must request from Support.*

Behavioral Health in DRVS for CCBHC

SHARED DATA

Access pertinent patient health information by connecting with a partnered center's EMR* (i.e., if you partner with a separate organization to provide your primary care services) to view data like patient medications or diagnoses that are not documented in *your* EMR.

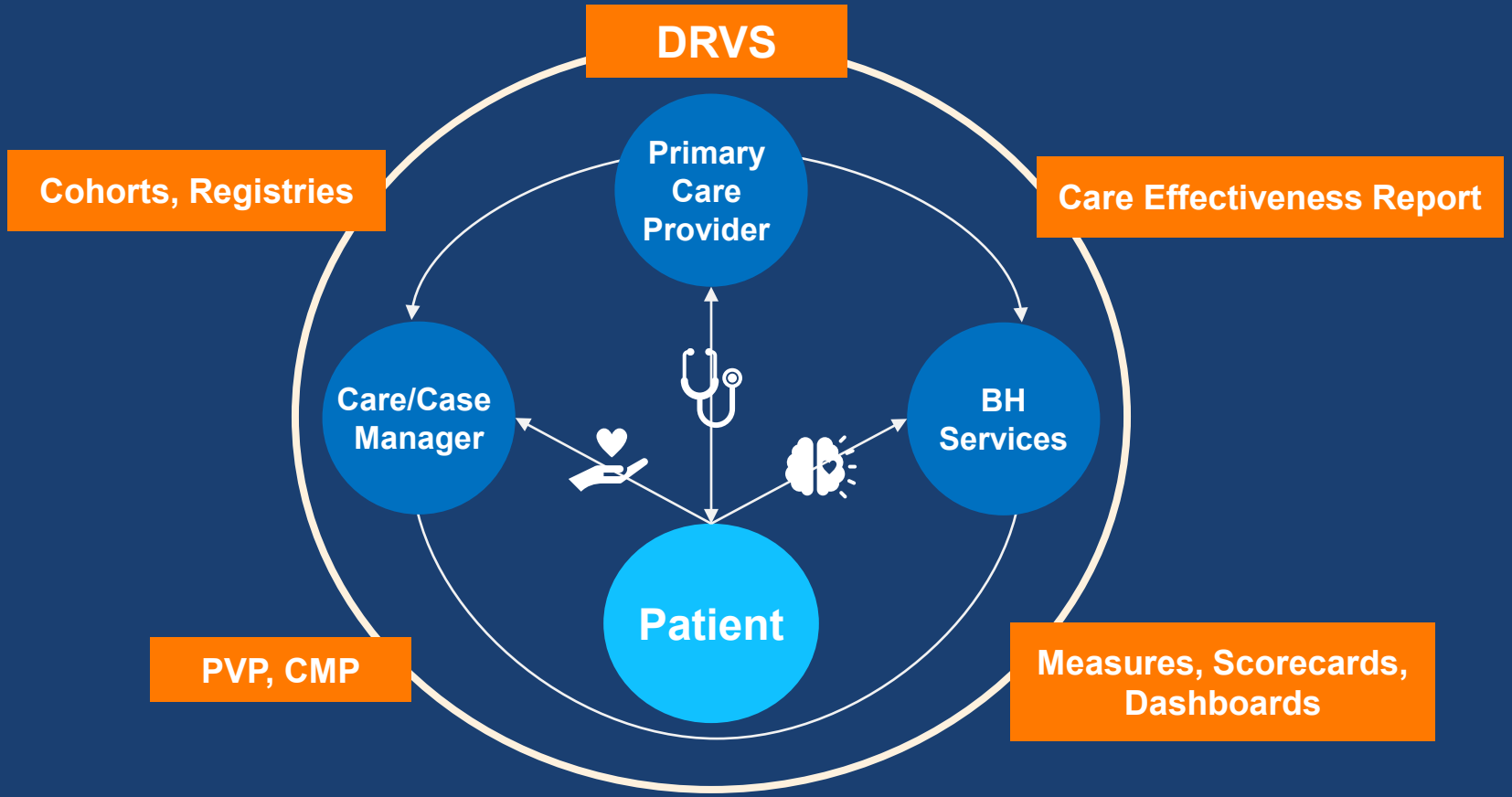
Indicators on the PVP, CMP, and ACC-CM help you **easily distinguish shared data** that come from your partnered practice.



*Requires separate data sharing agreement and implementation

Integrated behavioral health care blends care for **medical** conditions and related **behavioral health** factors that affect health and well-being **into one setting.**

Integrated Behavioral Health Care



https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care/learn

Stages of BH & PC Integration

1

Screening & Enhanced Referral

2

Care Management and Consultation

3

Comprehensive Treatment and Population Management

Collaborative Care Team Structure

Primary Care Provider (PCP)

- Primary treatment relationship
- Links with Collaborative Care Model team
- Prescribes medication
- Monitors medication, management, together with BH care manager
- Supports treatment plan
- Consults with care team
- Supports system change

Behavioral Health Care Manager (BHCM)

- Track and coordinate care
  - Facilitates patient engagement
  - Performs systematic initial and follow-up assessments
  - Systematically tracks treatment response
  - Supports treatment plan with PCP
  - Reviews challenging patients with psychiatric consultant weekly
- Evidence-based brief behavioral interventions
  - Problem solving treatment (PST)
  - Behavioral Activation
- Other functions
  - General BH interventions
  - Address Substance use
  - Social work services

Psychiatric Consultant

- Review cases with BHCM using the registry
  - Scheduled (ideally weekly)
  - Prioritize patients not improving
- Consult urgently (as needed) with PCP or BHCM

Integrated Care Team Roles

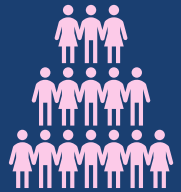
Role	Responsibilities
Nurse Care Manager – FQHC	• Serve persons with co-occurring conditions • Provide routine health screenings
SU/MI Professional – FQHC	• Serve persons with co-occurring conditions • Provide screenings, assessments and care management to persons and have ability to connect individuals to needed services
Certified Peer Support Specialist	• Co-located between SUD program and FQHC • Provide both mental health peer support and recovery coaching
Nurse Care Manager – SUD	• Integrate physical health care into continuum of services • Provide routine health screenings • Population managed: clients served by SUD treatment program
Care Coordinator – SUD	• Integrate physical care into continuum of services • Coordinate services, complete evaluation activities, perform GPRA and collection of IPP (infrastructure development, prevention and mental health promotions) data • Population managed: clients served by SUD treatment program

DRVS Tools To Support Integration

Point of Care

Population Health

Performance Management



Patient Visit Planning Report

7:15 AM Tuesday, April 16, 2024 — **Visit Reason:** **EXT-DIABET Diabetic w/ fasting labs**

Sex at Birth: F
GI:
SO: straight or heterosexual

Phone:
Lang: English
Risk: Low (8)

Portal Access: Y

DIAGNOSES (4)

Anxiety	Depression	DM
HTN-E		

RISK FACTORS (1)

TOB

SDOH (1)

RACE

RAF GAPS DIAGNOSIS CATEGORIES (3)

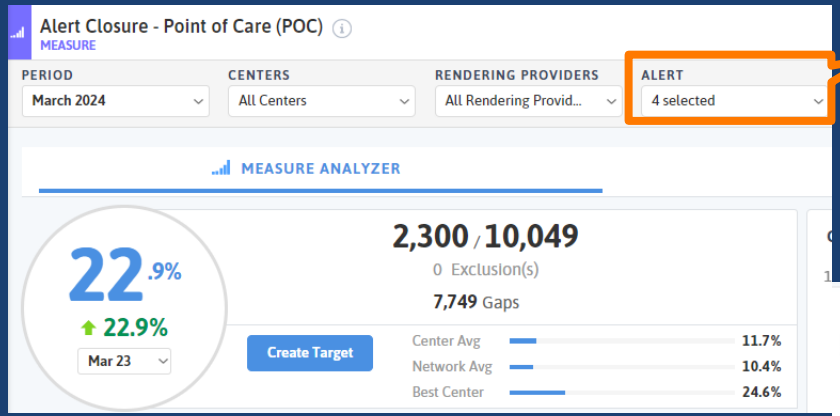
Cardiovascular	Psychiatric	Diabetes

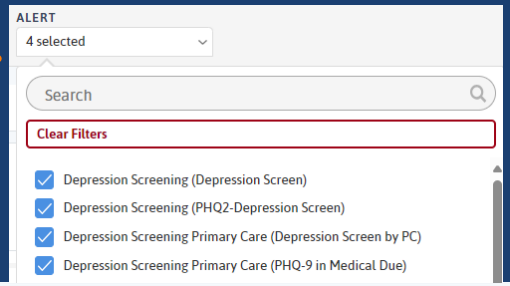
ALERT	MESSAGE	DATE	RESULT
Colon CA 45+	Overdue	4/7/2023	Negative
Hep C - Baby Boomer	Missing		
Drug Screening	Overdue	1/16/2023	
SBIRT	Overdue	1/16/2023	0
Flu - Seasonal	Overdue	9/2/2020	
Statin Rx	Missing		DM
Preventive Care Visit	Overdue	7/8/2022	
Well Visit 19+	Overdue	7/8/2022	
Anxiety Screen w/Dx	Missing		

Alerts | Depression

Alert	Description
Depression Remission	Alert will trigger if patient has a diagnosis of depression or dysthymia and has not had a follow-up PHQ9, or has had a follow-up PHQ9 >=5. Alert will begin firing 1 month before the follow-up period starts (i.e., 9 mo. After the initial screen), and will be capped by 12 months after the follow-up period closes (i.e., 26 mo. After initial screen). This alert is not configurable.
Depression Screen with Diagnosis	Alert will trigger if Depression Screen has not occurred in the last 1 year. Alert only applies to patients >12 yrs old. Patients must have active diagnosis of Depression. This alert is not configurable.
Depression Screening	Alert will trigger if Depression Screen Result has not occurred in the last 1 years. Alert only applies to patients >=12 yrs old. Patient must not have Depression Screen Refused or Depression Screen Contraindicated or Depression or Bipolar Dx.
Depression Screening Follow-up	Alert will trigger if patient had positive depression screen results AND had a qualifying encounter on the same day of or within 14 days after the positive screening AND had no depression follow-up performed on the same day of the encounter. Patient must not have Depression/Bipolar. This alert is not configurable

POC Alert Closure Measure

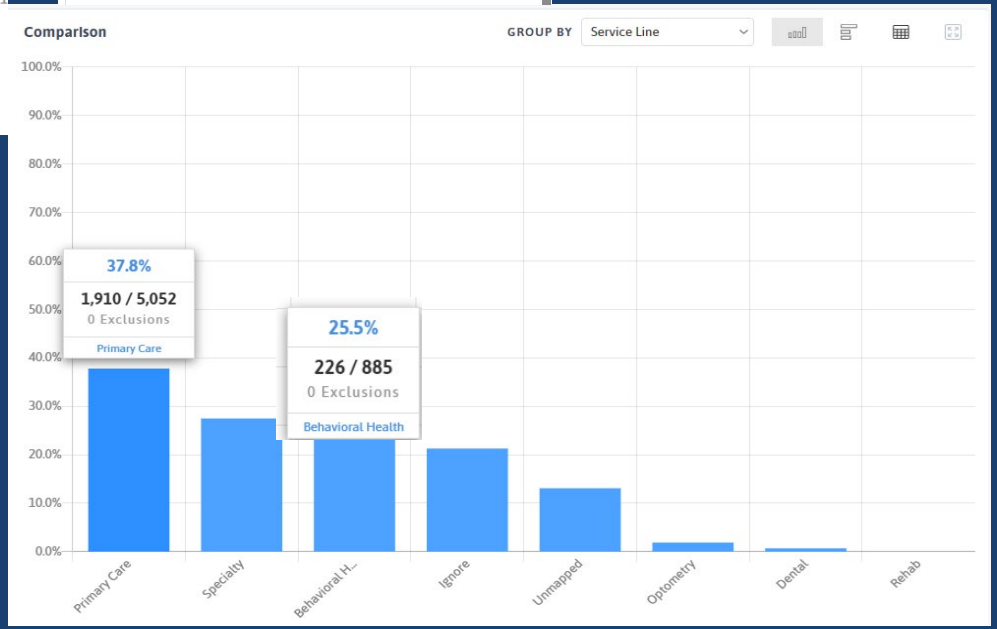




How effective are care teams in **closing care gaps**?

How are **new/enabled** alerts being **closed**?

Are care teams **across service lines** closing gaps?



Alerts | PHQ9

Alert	Description
PHQ-9 Follow-Up	Alert will trigger if a patient PHQ-9 screen is >=10 and there is no follow-up on the same day as the positive screening. Patient must not have Depression/Bipolar. This alert is not configurable.
PHQ-9 Screen	Alert will trigger if PHQ-9 Depression Screen has not occurred in the last 1 years. Alert only applies to patients >=12 yrs old. Patient must not have Depression or Bipolar Dx.
PHQ-9 Utilization	Alert will trigger if a patient has a diagnosis of depression or dysthymia and has not completed a PHQ9 during each applicable 3 month period in which there was a qualifying visit. This alert is not configurable.
Positive PHQ-9 Follow-Up	Alert will trigger for patients age >=18 with a diagnosis of depression whose last PHQ9 was positive and was over 90 days to 1 year old, but has not had a recurrent PHQ9 to follow up. This alert is not configurable.

Alerts | Behavioral Health

Alert	Description
Diabetes Screen – Antipsychotics	Alert will trigger if A1C has not occurred in the last 1 years. Patient must have Antipsychotic Medications. Patient must not have Palliative Care or hospice care.
Metabolic Monitoring – Antipsychotics	Alert will trigger for patients prescribed an antipsychotic medication in the last year who have not had metabolic testing (CMP, TSH, CBC w/dif AND LDL) within the last 12 months. This alert is not configurable.
Anxiety Screen	Alert will trigger if Anxiety Screen has not occurred in the last 1 years. Alert only applies to patients >=18 yrs old. Patient must not have Anxiety,
Anxiety Screen with Diagnosis	Alert will trigger if GAD-7 Score has not occurred in the last 1 years. Alert only applies to patients >=16 yrs old. Patient must have Anxiety.

Alerts | Suicide Assessments

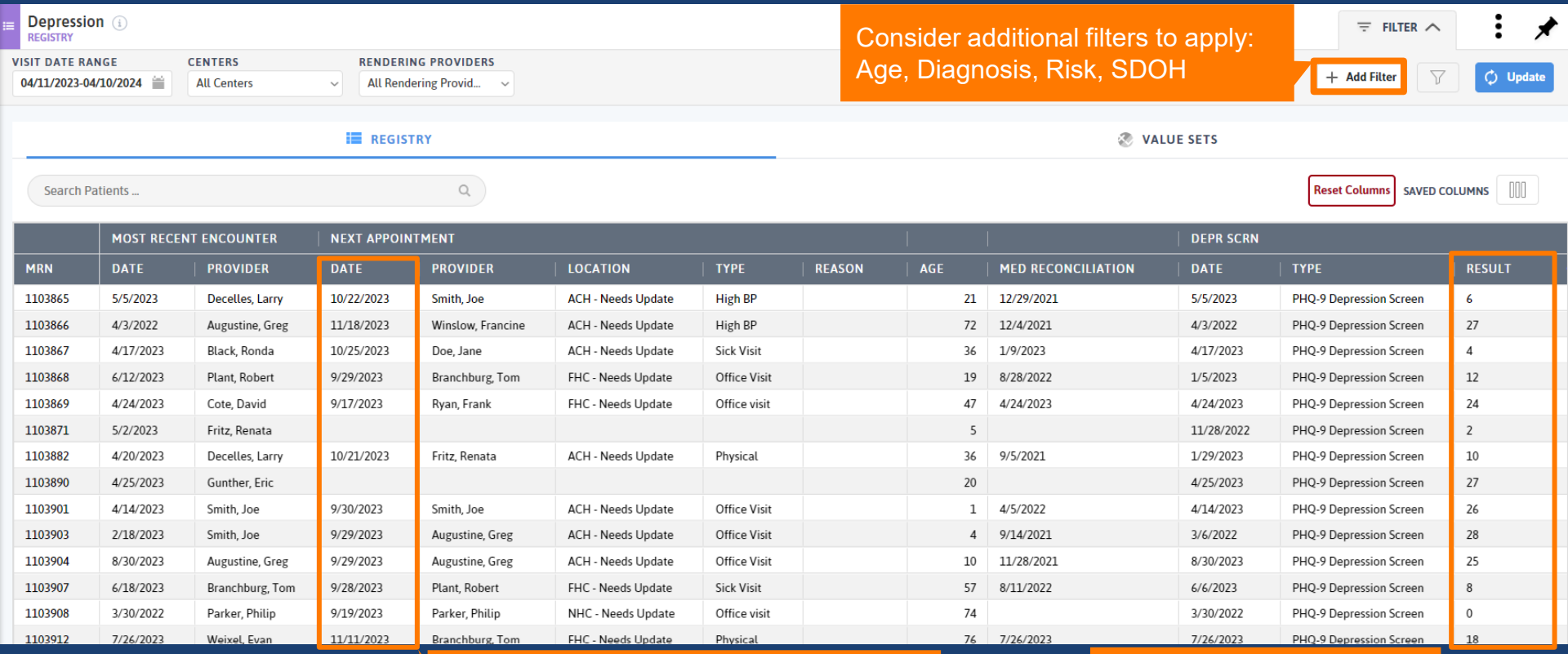
Alert	Description
MDD Suicide Risk Assessment	Alert will trigger if Suicide Risk Assessment has not occurred in the last 0 days. Alert only applies to patients >=6 yrs old and <=17 yrs old. Patient must have Major Depressive Disorder.
Suicide Risk Assessment Ages 10-17	Alert will trigger if Suicide Risk Assessment has not occurred in the last 6 months. Alert only applies to patients >=10 yrs old and <=17 yrs old. Patient must have Suicide Risk Assessment.
Suicide Risk Assessment Ages 18+	Alert will trigger if Suicide Risk Assessment has not occurred in the last 1 years. Alert only applies to patients >=18 yrs old. Patient must have Suicide Risk Assessment.

Registry Use Cases | Tip of the Iceberg

- Identify **patients due** for depression screening (and/or follow-up)
- Identify patients with **chronic condition**(s) AND **behavioral health diagnoses** (or PHQ-9 score)
- Identify patients **seen by both** primary care and behavioral health
- Track patients' **clinical outcomes**: A1C, BP, PHQ-9, GAD-7,...
- Stratify patients for **care coordination** and/or for **care management**

More information about Registries

Registry | Depression (stock)



Consider additional filters to apply:
Age, Diagnosis, Risk, SDOH

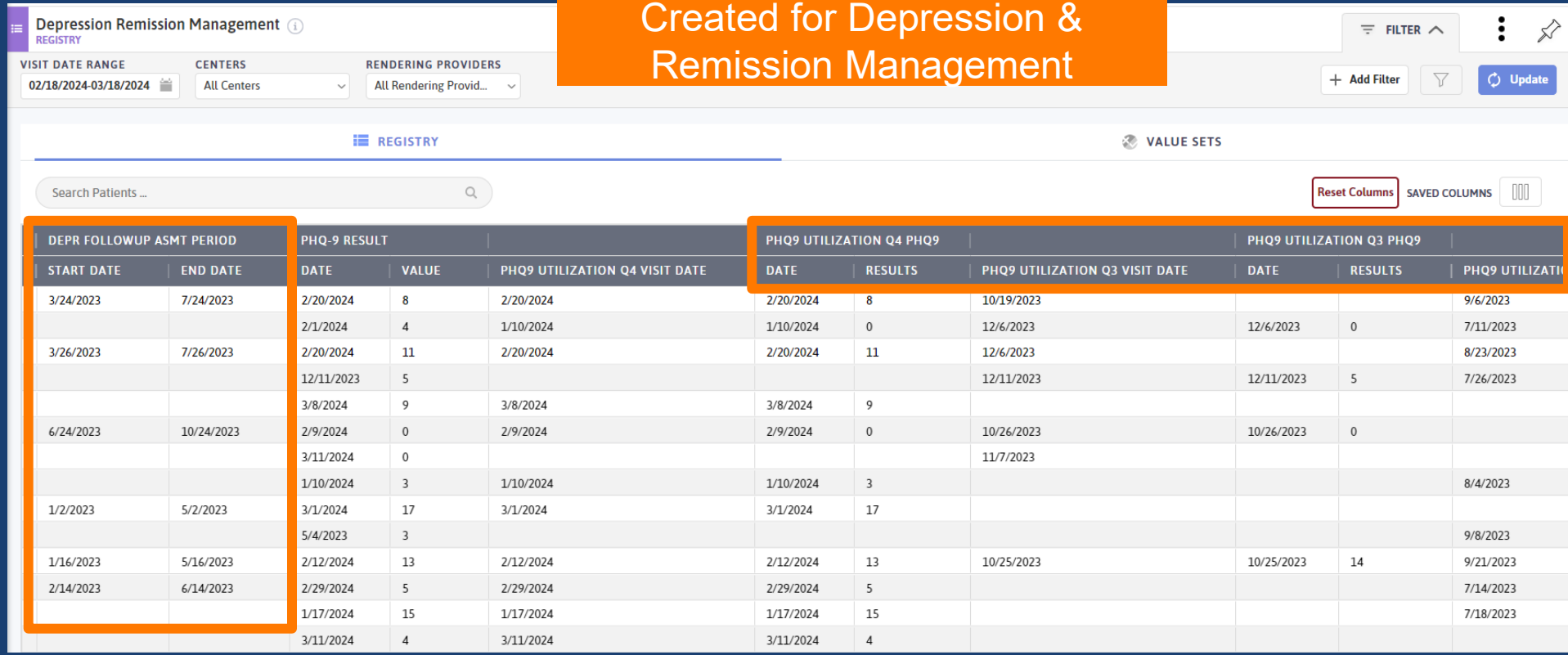
	MOST RECENT ENCOUNTER		NEXT APPOINTMENT							DEPR SCRN		
MRN	DATE	PROVIDER	DATE	PROVIDER	LOCATION	TYPE	REASON	AGE	MED RECONCILIATION	DATE	TYPE	RESULT
1103865	5/5/2023	Decelles, Larry	10/22/2023	Smith, Joe	ACH - Needs Update	High BP		21	12/29/2021	5/5/2023	PHQ-9 Depression Screen	6
1103866	4/3/2022	Augustine, Greg	11/18/2023	Winslow, Francine	ACH - Needs Update	High BP		72	12/4/2021	4/3/2022	PHQ-9 Depression Screen	27
1103867	4/17/2023	Black, Ronda	10/25/2023	Doe, Jane	ACH - Needs Update	Sick Visit		36	1/9/2023	4/17/2023	PHQ-9 Depression Screen	4
1103868	6/12/2023	Plant, Robert	9/29/2023	Branchburg, Tom	FHC - Needs Update	Office Visit		19	8/28/2022	1/5/2023	PHQ-9 Depression Screen	12
1103869	4/24/2023	Cote, David	9/17/2023	Ryan, Frank	FHC - Needs Update	Office visit		47	4/24/2023	4/24/2023	PHQ-9 Depression Screen	24
1103871	5/2/2023	Fritz, Renata						5		11/28/2022	PHQ-9 Depression Screen	2
1103882	4/20/2023	Decelles, Larry	10/21/2023	Fritz, Renata	ACH - Needs Update	Physical		36	9/5/2021	1/29/2023	PHQ-9 Depression Screen	10
1103890	4/25/2023	Gunther, Eric						20		4/25/2023	PHQ-9 Depression Screen	27
1103901	4/14/2023	Smith, Joe	9/30/2023	Smith, Joe	ACH - Needs Update	Office Visit		1	4/5/2022	4/14/2023	PHQ-9 Depression Screen	26
1103903	2/18/2023	Smith, Joe	9/29/2023	Augustine, Greg	ACH - Needs Update	Office Visit		4	9/14/2021	3/6/2022	PHQ-9 Depression Screen	28
1103904	8/30/2023	Augustine, Greg	9/29/2023	Augustine, Greg	ACH - Needs Update	Office Visit		10	11/28/2021	8/30/2023	PHQ-9 Depression Screen	25
1103907	6/18/2023	Branchburg, Tom	9/28/2023	Plant, Robert	FHC - Needs Update	Sick Visit		57	8/11/2022	6/6/2023	PHQ-9 Depression Screen	8
1103908	3/30/2022	Parker, Philip	9/19/2023	Parker, Philip	NHC - Needs Update	Office visit		74		3/30/2022	PHQ-9 Depression Screen	0
1103912	7/26/2023	Weixel, Evan	11/11/2023	Branchburg, Tom	FHC - Needs Update	Physical		76	7/26/2023	7/26/2023	PHQ-9 Depression Screen	18

Do patients have a next appt scheduled?
Identify for outreach

When was their last phq-9?
What was the score?

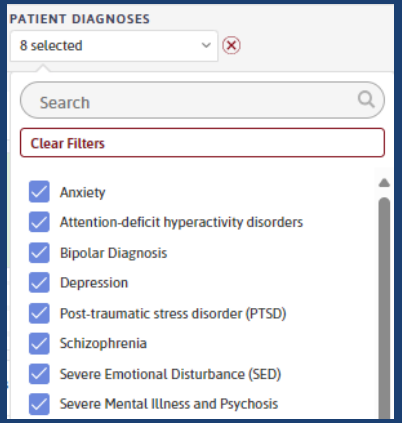
Registries | Customize by Use + Role

Created for Depression & Remission Management

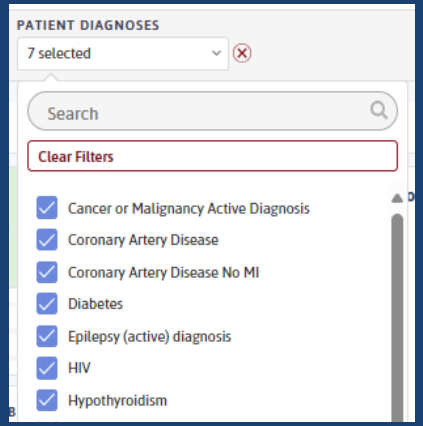


DEPR FOLLOWUP ASMT PERIOD		PHQ-9 RESULT			PHQ9 UTILIZATION Q4 PHQ9			PHQ9 UTILIZATION Q3 PHQ9		
START DATE	END DATE	DATE	VALUE	PHQ9 UTILIZATION Q4 VISIT DATE	DATE	RESULTS	PHQ9 UTILIZATION Q3 VISIT DATE	DATE	RESULTS	PHQ9 UTILIZATI
3/24/2023	7/24/2023	2/20/2024	8	2/20/2024	2/20/2024	8	10/19/2023			9/6/2023
		2/1/2024	4	1/10/2024	1/10/2024	0	12/6/2023	12/6/2023	0	7/11/2023
3/26/2023	7/26/2023	2/20/2024	11	2/20/2024	2/20/2024	11	12/6/2023			8/23/2023
		12/11/2023	5				12/11/2023	12/11/2023	5	7/26/2023
		3/8/2024	9	3/8/2024	3/8/2024	9				
6/24/2023	10/24/2023	2/9/2024	0	2/9/2024	2/9/2024	0	10/26/2023	10/26/2023	0	
		3/11/2024	0				11/7/2023			
		1/10/2024	3	1/10/2024	1/10/2024	3				8/4/2023
1/2/2023	5/2/2023	3/1/2024	17	3/1/2024	3/1/2024	17				
		5/4/2023	3							9/8/2023
1/16/2023	5/16/2023	2/12/2024	13	2/12/2024	2/12/2024	13	10/25/2023	10/25/2023	14	9/21/2023
2/14/2023	6/14/2023	2/29/2024	5	2/29/2024	2/29/2024	5				7/14/2023
		1/17/2024	15	1/17/2024	1/17/2024	15				7/18/2023
		3/11/2024	4	3/11/2024	3/11/2024	4				

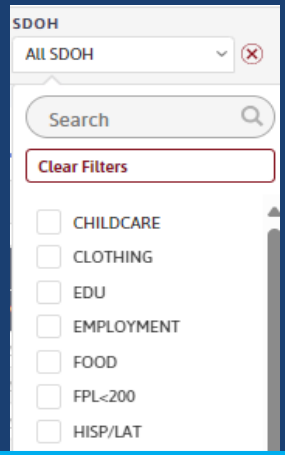
Filters to Layer Across DRVS



Patient Diagnosis Filter for **Behavioral Health Dx**



Patient Diagnosis Filter for **Chronic Condition Dx**



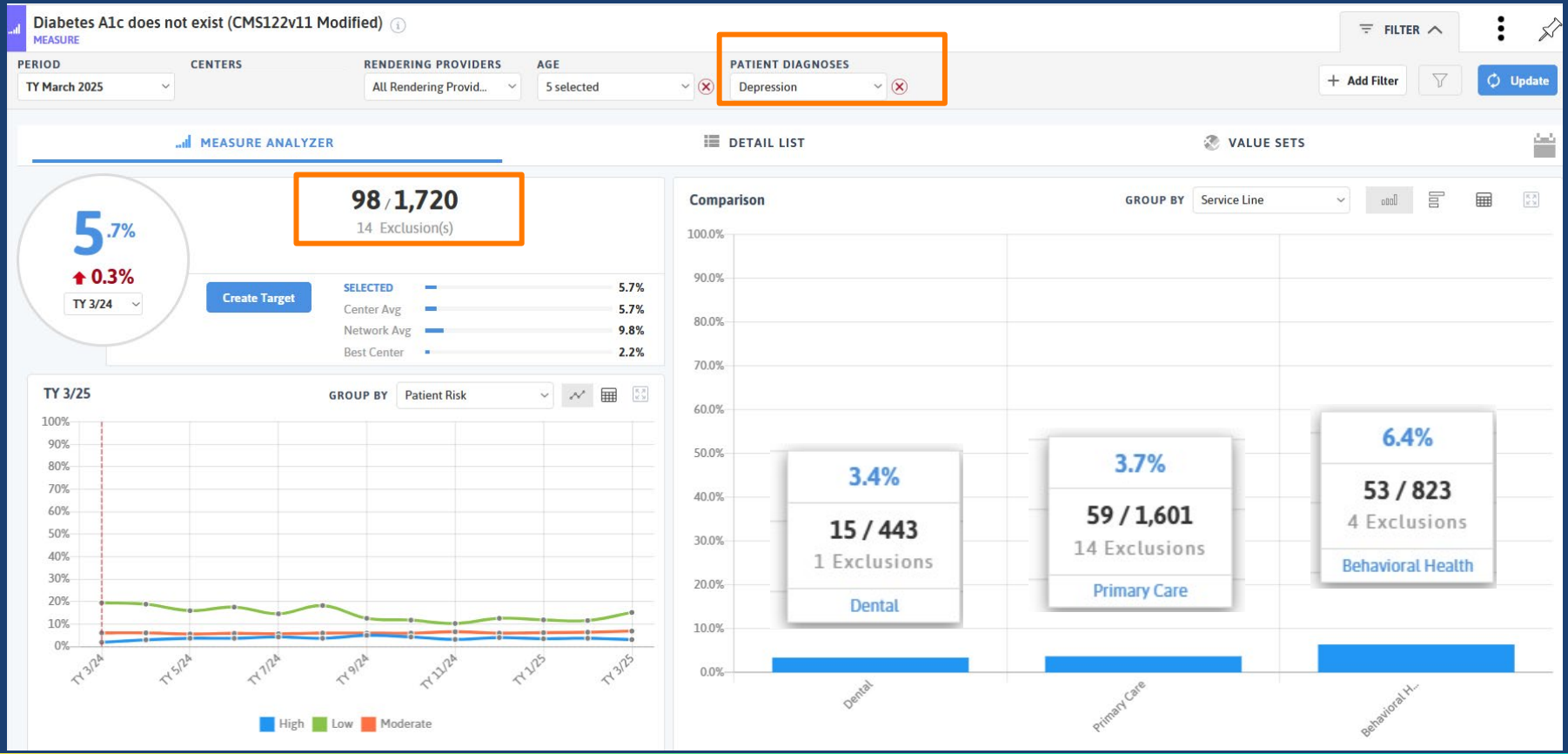
Filter for **SDOH** factors

A1C & Depression

Managing multiple conditions requires self care on the part of the person; Depression can make A1C Control more difficult

>40% of A1C >9 or untested

A1C Untested & Depression Dx



Patient Risk Stratification

DASHBOARD

PERIOD: TY March 2024 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | SERVICE LINES: Primary Care | PATIENT DIAGNOSES: Depression | Update

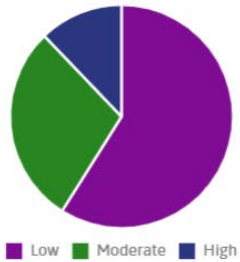
Apply Depression as DX Filter to Risk Dashboard

Understand the prevalence of various chronic conditions amongst pts with depression

Risk Criteria Weighting

DIAGNOSES	PATIENT COUNT	PREVALENCE	% RI	
Diabetes	3,929	14%		
Hypertension	8,869	32%		
Hyperlipidemia	7,700	28%		
ASCVD	1,622	6%		
CHF	773	3%	57%	3
CAD	1,077	4%	50%	2
Ischemic Stroke	333	1%	43%	2
Hemorrhagic Stroke	51	0%	43%	2
IVD	1,378	5%	45%	1
Afib	737	3%	52%	3
Persistent Asthma	1,160	4%	27%	2
COPD	2,195	8%	39%	2
Chronic NonMalignant Pain	6,276	23%	23%	1
Cirrhosis	341	1%	39%	2
CKD Stages 3&4	733	3%	36%	1
CKD Stage 5	33	0%	61%	2
ESRD	53	0%	55%	2

ory Distribution



High Risk Patients

3,357

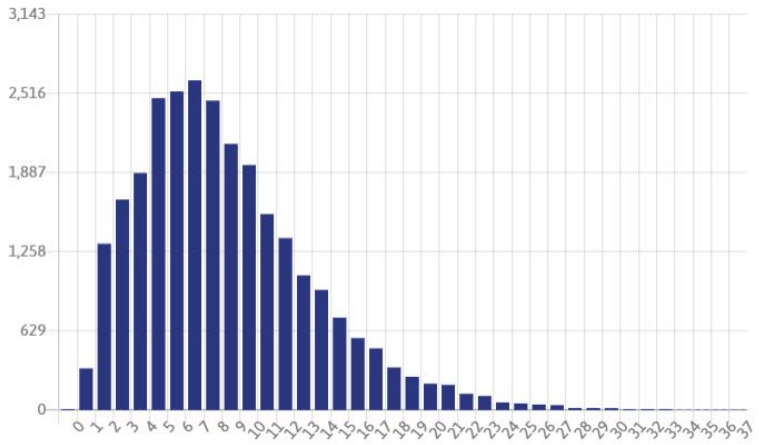
Pts w/ qualifying encounter

Total Patients

27,605

Pts w/ qualifying encounter

Risk Score Distribution



Risk Score Thresholds

Geriatric (65-149)

CATEGORY	# PATIENTS	PREVALENCE	THRESH
High	637	12%	18.00
Moderate	1,507	29%	12.00
Low	3,081	59%	0

Adult (22-64)

CATEGORY	# PATIENTS	PREVALENCE	THRESH
High	2,030	11%	15.00
Moderate	4,595	24%	10.00
Low	12,637	66%	0

Pediatric (0-21)

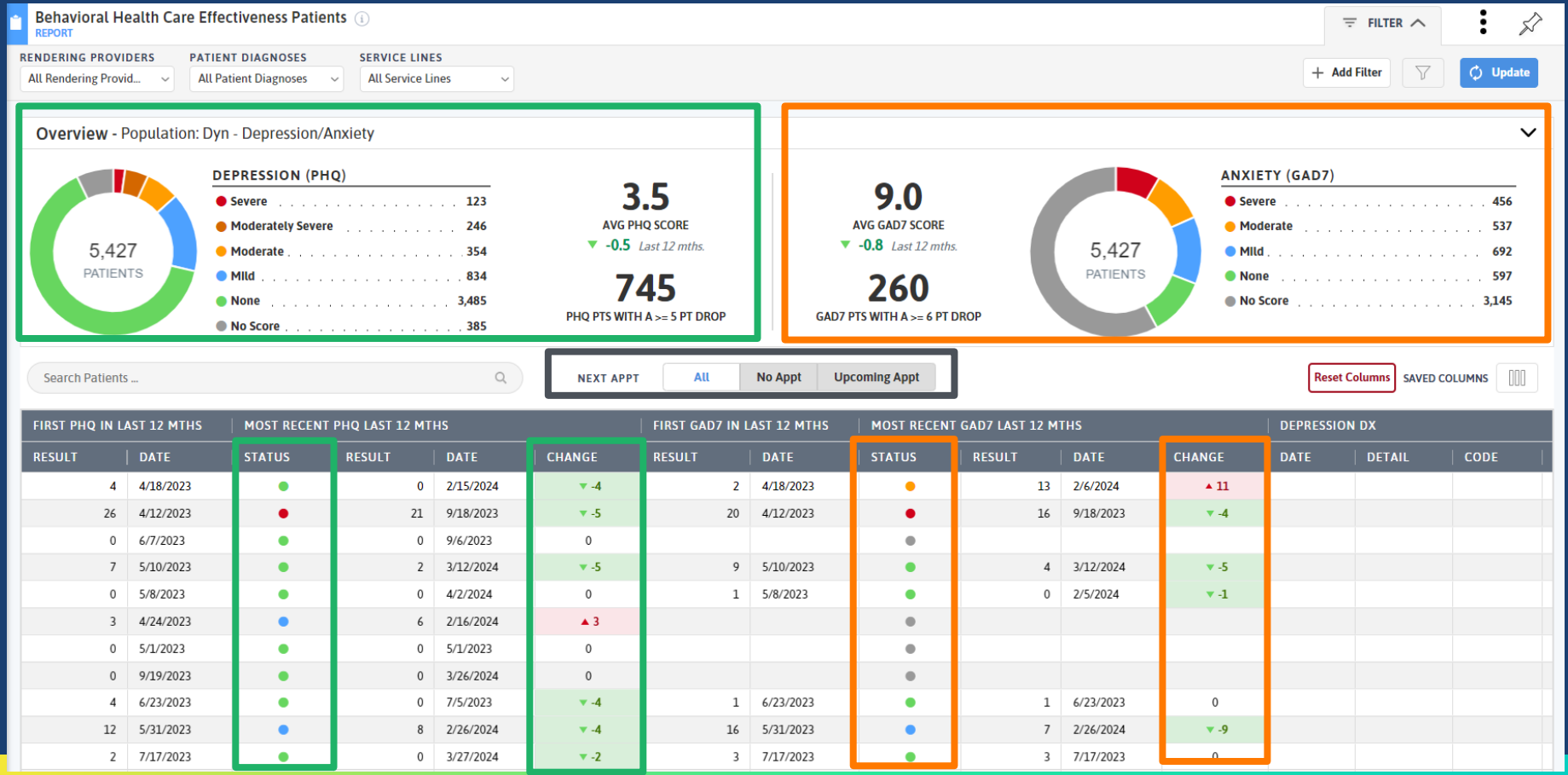
CATEGORY	# PATIENTS	PREVALENCE	THRESH
High	690	22%	10.00
Moderate	1,873	60%	6.00
Low	547	18%	0

Rising Risk Patients

329

Pts w/ New High Risk Level

Monitor Workflows Through Metrics



Monitor Operations Through Measures

- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 161v16)
- Anxiety Screening for Adults with Anxiety Diagnosis
- Diabetes Screening – Antipsychotics
- Depression Remission at Twelve Months (CMS159v11)
- Child & Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (CMS 177v9)
- Screening for Depression & Follow-Up Plan (CMS 2v12)
- Depression Screen – Adolescents with Depression
- Depression Screen – Adults with Depression
- Depression Utilization of the PHQ-9 Tool (CMS 160v6)
- Antidepressant Medication Management – Effective Acute Phase Treatment
- Antidepressant Medication Management – Effective Continuation Phase Treatment

Create **custom scorecards** with any collection of measures

Monitor Operations Through Measures

- Screening for Depression & Follow-Up Plan 12-17 yrs (CMS 2v12 Modified)
- Screening for Depression & Follow-Up Plan 18+ years (CMS 2v12 Modified)
- Depression Screen – Positive Result (CMS 2v12 Modified)
- Depression Screen Positive w/Follow-Up (CMS 2v12 Breakout)
- Screening for Depression (CMS 2v12 Modified)
- Annual Anxiety Screen 8+
- Metabolic Testing – Antipsychotics

Create **custom scorecards** with any collection of measures

Wrap Up

Resources/Links

- **CCBHC vs CMH**
  - https://klrd.org/publications/briefing-book-2022/differences-between-community-mental-health-centers-and-certified-community-behavioral-health-clinics/
- **National Council for Mental Wellbeing**
  - About Us - National Council for Mental Wellbeing (thenationalcouncil.org)
- **CCBHC Demonstration Program**
  - Certified Community Behavioral Health Clinics Demonstration Program (hhs.gov)
- **SAMHSA - CCBHCs**
  - Certified Community Behavioral Health Clinics (CCBHCs) | SAMHSA
- **2022 CCBHC Impact Report**
  - 2022-CCBHC-Impact-Report.pdf
- **CCBHC Measures**
  - CCBHC Measures.pdf

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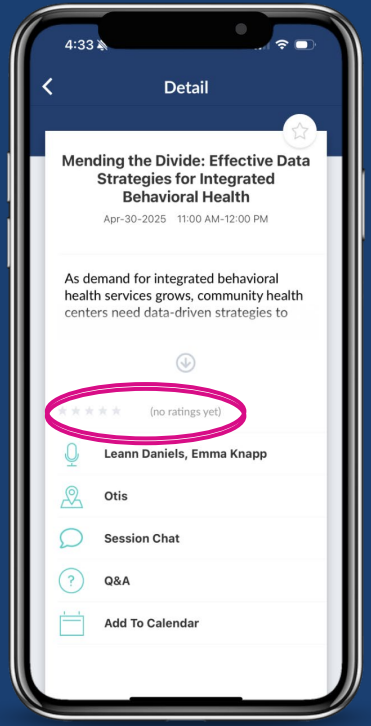

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Provide brief feedback or ideas

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