

Data Interoperability

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What is Data Interoperability?

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- The degree to which program databases can be combined to provide information on aggregate spending and service delivery, and/or to provide a more complete picture of individual provider performance, service use, and outcomes. Interoperability is affected by such variables as coding standards, payment methods, and reporting elements.

The Problem of Silos

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- States responsible for effective/efficient services, but cannot track across programs
- Providers – receive little info about how they perform
- Consumers/families – receive *no* info about their care across programs

Data Silo Problems

Survey



- Gaps/problems/new questions → programs revise IT systems constantly at great expense
- Separate IT systems can't answer important questions:
 - How to improve efficiency
 - How to improve quality of care

The Result

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- Fragmented data and reporting
- Same person or provider can't be found easily in 2 programs
- Sharing info about individuals costly and rarely done
- Managers fight fires rather than manage effectively



What is the Solution?

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- Interoperability:
 - Data Standards: Service Definitions and Privacy
 - Data Collection: Detail that can be aggregated by person, provider, program for many purposes



Need for interoperable systems

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- President's New Freedom Commission on Mental Health
 - harness the power of health information technology and leverage resources through better federal, state, and local collaborations
- Institute of Medicine quality report
 - MH/SA services lag behind general health care in the use of information technology
 - Recommends policies/infrastructure to create linkages among MH/SA patient records and related data, and standardization of different reporting/billing requirements

Need for interoperable systems

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- Both reports endorse:
 - electronic health records
 - better coding and reporting of MH/SA interventions
 - collection of client-level information under HIPAA-standardized payment transactions

SAMHSA Data Strategy – Goal 3

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Data Infrastructure - refers to activities directed at increasing the interoperability of MH & SA data systems with each other and other data systems, promoting the use of EHRs as a fundamental component of such systems, and ensuring appropriate behavioral health components in national health data standards.

SAMHSA Data Strategy – Goal 3

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Objective 3.3. Encourage States to create shared, client-centric data systems using common platforms that allow for efficient data sharing among mental health, substance abuse, and other relevant systems.

The Barriers to Interoperability

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- Data driven by immediate needs
- Cost and complexity of change
- Not knowing may be viewed as a “good” thing by some stakeholders
- And the biggie -

Confidentiality

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- Primary federal requirements – HIPAA and 42 CFR Part 2
- Both allow some sharing of data w/o patient consent, such as research or audits
- Sharing for health care operations also permitted under certain circumstances
- SAMHSA is developing a guide

Where are we today?

MH Agency Data – the Good

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- Most states use unique client identifiers
- Most states maintain a client-level dataset for those using community services
- Most have some form of encounter/claims data
- Most link such data with other client data using a common ID
- A majority link encounter data with 1 or more agencies

MH Agency Data – the Bad

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- Many states maintain multiple IT platforms, often w/separate systems for hosps
- Nearly half use “legacy” systems
- Many use state-owned or proprietary software
- Nearly half use unique service coding system and DSM IV for dx codes
- Less than half have detailed prescription drug data

Example

- Interoperability project: Compare Medicaid, MH/SA Hospital, and Community MH/SA databases
- How to evaluate? Some criteria:
 - Client ID
 - Provider ID
 - Assess common and unique data elements
 - Assess EHR “readiness”

Preliminary findings (1 state)

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- 3 major systems – Medicaid, State MH/SA hospital, MH/SA community system
- Client ID – Both Medicaid and community system have common ID, but hosp has its own patient ID
- Provider ID – no system carries national provider identifier; Medicaid – 20 digit ID & federal tax ID; Community – ID assigned by MH/SA agency; Hosp – single digit ID

Preliminary findings (1 state)

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- Common elements – All 3 have service level information and basic demographic info, **BUT**
 - Coding may be dissimilar – e.g., one coding convention for race/ethnicity in Medicaid, another for MH/SA, ICD-9 vs DSM IV
 - Reporting conventions may differ – e.g., admission vs treatment dx, billing vs treating provider (as well as who can bill)
- EHR readiness – under construction

Moving toward interoperability

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- Enlist “champions”
- Develop stakeholder collaboration
- Engage in serious planning
- Dedicate staff and resources
- Produce early results

Steps toward interoperability

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- Collect Encounter-Level Transactions (ie, 1 record for each svc interaction)
- Use HIPAA-Compliant Coding (e.g., HCPCS/CPT and ICD-9)
- Forge Linkages with Other Information Systems
- Align Provider and Client Identifiers with Those of Other Agencies

Steps toward interoperability

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- Invest in Flexible and Adaptable Data Systems and Business Processes (e.g., avoid “custom” or proprietary software)
- Analyze and Generate Information – use it!

CMS/SAMHSA Initiative

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- Be mutually beneficial to States and Feds
- Support state-wide client-centric systems (rather than provider-based systems)
- Create a richer information environment to serve multiple needs/constituencies
- Increase “return on investment” by reducing duplication and improving management

Why Now?

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- We are in a new day
- The EHR train is moving
- New emphasis on consumer-centric approaches
- Desire for better integration with primary care
- Need for improved quality of care and transparency