Independent Practice Integrated Care

A structural model and technology to provide mental health services in the era of health care reform.

5/17/2013

American Mental Health Alliance & Mentor Research Institute
GLOSSARY -- Developed by Michaele Dunlap Psy.D. & Michael Conner, Psy.D.

Glossary/Bibliography & on-line Resources **Prepared for Independent Practice Integrated Care Workshop 5/17/13**

See: www.AMHA-OR.org Click: **Professional Training** … lower left of Home page.

Powerpoints and other materials relevant to this training will be posted/linked by May 31, 2013

Term or acronym	Definition - Relevance/References 5-17-2013 IPIC Training Glossary
ACA	The **Patient Protection and Affordable Care Act** (**PPACA**), commonly called **Obamacare** or the **Affordable Care Act**, is a United States federal statute signed into law by President Barack Obama on March 23, 2010. Together with the Health Care and Education Reconciliation Act, it represents the most significant government expansion and regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965. The PPACA is aimed at increasing the rate of health insurance coverage for Americans and reducing the overall costs of health care. It provides a number of mechanisms—including mandates, subsidies, and tax credits—to employers and individuals to increase the coverage rate. Additional reforms aim to improve healthcare outcomes and streamline the delivery of health care. The PPACA requires insurance companies to cover all applicants and offer the same rates regardless of pre-existing conditions or sex. Issues of implementation and costs abound. http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act
ACO	An **Accountable Care Organization** (ACO) is a healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients. The ACO is accountable to the patients and the third-party payer for the quality, appropriateness and efficiency of the health care provided.
AHS	Accountable Health System -- commercial payers' designation for a system prepared to share risk.
Accountable Care	A requirement of the ACA, describes both the type and the process of health care reform intentions; overarching focus is the Triple Aim
Accountability	Responsibility to someone or some entity for some activity – used in ACA regulations to signify standards for health care performance
ASPPB	The Association of State and Provincial Psychology Boards (ASPPB) is the alliance of state, provincial, and territorial agencies responsible for the licensure and certification of psychologists throughout the United States and Canada. ASPPB was formed in 1961 to serve psychology boards in the two countries. http://www.asppb.net/i4a/pages/index.cfm?pageid=3285
Billing practices	Coherent, ethical, accountable, consistent; billing practices must be all of these if we are to maintain auditable and viable practice.
Bundling	Combining services provided into one payment code; if the services bundled would otherwise be unauthorized the payment code would be audited as fraudulent.
CarePaths	CarePaths is comprehensive mental health practice management software system that can address all the needs of a solo practitioner, a group practice, an IPA or hospital based mental health clinic. HL7 (health level 7) is security transmission standard for health care data exchange. Everyone is required to use this standard as a matter of law. CarePaths is a practice management company owned and operated by mental health professionals; a system designed for mental health. CarePaths is working with AMHA to co-create features that serve the objectives of Independent Practice Integrated Care. CarePaths is designed the way it is because they want us to be happy with their product. AMHA members receive a discount on the monthly cost of CarePaths. www.CarePaths.com
Charting for Audit preparedness	An essential element of practice management now and in the future. "Far too often," Paul Cooney wrote, "I have providers who are completely unaware of the documentation requirements of the various insurers. The old adage "so far, so good" definitely does not apply in these settings. The insurers can "look back" 18, 24, or even 72 months (depending on the contract language, state statute, and whether "fraud" or "abusive billing practice" -which is undefined in the statute - ORS 743.912) and seek repayment of any funds they deem as unsupported by your documentation."
CCO	Coordinated Care Organization - a network of all types of health care providers who have agreed to work together in their local communities for people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs will have the flexibility to support new models of care that are patient-centered and team-focused, and reduce health disparities. …CCOs will have one budget that grows at a fixed rate for mental, physical and ultimately dental care. CCOs will be accountable for health outcomes of the population they serve. https://cco.health.oregon.gov/Documents/cco-factsheet.pdf. Originally focused on the Medicaid insured population, Oregon's CCO structure is rapidly moving to inclusion of all third-party payers.
CDOI	Client Directed Outcome Informed - one strategy for giving evidence of mental health care process effectiveness – has been accepted in some states as an evidence-based practice. See http://www.slideshare.net/barrylduncan/cdoi-facts & https://heartandsoulofchange.com/

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CCHIT	CCHIT is an Office of the National Coordinator (ONC) authorized certification body (ACB) sanctioned to offer EHR certification for Complete EHRs that meet all of the 2011 Edition criteria adopted by the Secretary of Health and Human Services (HHS), as well as certification for EHR Modules that meet one or more – but not all – of the criteria. CCHIT is also an Accredited Testing Laboratory (ATL) for the purposes of testing EHRs.
Connecting Care also called IPIC	Connecting Care is a model high performance mental health project that is capable of providing practice-research level quality. Connecting Care involves interoperable records, clinical effectiveness measures, a screening and outcomes measures, and mental health IPA structure.
Continuity of Care	Insuring that there is transmission of information from one provider to a subsequent care situation. Continuity must be a feature of documentation.
Coordinated Care CCD – Coordinated Care Documentation	Insuring that there is necessary and useful interaction concerning caregiving and decision processes. Coordination must be a feature of documentation. A mental health/medical care coordination note would typically contain only such information as date/s patient/client was seen, is the patient/client attending with appropriate frequency; what do mental health professional and medical professional need to do collaboratively in service of the client/patient?, prognosis, progress.
CMS	The **Centers for Medicare & Medicaid Services** (**CMS**), previously known as the **Health Care Financing Administration** (**HCFA**), a federal agency within the United States Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. In addition to these programs, CMS has other responsibilities, including the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), quality standards in long-term care facilities (more commonly referred to as nursing homes) through its survey and certification process, and clinical laboratory quality standards under the Clinical Laboratory Improvement Amendments.
COMHPA	Central Oregon Mental Health Practitioners Alliance --- planned name for AMHA chapter project in Central Oregon
CPT code/s	CPT - Current Procedural Terminology CPT® is registered trademark of the American Medical Association. Webinar on psychiatry/psychiatry coding changes (suggest use by small study groups ± 40 min): https://cc.readytalk.com/cc/playback/Playback.do
coordinated care requirements	Care coordination is a vital aspect of health and healthcare services. When care is poorly coordinated—with inaccurate transmission of information, inadequate communication, and inappropriate follow-up care—patients who see multiple physicians and care providers can face medication errors, hospital readmissions, and avoidable emergency department visits. The effects of poorly coordinated care are particularly evident for people with chronic conditions, such as diabetes and hypertension, and those at high risk for multiple illnesses who often are expected to navigate a complex healthcare system. In this report, NQF has endorsed a portfolio of care coordination preferred practices and performance measures. These standards will provide the structure, process, and outcome measures required to assess progress toward care coordination goals and to evaluate access, continuity, communication, and tracking of patients across providers and settings. http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=49506
CSOQ	Comprehensive Screening and Outcome Questionnaire part of the Comprehensive Screening and Outcome System – a comprehensive online information gathering system which provides practice-research quality data concerning needs assessment and effects of interventions. This system, developed over the past 10+ years in collaboration with Mentor Research Institute is being refined to serve the objectives of IPIC
Down-coding	coding for service with less severe diagnosis than appropriate or coding for a lesser service than provided – can be viewed as fraud by auditors.
DSM V	If practitioners continue using the DSM-IV-TR (or the forthcoming DSM-5) for case conceptualization purposes, that is a matter of prerogative. However, ICD-9-CM codes are currently required for reporting diagnoses on health insurance claims, and ICD-10-CM codes will become the new standard when submitting claims to **insurers beginning in October 2014**. Clinicians are encouraged to review the educational materials distributed by the Centers for Medicare and Medicaid Services (CMS). More information about what the transition to the ICD-10-CM means for psychologists is also available on Practice Central: http://www.apapracticecentral.org/ In a potentially seismic move, the National Institute of Mental Health – the world's biggest mental health research funder, announced two weeks before the launch of the DSM-5 diagnostic manual that it will be "re-orienting its research away from DSM categories." In the announcement, NIMH Director Thomas Insel says the DSM lacks validity and that "patients with mental disorders deserve better." Further, NIMH has launched the Research Domain Criteria (RDoC) project to transform diagnosis by incorporating genetics, imaging, cognitive science, and other levels of information to lay the foundation for a new classification system.

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EBP	Evidence based practices – a wide range of interventions and measures of effective treatment. http://www.samhsa.gov/ebpwebguide/ see also: NREPP
eRecords /EHR/EMHR	Electronic records --- Electronic Health Record/s --- Electronic Mental Health Record/s … objectives: Lifetime and Portable Health Record; Available 24/7 to All; Performance Measurement; Reduction of Duplicative Services; Population/Disease Management; Source for Research & Public Health; Enhanced Billing/Revenue Collection; Closer Relationships with Health Systems; Increased Productivity & Coordination of Care; Required 2013-2016. Electronic billing & records requirements; are new standards for records keeping and "interoperability" embedded in the HITECH and ACA regulations.
Electronic Audits	Means for third party payers to maintain adherence to electronic billing & records standards. In the near future electronic audits will be the required audit format – opening all practitioner records (not just a sample) to external auditors.
Empirically Based Practice	Based on a process by which research practices are evaluated. (Could be based on a single study.)
Ethics	**Ethical Standards & Practice Guidelines for Assessment, Therapy, Counseling, & Forensic Practice – 174 links.** Our thanks, always, to Dr. Ken Pope: http://bit.ly/KenPopeEthicsCodesAndPracticeGuidelines
Evidence Based	A term used with regard to those practices which have evidence as deemed valid by some health authority – see Empirically Based Practice
Exchanges	Health insurance **exchanges** under the Affordable Care Act exchanges must be operational beginning in 2014. These exchanges are intended to create a marketplace where individuals and employees of small businesses can purchase affordable private health insurance from qualified health plans. Open enrollment for eligible individuals set to begin Oct. 1, 2013. Several states have opted out of creating exchanges, throwing the responsibility for creating them back to the Federal government. See: http://coveroregon.com/ All plans offered through the exchanges must be certified by federally recognized accreditors (currently, NCQA and URAC) (cf: https://www.urac.org/about/faqs.aspx) as a "qualified health plan (QHP)." To be accredited as a qualified health plan, plans must satisfy certain minimum criteria further defined in HHS regulations, i.e. plans must offer essential health benefits, which include mental health benefits, as defined by the Affordable Care Act and maintain cost-sharing limits (for example, deductibles, copayments and out-of-pocket maximum amounts). Qualified health plans are also subject to federal parity requirements.
GAD7	Generalized Anxiety Disorder Assessment – 7 question anxiety screening tool
Health Home	An integrated, person-centered, and physical and behavioral *service delivery system* aimed at populations with complex, chronic conditions – fueled by exchange of health information, evidence-based practices and care coordination. Intended to improve outcomes by reducing fragmented care and promoting patient-centered care.
Health Insurance Exchanges	One of the main objectives of the Affordable Care Act (ACA) is to expand access to affordable health care coverage to the approximately 45 million Americans who currently have no coverage. To achieve this goal, the ACA creates health insurance exchanges and calls for potential expansion of state Medicaid programs. Under the ACA, health insurance exchanges must be operational beginning in 2014. These exchanges create a marketplace wherein individuals and employees of small businesses can purchase affordable private health insurance from qualified health plans. Open enrollment for eligible individuals is expected to begin Oct. 1, 2013. http://www.apapracticecentral.org/update/2013/04-25/affordable-care.aspx
HEDIS	The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across 8 domains of care. Because so many plans collect HEDIS data, and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. http://www.ncqa.org/HEDISQualityMeasurement.aspx
HHS	Department of Health and Human Services http://www.hhs.gov/
HIPAA	The Health Insurance Portability and Accountability Act of 1996 Privacy and Security Rules. Learn about the Rules' protection of individually identifiable health information, the rights granted to individuals, OCR's enforcement activities, and how to file a complaint with OCR.(Office for Civil Rights): http://www.hhs.gov/ocr/privacy/ Link 2013 updates and changes: http://www.bricker.com/services/resource-details.aspx?resourceid=217
HITECH Act	**Health Information Technology for Economic and Clinical Health Act**, abbreviated **HITECH Act**, was enacted under Title XIII of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111–5). Under the HITECH Act, the United States Department of Health and Human Services is spending $25.9 billion to promote and expand the adoption of health information technology.

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Horizontal alignment	To align economic and clinical efforts across the continuum of care, work toward common goals around fundamentals—quality, efficiency, and cost reduction. "Horizontal alignment" of a group of mental health professionals with a medical group, and demonstrated effectiveness of care may support increase of mental health fees.
HL7	Health Level 7 -- a term relating to federal regulation concerning electronic records
integrated care requirements	Relates to the requirements for coordinating and integrating care between medical and specialty providers including mental health specialists.
Integrated Healthcare	Care integrated between medical and specialty providers including mental health specialists.
ICCE	The International Center for Clinical Excellence is a world-wide community of practitioners, healthcare managers, educators and researchers dedicated to promoting excellence in behavioral healthcare services. Their feedback acronym is: FIT www.centerforclinicalexcellence.com
ICD9-CM ICD10-CM	**International Classification of Disease, 9th edition, Clinical Modification**. A standardized classification of disease, injuries, and causes of death, by etiology and anatomic localization and codified into a 6-digit number, which allows clinicians, statisticians, politicians, health planners and others to speak a common language, both US and internationally. In current use. The DSM-IV codes roughly coincide with the ICD-9 codes. FREE: Start here: http://www.icd9data.com/2013/Volume1/default.htm ICD-10 codes will be significantly different from the DSM-5 codes. ICD-10-CM coming into use October 1, 2014. **Do not use before**. http://www.cdc.gov/nchs/icd/icd10cm.htm Free: http://www.icd10data.com/ICD10CM/Codes/F01-F99
IPA	Independent Practice Association – legal structure allowing those who might otherwise be viewed as competitors to collaborate in certain forms of contracting with third-party payers. IPAs can also be organized as horizontal alignments; -- integrated with medical IPAs.
IPIC	**Independent Practice Integrated Care … the model presented in this training; also referred to as "Connecting Care"**
LCD	Local Coverage Determination (LCD) Sets Local/Regional Policy- LCD may be more restrictive than national policy; Over-rides national policy; Changes frequently without warning or publicity; Applies to Medicare and private payers: Information on respective web pages – i.e. OHA
Medicare	By 2015, Medicare will represent approximately 50% of all health care payments in the United States; many expect that eventually, a national (US) health insurance will be established; one possible model - introduce Medicare to younger citizens in age increments (e.g., 60-64, then 50-59, etc.); Medicare administrative and payment structures will likely come to set standards for all of health care.
medical cost offsets	An "offset" occurs if medical utilization decreases as a result of mental health interventions. There is a robust research basis for these offsets developed over the past several decades.
Medical home	"Hospital medical home" or "primary care medical home" – authorized by a health authority to, in turn, authorize all specialty services
Medication Reconciliation	Professionals are increasingly being required to gather information about what a patient is prescribed and/or using and to reconcile with one-another about what is being used.
Mental Health Carve-Out	"carve-out" refers to payment structures for services not covered in a health insurance contract. Carved out services are usually reimbursed according to a different arrangement or rate formula than those services specified under the contract umbrella.
Minimum Necessary Information	the "minimum necessary" information that is needed by, and may therefore be disclosed to, third party payers in order for them to authorize payment for outpatient psychiatric services. Current standards for administrative billing information: Patient's name, address, sex, date of birth, insurance information/ID number. Note: If patient is not the same person as the subscriber of the plan to which a claim is being billed (e.g., a dependent) the "837" Standard requires that certain subscriber information (e.g., name, ID number) be provided to process the claim. Correspondingly, in such situations, information regarding the patient's relationship to the insured (e.g., spouse, child) is also required. Patient's diagnosis by current ICD code (currently ICD-9-CM) Clinician's name, ID number (i.e., SSN or EIN, and/or clinician's provider number) and address/Facility where services were performed (i.e. office, hospital, clinic) /Date(s), type and location of service/current and planned/Condition's date of onset (if different than date of service)/Procedure code/CPT code Charges/Clinical information for authorization of benefits/Treatment planned/CPT code(s), including recommended/ expected frequency/Currently on psychiatric medications? Y/N /Patient's status (i.e., voluntary, involuntary)/Functional status (impairment: none, mild, moderate or severe) or Axis V (GAF) Current Highest in past year Estimated GAF at treatment's completion (would address treatment goal)/Level of distress (none, mild, moderate or severe) or Axis IV rating/Prognosis/ the estimated minimum duration of the treatment for which authorization is

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	sought.
Multidisciplinary IPA	Multidisciplinary Independent Practice Association, the structure intended for Independent Practice Integrated Care, contracting groups – that include licensed independent mental health practitioners of all disciplines.
Needs assessment	A *needs assessment* is a systematic process for determining and addressing needs, or "gaps" between current conditions and desired conditions or "wants". Community needs assessment concerning mental health problems may be done by such strategies as the use of community wide CSOQ screenings or by screenings with specific module from the Comprehensive Screening and Outcome System (tools in current development.)
NREPP	National Registry of Evidence Based Programs and Practices. http://www.nrepp.samhsa.gov/
NCQA	National Commission on Quality Assurance
NCQA Tier system	System for designating the level and quality of care (adopted and expanded by OHA)
outcomes measures (quality, clinical)	Those measures which define and report the quality of care provided, "as the desire to evaluate and improve health care intensifies, there remains little consensus as to which measures are scientifically valid and accurate assessments of quality."
Office Ally	Office Ally is a clearinghouse that is paid for by insurance companies to process their claims. They are also a portal for electronic billing software that is used by private practices, groups and large companies. Insurance companies use different clearinghouses. Not every insurance company uses Office Ally. Claims are generally processed quicker and more reliably if you submit claims to the proper clearinghouse. These clearing houses are responsible for security, accurate processing and communicating between providers and payers. One can use Office Ally billing and their eRecord. But you get what you pay for. Since it is free, you are not in position to request changes to their system. You have to live with their services as they are. They do not work for you. Office Ally works for the payers. CarePaths does pass a limited amount of information (name, address, date of service, cpt code, payer, id) to a number of clearinghouses of which Office Ally is the biggest-- there are also Availity and others. No clinical information can pass to Office Ally from CarePaths.
OEBB	Oregon Employee Benefits Board
OHA	Oregon Health Authority - http://www.oregon.gov/oha/Pages/index.aspx
OHA Tier system	Strategy for categorizing the level and quality of care provided by an accountable health system. Tier 1 is lowest, Tier 3 is highest.
ONC	Office of the National Coordinator
Performance Codes	The trend for use of CPT codes is toward Payment for Performance/Quality; Starts with Documentation; Will Evolve into Performance - not Service as the Determination of Payment; At present- Depression is primary focus of research on performance measures; (Note: US is last of 7 countries that use performance measures)
PHQ9	PHQ9 Patient Health Questionnaire 9 questions – funded by Pfizer Pharmaceuticals. Is a DSM 4 Depression schedule converted to a questionnaire used in many medical offices – it misses anxiety problems, confuses and ignores many MH problems.
PCMH	NCQA term -- means "Primary Care Medical Home"
PCPCH	OHA term -- means "Patient Centered Primary Care Home"
pre-authorizations	Permissions by 3rd party payers to provide services, now may often originate from patients' medical home.
pro-active self-audits	Connecting Care/IPIC term for what in medical care are routine self-audits. Independent Practice Integrated Care can support pro-active self-audits for participating clinicians. A robust protection against unjustified demands for paybacks, penalties and/or allegations of fraud.
PCOMS	Partners for Change Outcome Management System (PCOMS). PCOMS is included in the Substance Abuse and Mental Health Services Administration's (SAMHSA)
PEBB	Public Employee Benefits Board
PQRS	**Physician Quality Reporting System** …initiatives for Medicare providers via the Physician Quality Reporting System. PQRS will transition from offering bonuses for successful participation to imposing penalties for the failure to successfully participate beginning in 2015
QHCP	Qualified Health Care Professionals – AMA (American Medical Association) term for any non-physician qualified to use CPT codes
RAC	Recovery Audit Contractor. Insurance companies are using Recovery Audit Contractors, or RACs to audit medical and mental health records. RACs are paid on a percentage of the money they recover. They are ruthless in their attempts to find providers negligent and demand repayment of reimbursements.

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reimbursement incentives	"Pay for Performance" contract term, reimbursements increased yearly or more often based on some performance incentive.
Risk Sharing - Financial	Any system which allows payors to share some of the financial risk associated with a particular patient population with providers. Providers agree to adhere to fixed fee schedules in exchange for an increase in their payor base and a chance to benefit from cost containment measures. Common risk-sharing methods are prospective payment schedules, capitation, diagnosis-related fees, and pre-negotiated fees. http://www.reference.md/files/D020/mD020414.html
Safe Harbor	Federal Trade Commission term concerning exceptions to Anti-Trust legislation. The "electronic infrastructure" of the IPIC model insures a level of integration necessary to provide a "safe harbor" from "anti-trust violations". In this safe harbor, physician and mental health professional can discuss and set fees based on patient "access", "level of care", and "co-participation" in "quality improvement programs".
Screening – simple or comprehensive	Mental Health screening is a pre-diagnostic process – required under ACA to determine patients' needs for services/referral. Ultra-brief screening questionnaires, such as the PHQ9 or GAD7 • do not effectively allow the benefits of therapy to be represented. • tend to limit length of treatment because they measure limited clinical factors • their few questions are reliable predictors of invalid diagnoses, (they are circular -- suggesting DSM diagnoses from DSM symptoms.) More comprehensive screening instruments, particularly those delivered privately on the internet allow attention to a broad variety of mental health, medical, situational and behavioral issues and concerns, support appropriate diagnoses and interventions; allow robust assessment of process outcomes and effect size measures concerning treatments provided.
Standard of care	Standard for services provided by health care professionals. For example, a clinical practice guideline for treatment of depression becomes the "standard of care" based on the extent to which it is followed.
Standard of practice	Standard which encompasses the processes, business and delivery of services
Triple Aim	A term of the ACA also used by the OHA -- Quality is defined in the "Triple Aim" as measures of (1) access, (2) improved group health and well-being and (3) management or containment of cost.
Un-bundling	Refers to coding for billing, to separating services among diagnostic or service codes, i.e. Creating 2 diagnoses where one is appropriate or other coding that shows more billable services than are justified.
Up-coding	Refers to coding for billing, to converting a diagnosis to a more severe diagnosis than is justifiable or increasing the CPT code to a higher level of reimbursement than is justified.
Urgent care vs emergency service	An emergency is defined as a medical condition that could threaten life, limb or eyesight without immediate treatment. Urgent care is defined as an illness or injury that won't cause further disability or death if not treated immediately, but needs attention to keep it from evolving into a greater threat.

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