Using Information Technology to Support Collaborative Integrated Health Care

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Session 24 - July 17, 2013

Presented by
Michael R. Zent, Pres/CEO, Jewish Family & Children’s Service
Kurt Sheppard, CEO, Valle Del Sol
Agenda

• An overview of the **current health care landscape** and the forces driving care coordination in behavioral health
• The **role that technology**, specifically EHRs and HIE, plays in coordinating care
• Case study of a provider organization **coordinating care**
Key Drivers of Integrated Health

• Patient Protection and Affordable Care Act
• State Health Insurance Exchanges
• Mental Health Parity
• Medicaid Expansion
Why Integrate Physical and Behavioral Health Care?

- Behavioral and physical health care have historically operated in silos.

- Health care integration is designed to:
  - Improve patient access to care in a setting where patients are most comfortable.
  - Reduce health care disparities.
  - Contain costs by promoting a whole health approach.
  - Improve patient outcomes through coordination of care.
The Cost of Health Care
How does it compare?

If other prices had grown as quickly as healthcare costs since 1945...

- a dozen eggs would cost $55
- a gallon of milk would cost $48
- a dozen oranges would cost $134
The Changing Healthcare System

• Moving from procedure and episodic based payment to payment based on health outcomes

• The Affordable Care Act
  - Accountable Care Organizations
  - Other Shared Savings Models
  - Patient Centered Medical Homes
  - Health Homes
  - Wellness Approach to Care vs. Episodic Disease Approach
ACA & Disruptive Innovation are Driving

- Improving the U.S. health care system requires simultaneous pursuit of three aims: better care, better health, better costs.
- This, in turn, requires the existence of an organization (an “integrator”) that accepts responsibility for all three aims for that population.
- The integrator’s role includes:
  - Partnership with individuals and families,
  - Redesign of primary care,
  - Population health management,
  - Financial management, and
  - Macro system integration.

*(Don Berwick)*
What does all this have to do with Behavioral Health?

• 1 % of the population use 20% of the healthcare resources
• 5% use 50% -- the 5/50 population
• Half of both groups have a behavioral health disorder
• We cannot achieve the triple aim (especially the cost saving part) without addressing BH!
<table>
<thead>
<tr>
<th>Chronic Condition</th>
<th>No Mental Health Issue - Annual Cost</th>
<th>Mental Health Issue - Annual Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>$8,000.00</td>
<td>$24,598.00</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488.00</td>
<td>$24,927.00</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788.00</td>
<td>$24,443.00</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498.00</td>
<td>$36,730.00</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,296.00</td>
<td>$35,840.00</td>
</tr>
</tbody>
</table>

This population also experiences high readmission rates to the hospital, adding $15 billion in annual Medicaid/Medicare payments. These patients see multiple specialists and experience some follow-up from ED visits/hospitalizations with 20% of Medicare hospitalizations readmitted within 30 days of discharge. This is often due to poor coordination of care.
The Changing Healthcare System

System will not work unless Behavioral Health is included

Cost without vs. Cost with Mental Illness

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost without</th>
<th>Cost with Mental Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>20,000</td>
<td>15,000</td>
</tr>
<tr>
<td>CHF</td>
<td>10,000</td>
<td>8,000</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5,000</td>
<td>3,000</td>
</tr>
<tr>
<td>COPD</td>
<td>2,000</td>
<td>1,000</td>
</tr>
<tr>
<td>Asthma</td>
<td>1,000</td>
<td>500</td>
</tr>
</tbody>
</table>
In 2014: Millions More Americans Will Have Health Care Coverage

- Currently, 37.9 million are uninsured <400% FPL *
  - 18.0 M – Medicaid expansion eligible
  - 19.9 M – ACA exchange eligible **
  - 11.019 M (29%) – Have BH conditions (s)

*Source: 2010 NSDUH
**Eligible for premium tax credits and not eligible for Medicaid
SAMHSA
Expansion Prevalence Data
Prevalence of Serious Mental Illness Among Adults Ages 18 – 64 by Current Medicaid Status and Eligibility for Medicaid Expansion or Health Insurance Exchanges: Arizona, US

CI = Confidence Interval
Sources: 2008 – 2010 National Survey on Drug Use and Health (Revised March 2012)
2010 American Community Survey

Current Medicaid Population
(Arizona: 544,729)
AZ CI: 7.9% - 28.3%
U.S. CI: 10.8% - 12.7%

Medicaid Expansion Population
(Arizona: 421,522)
AZ CI: 1.7% - 9.7%
U.S. CI: 6.3% - 7.7%

Health Insurance Exchange Population
(Arizona: 405,206)
AZ CI: 2% - 7.7%
U.S. CI: 5.5% - 6.6%
Prevalence of Serious Psychological Distress Among Adults Ages 18 – 64 by Current Medicaid Status and Eligibility for Medicaid Expansion or Health Insurance Exchanges: Arizona, US

<table>
<thead>
<tr>
<th>Population</th>
<th>Arizona</th>
<th>National</th>
<th>AZ CI</th>
<th>U.S. CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Medicaid Population</td>
<td>23.4%</td>
<td>22.1%</td>
<td>15.1%</td>
<td>21%</td>
</tr>
<tr>
<td>(Arizona: 544,729)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid Expansion Population</td>
<td>11.7%</td>
<td>14.9%</td>
<td>6.4%</td>
<td>14%</td>
</tr>
<tr>
<td>(Arizona: 421,522)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Insurance Exchange Population</td>
<td>18.4%</td>
<td>13.3%</td>
<td>11.5%</td>
<td>12.5%</td>
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<td>(Arizona: 405,206)</td>
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CI = Confidence Interval
Sources: 2008 – 2010 National Survey on Drug Use and Health (Revised March 2012)
2010 American Community Survey

SAMHSA
www.samhsa.gov • 1-800-662-HELP (4357)
Prevalence of Substance Use Disorders Among Adults Ages 18 – 64 by Current Medicaid Status and Eligibility for Medicaid Expansion or Health Insurance Exchanges: Arizona, US

<table>
<thead>
<tr>
<th>Population</th>
<th>Prevalence Rate</th>
<th>Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Medicaid Population</td>
<td>12.4% - 14.4%</td>
<td>AZ CI: 9.1% - 22.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>U.S. CI: 11.5% - 13.3%</td>
</tr>
<tr>
<td>Medicaid Expansion</td>
<td>14.2% - 15.0%</td>
<td>AZ CI: 9.4% - 23.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>U.S. CI: 13.2% - 15.2%</td>
</tr>
<tr>
<td>Health Insurance Exchange</td>
<td>14.6% - 12.4%</td>
<td>AZ CI: 7.6% - 19.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>U.S. CI: 13.7% - 15.6%</td>
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CI = Confidence Interval

Sources: 2008 – 2010 National Survey on Drug Use and Health (Revised March 2012)
2010 American Community Survey

SAMHSA

Uninsured Adults Ages 18 - 64 with Incomes Between 133-399% of the Federal Poverty Level (Arizona: 405,206)

- **Serious Mental Illness**
  - AZ CI: 2% - 7.7%
  - U.S. CI: 5.5% - 6.6%
  - National: 6.0%
  - Arizona: 3.9%

- **Serious Psychological Distress**
  - AZ CI: 11.5% - 28.1%
  - U.S. CI: 12.5% - 14.2%
  - National: 13.3%
  - Arizona: 18.4%

- **Substance Use Disorder**
  - AZ CI: 7.6% - 19.6%
  - U.S. CI: 13.7% - 15.6%
  - National: 14.6%
  - Arizona: 12.4%

CI = Confidence Interval

Sources: 2008 – 2010 National Survey on Drug Use and Health (Revised March 2012)
2010 American Community Survey

SAMHSA

Uninsured Adults Ages 18-64 with Incomes < 139% of the Federal Poverty Level (Arizona: 421,522)

- **Serious Mental Illness**
  - Arizona: 4.1%
  - CI: 1.7% - 9.7%
  - U.S.: 6.3% - 7.7%

- **Serious Psychological Distress**
  - Arizona: 11.7%
  - CI: 6.4% - 20.2%
  - U.S.: 14% - 15.9%

- **Substance Use Disorder**
  - Arizona: 15.0%
  - CI: 9.4% - 23.2%
  - U.S.: 13.2% - 15.2%

CI = Confidence Interval

Sources: 2008 – 2010 National Survey on Drug Use and Health (Revised March 2012)
2010 American Community Survey
Importance of Integration: BH Impact on Physical Health

- MH problems increase risk for physical health problems & SUDs increase risk for chronic disease, sexually transmitted diseases, HIV/AIDS, and mental illness.

- People with M/SUDs are nearly 2x as likely as general population to die prematurely, often of preventable or treatable causes.

- Cost of treating common diseases higher when a patient has untreated BH problems:
  - *Hypertension* – 2x the cost
  - *Coronary heart disease* – 3x the cost
  - *Diabetes* – over 4x the cost

- M/SUDs rank among top 5 diagnoses associated with 30-day readmission; one in five of all Medicaid readmissions:
  - 12.4 percent for MD
  - 9.3 percent for SUD

![Individual Costs of Diabetes Treatment for Patients Per Year](chart)

<table>
<thead>
<tr>
<th>Cost Level</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>$300,000,000</td>
<td>With behavioral health problems and diabetes</td>
</tr>
<tr>
<td>$250,000,000</td>
<td>With diabetes alone</td>
</tr>
<tr>
<td>$200,000,000</td>
<td></td>
</tr>
<tr>
<td>$150,000,000</td>
<td></td>
</tr>
<tr>
<td>$100,000,000</td>
<td></td>
</tr>
<tr>
<td>$50,000,000</td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

Caring Helping Healing
Behavioral Health & Readmissions

Mental and substance use disorders rank among top five diagnoses associated with 30-day readmissions, accounting for about **one in five of all Medicaid readmissions**
Responses Resulting from the ACA

- Health Homes—start with people who have a variety of chronic conditions
- Accountable Care Organizations—start with Medicare population
- Patient Safety Initiative—reward hospitals and other facilities for fewer incidents
- Quality Measures—focus on identifying people who are at risk of certain conditions
Health Reform: Impact of the Affordable Care Act

- Focus on primary care & coordination w/ specialty care
- Emphasis on home & community-based services; less reliance on institutional & residential care (health homes)
- Priority on prevention of diseases & promoting wellness
- Focus on quality rather than quantity of care (HIT, accountable care organizations)
- Behavioral health is included – parity
Affordable Care Act, Section 2703
Health Homes

- Eligible individuals are those with chronic conditions, meaning an individual who is eligible for medical assistance under the state plan or under a waiver of such plan and has at least
  - 2 chronic conditions; or
  - 1 chronic condition and is at risk of having a second chronic condition; or
  - 1 serious and persistent mental health condition

- Chronic conditions must include:
  - A mental health condition
  - A substance use disorder
  - Asthma
  - Diabetes
  - Heart disease
  - Being overweight, as evidenced by having a BMI >25
What is Coordinated Care?
Models of Integrated Care

• Coordinated Care
• Co-Located Care
• Transformed/Full Integration
• Virtual Integration
Concepts Common to All Integrated Care Models

- Medical or Health Home
- Health Care Team
- Stepped Care
- Four Quadrant Clinical Integration
## Four Quadrant Clinical Integration

<table>
<thead>
<tr>
<th>Quadrant II</th>
<th>Quadrant IV</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong> → Behavioral Health Risk/Complexity → <strong>High</strong></td>
<td></td>
</tr>
<tr>
<td>Patients with high behavioral health and low physical health needs</td>
<td></td>
</tr>
<tr>
<td>Served in primary care and specialty mental health settings</td>
<td></td>
</tr>
<tr>
<td>(Example: Patients with bipolar disorder and chronic pain)</td>
<td></td>
</tr>
<tr>
<td>Note: When mental health needs are stable, often mental health care can be transitioned back to primary care.</td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong> → Physical Health Risk/Complexity → <strong>High</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quadrant I</th>
<th>Quadrant III</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with low behavioral health and low physical health needs</td>
<td></td>
</tr>
<tr>
<td>Served in primary care settings</td>
<td></td>
</tr>
<tr>
<td>(Example: Patients with moderate alcohol abuse and fibromyalgia)</td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong> → Physical Health Risk/Complexity → <strong>High</strong></td>
<td></td>
</tr>
</tbody>
</table>
Meaningful Use

Stage 1 ➔ capture structured information in EHRs

Stage 2 ➔ exchange structured information among providers and patients

Stage 3 ➔ improve outcomes through analytics
Steps to Delivering Accountable Care

Improve Outcomes
- Clinical Innovation
  - EHR & Medication Management
  - Meaningful Use
  - Clinical Decision Support

Care Coordination
- Information Exchange
- Primary Care Integration
- Population & Community Health Management

Business Efficiencies
- Hosting & SaaS
- Revenue Cycle Management
- Managed Services
- Technology Partners
Steps to Delivering Accountable Care

Clinical Innovation

- Meaningful Use
- Clinical Decision Support

Care Coordination

- Information Exchange
- Primary Care Integration
- Population & Community Health Management

EHR & Medication Management
What is an HIE?

- The technology infrastructure for moving healthcare information electronically based on national standards:
  - Across Organizations
  - Within a Region (city, county, state, nation, global)
  - Within a Community
  - Hospital Systems

- Designed to:
  - Move clinical information among disparate health care information systems
  - Facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, equitable, patient/client centered-care.
Health Information Exchange

• Disparate IT Systems unified through a shared architecture
• Patient-Centric Delivery Model
• All providers have complete, up to date information
• Collaborative Care Model
Types of HIE Models

• Public

• Regional

• Private
Public versus Private HIE

**Public**

- Availability and efficient distribution of a large volume of patient data
- Efficient exchange of standards-based data (CCD, IHE, etc.)
- Gateway to the National Health Information Network
- Aggregator of data of national interest

**Private**

- Coordination of care among the providers in a community – workflow improvement
- Connecting systems and users with different technical capabilities and workflow needs
- Access to the entire patient chart
- Business intelligence service to optimize pay-for-performance and quality improvement
THANK YOU

Michael R. Zent, Ph.D.
President & CEO
Jewish Family & Children’s Service
michael.zent@jfcsaz.org

4747 N. 7th Street, Suite 100
Phoenix, AZ 85014
602-279-7655
Valle del Sol Approach

Total Health
Our Integrated Health Record
“Creating a Community of Care”
Tracking and Managing Outcomes

- National Standards
  - HEDIS
  - Meaningful Use
- Contract Specific Population Management
THANK YOU

Kurt Sheppard
CEO
Valle del Sol
kurts@valledelsol.com

3807 N. 7th Street
Phoenix, AZ 85014
602-258-6797