Care and EHR Integration
Connecting Physical and Behavioral Health in the EHR

Tarzana Treatment Centers
Integrated Healthcare
Outline of Presentation

• Why Integrate Care?
• Integrated Care at Tarzana Treatment Centers
• Integrated Care for Diabetes, SUD, & MH
• An Integrated EHR
The Triple Aim

“...we call those goals the “Triple Aim”:

improving the individual experience of care;

improving the health of populations; and

reducing the per capita costs of care for populations.”

“The Triple Aim: Care, Health, and Cost”

The remaining barriers to integrated care are not technical; they are political.

Donald M. Berwick, Thomas W. Nolan, and John Whittington, Health Affairs, 27, no.3 (2008):759-769
Where is care integration happening today?

- Low Income Health Plan

- SAMHSA - Primary Care Behavioral Health Integration
  - 11 Grantees in California

- FQHCs
  - $50,000,000 to expand behavioral health integration in FY 2014
  - Must report on SBIRT and Depression Screening in UDS
Drivers for future care integration?

• Section 2703 Medicaid Health Homes

• Joint Commission & CARF Behavioral Health Home Certification

• Certified Community Behavioral Health Clinics
Section 2703 Medicaid Health Homes

Section 2703 Health Homes are for people with Medicaid who:

- Have 2 or more chronic conditions
- Have one chronic condition and are at risk for a second
- Have one serious and persistent mental health condition
Section 2703 Medicaid Health Homes

Chronic conditions listed in ACA Section 2703 include:

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Being overweight
- Additional chronic conditions, such as HIV/AIDS, may be considered by CMS for approval
Section 2703 Health Home Quality Measures

Quality measures tracked by CMS are:

- Adult Body Mass Index (BMI) Assessment
- Ambulatory Care - Sensitive Condition Hospital Admission
- Care Transition – Transition Record Transmitted to Health care Professional
- Follow-up After Hospitalization for Mental Illness
- Plan- All Cause Readmission
- Screening for Clinical Depression and Follow-up Plan
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- Controlling High Blood Pressure
AB-361 Health Homes for Medi-Cal Enrollees

• Enacted and signed in 2013

• Authorizes DHCS to submit Medicaid State Plan Amendment and 1115 Waiver to implement
California State Health Care Innovation Plan

The California Innovation Plan includes four initiatives and six building blocks, which are collectively designed to achieve savings within three years, as well as to catalyze longer term transformations of the health care delivery system. The Innovation Plan brings together leadership from California’s public and private sectors to work together to implement these initiatives and building blocks.

The Innovation Plan has three overarching goals designed to advance the Triple Aim:

1. Reduce health care expenditures regionally and statewide.
2. Increase value-based contracts that reward performance and reduce pure fee-for-service reimbursement.
3. Demonstrate significant progress on the Let’s Get Healthy California dashboard.

TRIPLE AIM

Lower Costs Better Health Care Better Health

MATERNITY CARE

Cesarean sections are more costly than vaginal deliveries and can lead to adverse maternal outcomes. Cesarean sections have decreased from 32% to 23% from 1996-2006.

Reduce elective early deliveries, reduce Cesareans, increase Natural Birth After Delivery.

HEALTH HOMES FOR COMPLEX PATIENTS (WHCHP)

14 million CA adults have 1 or more chronic conditions. 39% of CA population accounts for over 50% of health care expenditures.

Expand HHCP model to provide high-risk patients with better coordinated care.

PALLIATIVE CARE

70% of Californians report preference to die in their homes, only 12% do.

Better align care with patient preferences with new benefit and payment approaches.

ACCOUNTABLE CARE COMMUNITIES (ACC)

More than 75% of health care costs are due to chronic diseases, which are highly preventable, and in which significant social and ethnic disparities exist.

RNC ACC to improve the health of the entire community by linking community prevention activities with health care.

BUILDING BLOCKS

WORKFORCE

Fewer than 25% of the state’s medical graduates enter into primary care. More demand is expected as up to 63 million Californians gain insurance coverage.

Enhance training opportunities for key health care workforce personnel. Expand and integrate the use of frontline and lower cost health workers such as community health workers.

HEALTH INFORMATION TECHNOLOGY & EXCHANGE (HIE & HIE)

HIE and HIE are vital components for achieving greater health care clinical integration and efficiency and improving quality and accountability.

While adoption of electronic health records is increasing, gaps remain across the state.

Continue California’s strong track record and improve the spread and use of HIE and HIE.

ENCH CITY

There may be rules and regulations that impede the implementation of the initiatives and building blocks.

Explore any changes in authorizations that could facilitate faster, better or cheaper spread of transformation.

PUBLIC REPORTING

Greater public reporting is needed to enhance transparency and accountability to spur competition and improvement.

Create a reliable and robust reporting system that promotes transparency and monitors trends in health care costs and performance.

ACCOUNTABILITY & INNOVATION INCUBATOR

Continued innovations are needed to achieve the goals of the Innovation Plan.

Develop, implement, evaluate, and spread successful payment reforms to better align incentives and reward value.
Joint Commission and CARF Behavioral Health Home Certification

Joint Commission BHH Certification:

- Optional certification available to any organization accredited under the Joint Commission Behavioral Health Care program.

- Requirements emphasize the need for the behavioral health home to coordinate and integrate care.

- Through strong focus on coordination and integration of care, treatment, or services expected to be effective in decreasing the high rates of morbidity and mortality of individuals with serious mental illness and other behavioral health conditions.
Certified Community Behavioral Health Clinics

- Protecting Access to Medicare Act of 2014
- Authorizes $25M for planning grants to 8 states
- Authorizes guidelines for creation of prospective payment system
- Requires coordination with primary care
Improving Health and Lowering Cost

Making SUD & MH relevant to the concerns of the rest of Medicine
# Reducing ER & Hospital Admissions and Readmissions

Table 1. Potentially Preventable Readmission (PPR) Rates per 100 At Risk\(^1\) Admissions by Medicaid Recipient Health Condition at Initial Admission and Region: New York State, 2007

<table>
<thead>
<tr>
<th>Recipient Health Condition</th>
<th>New York City</th>
<th>Rest of the State</th>
<th>New York State</th>
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<tr>
<td></td>
<td>Initial Admissions(^1)</td>
<td>At Risk Events(^2)</td>
<td>PPR Rate</td>
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<tr>
<td>Mental Health</td>
<td>6,808</td>
<td>79,815</td>
<td>8.5</td>
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<tr>
<td>Substance Abuse</td>
<td>4,111</td>
<td>35,578</td>
<td>11.6</td>
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<tr>
<td>Mental Health and Substance Abuse</td>
<td>13,043</td>
<td>62,409</td>
<td>20.9</td>
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<tr>
<td>All Others</td>
<td>6,485</td>
<td>132,269</td>
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<tr>
<td>Total</td>
<td>30,447</td>
<td>310,071</td>
<td>9.8</td>
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\(^1\) Non-excluded admissions followed by at least one clinically related readmission.
\(^2\) All inpatient events that were not excluded according to defined PPR criteria.

[Source](https://www.health.ny.gov/health_care/managed_care/reports/statistics_data/3hospital_readmissions_mentahealth.pdf)
Reducing Hospital Admissions for Ambulatory Care Sensitive Conditions

Persons with mental illness 2.3 times more likely to be admitted to hospital for ACSC – based on New York State hospital discharge data for 2004.

Li Y, Glance LG, Cai X, Mukamel DB “Mental illness and hospitalization for ambulatory care sensitive medical conditions” Med Care. 2008 Dec;46(12):1249-56

- Short and long-term diabetes complications
- Uncontrolled diabetes
- Lower extremity amputation among diabetic patients
- Perforated appendix
- Pediatric asthma
- Adult asthma
- Chronic Obstructive Pulmonary Disease

- Pediatric gastroenteritis
- Hypertension
- Angina without procedure
- Congestive heart failure
- Low birth weight
- Dehydration
- Bacterial pneumonia
- Urinary Tract Infection
Integrated Care at Tarzana Treatment Centers
Demographics

- Persons served in Calendar 2013:
  - Primary care = 11,041 persons
  - Substance use disorder specialty care = 4,687
  - HIV/AIDS specialty care = 1,072
  - Mental health specialty care = 1,059
Primary Care

– Five Primary Care Clinics Integrated with Other Services

– 11 Providers (MD, NP, PA)

– All primary care patients assigned to a Care Team
Specialty Care

- Substance Use Disorder Treatment
- Mental Health Disorder Treatment
- HIV / Medical Care and related services
- Housing
- Assessment and Referral Services in Hospital EDs
- In Home Services
Acute Psychiatric Hospital

- 60 bed unit staffed 24/7 by psychiatrists and other medical staff
- Referral Sources
  - Step downs from Acute Hospitals - Medicare
  - Contracts with LA County Department of Public Health
  - Kaiser and other Managed Care Organizations
- Average Length of Stay
  - Insurance funded - 3 days
  - Block Grant funded – 7 days
Specialty HIV/AIDS Care

- HIV/AIDS Medical Clinics
  - Palmdale
  - Reseda
- Prevention and Testing
- Case Management
- Jail In-Reach
- MH/SU Disorder Treatment
- Transitional Housing
- Home Heath Care
Joint Commission Certification

Certified under:
• Hospital Standards
• Behavioral Health Standards
• Opioid Treatment Standards

Scheduled during triennial survey in 2014:
• Patient Centered Medical Home
• Behavioral Health Home
SAMHSA - Primary Care Behavioral Health Integration

- Four Year - $2 Million Grant

- To integrate primary care with MH/SUD services for patients with a chronic physical health condition and a serious mental illness
Department of Mental Health
Full Service Partnership (FSP)

• For individuals with severe and persistent mental illness who meet criteria based on prior psychiatric hospitalizations, homelessness and/or incarceration

• Intensive case management, mental health and psychiatric services with the aim of keeping patients out of the hospital, stabilization, and movement to a lower level of care

• Most have concomitant SUDs and chronic medical conditions, which are all addressed
Department of Mental Health
Integrated Service Model

• Individuals not currently seen by MH System
• Engagement in non-traditional health settings (e.g. faith based institutions)
• Focus on Latinos who are monolingual
• Patient enrolled in TTC’s primary medical care services
• Wellness classes, group education, MH therapy, psychiatric services, non-traditional services (curandero, sobador, botanica) and integrated case management
Department of Mental Health-Healthy Way LA (HWLA)

- Mild to moderate mental health problems
- Short-term, evidenced-based model – Mental Health Integration Program (MHIP)
- Referred by primary care based on mental health screen for depression, anxiety, and/or trauma
- Psychiatrist consultant with mental health and primary care providers (PCPs)
- PCPs prescribe psychotropic meds, if needed
- Case conferences with PCP, psychiatrist and mental health clinicians to coordinate care
Capitated and Incentivized Care

- Members of Health Care LA IPA (HCLA IPA)
- Composed of Safety Net Clinic Organizations
- HCLA IPA Contracts with Safety Net Health Plans in Los Angeles County
- 350,000 Lives under capitated Managed Care contracts
- Clinic Compensation
  - Per Member Per Month Capitation
  - Quality of care incentives
  - Share of net revenue
Integrated Care for Chronic Conditions
Diabetes, Substance Use Disorders and Mental Illness
Type 2 Diabetes and SUD

Persons with type 2 diabetes and a coexisting substance use disorder (SUD) compared to diabetics without SUD:

• Have higher rates of type 2 diabetes-related complications and hospitalizations

• Have lower odds of full adherence with measures of quality for type 2 diabetes

Impact of Mental Illness & Substance Use Disorders on Cost and Hospitalization for People with Diabetes

Beneficiaries with Diabetes

Per Capita Cost Per Year

Per Capita Hospitalization Per Year

What Does Integrated Care for Diabetes, SUD, and MH Look Like?

All conditions are addressed by all staff and are:

– Included in the problem list
– Included in the treatment plan
– Included in the Integrated Summary
– Addressed with motivational interviewing to improve compliance with monitoring, treatment interventions and lifestyle changes
Electronic Health Record

• 1\textsuperscript{st} Patient Information System implemented in 1996
• Behavioral Health EHR implemented in 2004
• Hospital Pharmacy Management / Order Entry / MAR implemented in 2008
• e-Prescribing implemented in 2009
• Laboratory results imported into EHR 2012
• Primary Care EHR implementing in June 2013
  – iPad-based Primary Care Module
  – Integrated with Netsmart Avatar Behavioral Health EHR
**DSM Diagnosis**

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### Patient Chart

**Patient ID:** 102772  
**Date Of Birth:** 10 Mar 1963  
**Gender:** Male  
**Address:** 8330 Reseda Blvd, Northridge CA 93054  
**Critical Alerts:** No Critical Alerts

### Behavioral Health / Substance Abuse Information

#### Progress Notes

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## Problem List with all Conditions

### Test Client (000102772)
- **M**, 51, 03/10/1963
- Ht: 6'0'', Wt: 160 lbs, BMI: 21.7

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<th>Problem</th>
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<th>Date of Onset</th>
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<td>Alcohol withdrawal delirium (SNOMED-86350005)</td>
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Client Treatment Plan: TEST CLIENT

Problem: Asthma

Goals
- Maintain a program of recovery free of substance abuse and the negative effects of medical issues.

Interventions
- Physician will examine the patient and make recommendations as indicated to treat the asthma and alleviate symptoms.

Objectives
- Visit with physician for exam of asthma issues and substance abuse and cooperate with all treatment plans.

Problem: Diabetes mellitus type 2

Goals
- Compliance with medication, dietary recommendations, and ongoing follow-up.

Objectives
- Patient will comply with dietary restrictions as ordered by physician.

Objective
- Patient will comply with dietary restrictions as ordered by physician.

Date Opened
04/22/2014

Status
Active
Client Portal PIN

Your client's portal is ready. The following PIN may be used to connect to your records.

SKT-XUBVHQD
### Diagnoses Form

#### Type Of Diagnosis
- Admission
- Discharge
- Onset
- Update

#### Date Of Diagnosis
- [ ] T
- [ ] Y

#### Time Of Diagnosis
- [ ] Current
- [ ] H
- [ ] M
- [ ] AM/PM

#### Diagnoses

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- **New Row**
- **Delete Row**

#### Show Active Only
- [ ] Yes
- [ ] No

#### Diagnosis Search

- [ ] Active
- [ ] Working
- [ ] Rule-out
- [ ] Resolved

#### Estimated Onset Date
- [ ] T
- [ ] Y

#### Resolved Date
- [ ] T
- [ ] Y

#### Ranking
- [ ] Primary
- [ ] Secondary
- [ ] Tertiary

#### Bill Order

#### Code Crossmapping

- Present On Admission Indicator
- Classification
- Diagnosing Practitioner

#### Remarks
Wireless Glucometer Readings for a Diabetic with SMI
California Telehealth Network Eceptionist
HIT as Care Integration Driver

• Provide the tools for referrals and HIE
• Provide the tools for integrated care
  – Assessments
  – Integrated summary
  – Integrated problem list
  – Integrated treatment plan
  – Integrated view of the record
  – Integrated registries
• Provide the ability to bill for integrated services
  – Procedure Codes
  – Guarantors and claims
Jim Sorg, PhD
Director of Information Technology
Tarzana Treatment Centers
www.tarzanatc.org
jsorg@tarzanatc.org