HIT and Integrated Care: A Primary Care Perspective

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LifeLong Medical Care
Behavioral Health Information Management Conference and Exposition
April 3, 2013
Setting the Stage

Who, What, and Why
Lifelong Medical Care

- FQHC
- 29 sites in Alameda, Contra Costa, Marin
- 41,536 patients in 216,489 visits
  - Primary Care
  - Behavioral Health
  - Podiatry
  - Dental
  - Adult Day Health
  - School-Based Clinics
  - Supportive Housing
  - Satellite Primary Care Clinic embedded in Outpatient Mental Health Clinic
  - Adolescent Substance Abuse Treatment Facility
Goals of Integrated Care – Can IT Tools Contribute?

- Improve physical and behavioral health outcomes
- Improve access to behavioral health care
- Reduce stigma
- Improve access to primary health care for SMI population
- Enhance early detection and treatment of behavioral health conditions
- Reduce costs
- Create county wide system of care
Key Principles

- Patient centered *team care*
- Population based
- Measurement based: treat to target
- Evidence based
- Accountable care
Integrated Care Model

- Behavioral health staff at all primary care sites (LCSWs, psychiatrists, psychologists)
- Co-located
- Shared medical record
- Regular multi-disciplinary team meetings
- Shared training/CME
Environmental Motivators

- Pay for performance pilot with County Behavioral Health Agency
- Momentum/pressure to adopt QI/Outcome measurements for behavioral health
- Need to establish track record on impact of behavioral health services – quality and cost
- Health care reform – requires a coordinated, accessible system of care for all levels of BH needs
Choosing a HIT System

Perfection is the Enemy of Good
Decision Drivers

- What agencies will be using the systems?
- What is main business need? Primary care? Behavioral Health?
- What tools are already in use – replace, adapt?
- What are benefits of using existing systems?
EHR Limitations

• Weak or no population management tools

• Primary care EHRs lack robust BH templates, behavioral health EHRs lack PC functionality

• Expensive and time consuming to change

• Work arounds are inevitable
Benefits of a Registry

1. Data Collection
   - Assessment Scores
   - Panel Assignment
   - Patient Follow-up actions

2. Data Management and Reporting
   - Data Validation
   - Panel Reports
   - Population Performance Monitoring
   - P4P Reports

3. Clinical Decision Support
   - Evidence-based prompts for care services on a schedule
   - Identifying unmet care needs through searches of patients
Strategy

- Use existing tools
- Minimize costs of manual entry
- Automate data flow using CPT or ‘dummy’ codes entered by billers
- Panel managers, not billable staff, enter data
- Only enter outcomes data for population performance measurements
Data Collection & Flow

- Lab Data
- NextGen Electronic Practice Management System
- NextGen Electronic Health Record
- Manual Entry
- Demographics
- Appointments
- Billing History (Visit and Dx Codes)
- Clinical Data
- E-Prescribing Referrals
- Pre-EHR Clinical Data Follow-up Tasks and Actions
- i2iTracks Population Registries
i2iTracks Configuration

- Common build allowing for panels with diversity of populations, staffing, skill level

- Data Elements:
  - Status: Active, Waiting List, Case Closed, Care Elsewhere, Enrollment Date
  - Panels: Case Manager, Mental Health Specialist, Psychiatrist
  - Assessment Scores: PHQ, GAD, PCL-C, UNCOPE, Edinburgh
  - Medication Classes
  - Psychiatry Consults
  - Referrals tracking
Promoting Integration

HIT as a Tool for Change
Functions

• Easy access to behavioral health assessments
• Track referrals for behavioral health
• Track utilization/outcomes
• Inform PC/BH providers of total care provided
• Provide management support
  ▫ Individual provider productivity, panel size
  ▫ Referral patterns between primary care/behavioral health
• Promote patient involvement/education (concurrent documentation, materials)
Transition to EHR

• Pre-EHR
  ▫ All BH assessment scores entered by hand into i2i
  ▫ Some primary care markers auto populate into i2iTracks, some need hand entry

• With EHR:
  ▫ Most primary care outcomes entered into EHR during patient visit, auto populate into i2iTracks
  ▫ BH Assessment tools loaded into EHR, still need to map to i2i
  ▫ Referrals tracked in EHR
Behavioral Health Visit Summary

- Provider tool
- Generate for all BH visits
- Promotes timely use of BH assessment tools and outcome tracking
- Promotes attention to chronic disease outcomes, standing orders
- Alerts if client is in pain management program
Date Printed: 3/14/2013

Patient Visit Summary (Behavioral Health)

<table>
<thead>
<tr>
<th>Patient ID:</th>
<th>Name:</th>
<th>Age:</th>
<th>DOB:</th>
<th>Sex</th>
<th>Last Vitals</th>
<th>Date:</th>
<th>Weight (lbs):</th>
<th>Height (inches):</th>
<th>Pulse:</th>
<th>Blood Pressure:</th>
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<td>MR:</td>
<td></td>
<td>51 Yrs</td>
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<td>F</td>
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<td>2/4/2013</td>
<td>285.4</td>
<td>75.75</td>
<td>83</td>
<td>125/78</td>
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<th>State:</th>
<th>Address 1:</th>
<th>Address 2:</th>
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<th>ZIP:</th>
<th>PCP:</th>
<th>Insurance:</th>
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<tr>
<td>CA</td>
<td>Oakland</td>
<td></td>
<td></td>
<td>94606</td>
<td></td>
<td>Medi-CAL/Alameda Alliance Medi-Cal</td>
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</table>

TRACKED PROBLEMS: Asthma; Depression; DM 2; DM Circ Manif; DM Complic NOS; DM Neuro Manif; DM Ophth Manif; HTN; Hypothyroid; Obesity

TRACKED MEDICATIONS: Metformin

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<tr>
<th>Medication</th>
<th>Due: Education: Self-Mgmt; Goal DM</th>
<th>Due: Immunization: Flu (62)</th>
<th>Due: Procedure / Referral; Dental Visit (12)</th>
<th>Due: Lab: Cholesterol (Total)</th>
<th>Due: Lab: Microalbumin / Creatinine Ratio</th>
<th>Abnormal EyePACS Case (12/21/2012)</th>
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# Patient Health Dashboard

<table>
<thead>
<tr>
<th>Date Range:</th>
<th>7/1/2012 - 9/30/2012</th>
<th>4/1/2012 - 6/30/2012</th>
<th>1/1/2012 - 3/31/2012</th>
<th>10/1/2011 - 12/31/2011</th>
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</thead>
<tbody>
<tr>
<td>Term</td>
<td>Target</td>
<td>Value</td>
<td>%</td>
<td>Value</td>
</tr>
<tr>
<td>1. Chronic Disease Management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A. Diabetes Tracking Type</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Total Patients in Tracking type</td>
<td>918</td>
<td>100%</td>
<td>918</td>
<td>100%</td>
</tr>
<tr>
<td>B. Diabetes Eligible Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Total Eligible Population</td>
<td>612</td>
<td>100%</td>
<td>573</td>
<td>100%</td>
</tr>
<tr>
<td>2. HbA1c Testing</td>
<td>&gt; 95%</td>
<td>577</td>
<td>94.28%</td>
<td>542</td>
</tr>
<tr>
<td>a. HbA1c Control (&lt;7.0%)</td>
<td>&gt; 40%</td>
<td>238</td>
<td>41.25%</td>
<td>✓</td>
</tr>
<tr>
<td>b. HbA1c Value (7.0-9.0%)</td>
<td>205</td>
<td>35.53%</td>
<td>213</td>
<td>39.3%</td>
</tr>
<tr>
<td>c. HbA1c Poor Control (&gt;9.0%)</td>
<td>133</td>
<td>23.05%</td>
<td>112</td>
<td>20.66%</td>
</tr>
<tr>
<td>1. Behavioral Health</td>
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<td></td>
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</tr>
<tr>
<td>A. Total Eligible Population</td>
<td>121</td>
<td>99.5%</td>
<td>111</td>
<td>99.11%</td>
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<tr>
<td>1. Psychological Assessment of High-Risk Patients with Diabetes</td>
<td>25</td>
<td>19.08%</td>
<td>21</td>
<td>18.92%</td>
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<td>3. Blood Pressure Recorded</td>
<td>&gt; 93%</td>
<td>610</td>
<td>93.07%</td>
<td>✓</td>
</tr>
<tr>
<td>a. BP Control (&lt;140/90)</td>
<td>&gt; 75%</td>
<td>487</td>
<td>79.84%</td>
<td>✓</td>
</tr>
</tbody>
</table>
Changes in Diabetes Control

Pilot Site - HbA1c Populations

- FY11_Q3
  - 38% >= 9.0%
  - 35% 7.0 - 8.9%
  - 27% < 7.0%

- FY11_Q4
  - 38% >= 9.0%
  - 37% 7.0 - 8.9%
  - 25% < 7.0%

- FY12_Q1
  - 40% >= 9.0%
  - 40% 7.0 - 8.9%
  - 20% < 7.0%

- FY12_Q2
  - 39% >= 9.0%
  - 37% 7.0 - 8.9%
  - 24% < 7.0%
Practical Considerations

It Takes More Than Technology to Create Change
Culture Change

- Fear of IT
- Outcomes/accountability averse
- Time constraints
- Changing Roles
Implementation Hurdles

• Defining panels and schedules of care
• Educating BH providers on population management
• Identifying additional panel management staff
• Training PM staff on BH workflows in EHR
• Integrating use of data into case management
• Integrated BH performance measure to incentivize ourselves:
  ▫ Federal grant
  ▫ Other P4P programs
  ▫ Internal patient health dashboard reviewed monthly
Empowering Staff

Create vision  Build tools  Train  Articulate expectations  Incentivize performance
Contact

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