Treating the Whole Person:
The Future of Care Coordination

Dennis Morrison, PhD
Chief Clinical Officer
Netsmart Technologies
The Netsmart Connected Community

Clinical
- EHR
- Order Entry/eMAR
- E-Prescribing
- Pharmacy

Management
- Practice Management
- Scheduling
- Compliance
- Agency e-Learning

Financial
- Revenue Cycle Management
- Accounts Receivable & Billing
- Accounting

Connected Care
- Health Information Exchanges (HIEs)
- Consumer Portals
- Mobile EHRs

18,000+ Organizations, 35+ States
4,000 Facilities
350,000+ Providers
2,500,000 Prescriptions/year
25,000,000 People Served
Netsmart

Providing solutions that focus on interoperability.

Providing opportunities to aggregate data, create benchmarks and do in-depth data analytics

Providing a framework for Electronic Medical Records (EMR), Billing, Scheduling and Clinical Workflows.

Providing solutions that integrate and manage care for populations.

Providing solutions that focus on consumer directed care

Driving down the cost of ownership through specialized services allowing providers to do more with less.
WHY INTEGRATED CARE?
Healthcare Costs

If other prices had followed the same trend as healthcare...

$55/doz  $48/gal  $134/doz

Source: The Healthcare Imperative. Institute of Medicine
Triple Aim

1. Improve the Health of the Population
2. Reduce/Capita Cost of Care
3. Enhance the Patient Experience (Quality, Safety, Access)
### Leading Sources Of Disease Burden in Middle Income Countries

<table>
<thead>
<tr>
<th>2004</th>
<th>Total DALYs (millions)</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>All causes</td>
<td>98.7</td>
<td>.</td>
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<tr>
<td>1</td>
<td><strong>Unipolar major depression</strong></td>
<td><strong>29.0</strong></td>
</tr>
<tr>
<td>2</td>
<td>Ischemic Heart Disease</td>
<td>28.9</td>
</tr>
<tr>
<td>3</td>
<td>Cerebrovascular disease</td>
<td>27.5</td>
</tr>
<tr>
<td>4</td>
<td>Road traffic accidents</td>
<td>21.4</td>
</tr>
<tr>
<td>5</td>
<td>Lower Respiratory Infections</td>
<td>16.3</td>
</tr>
</tbody>
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## Leading Sources Of Disease Burden in High Income Countries

### 2004

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<tr>
<td>3</td>
<td>Cerebrovascular disease</td>
<td>4.8</td>
</tr>
<tr>
<td>4</td>
<td>Alzheimer &amp; other dementias</td>
<td>4.4</td>
</tr>
<tr>
<td>5</td>
<td>Alcohol Use Disorders</td>
<td>4.2</td>
</tr>
</tbody>
</table>
Putting DALY’s in Perspective

Major depression is equivalent in societal burden to blindness or paraplegia.

Active psychosis seen in schizophrenia is equal in societal burden to quadriplegia.
The Stats

- 30% of family practice physician visits involve psychological counseling
- 21% of patients seen by primary care physicians are depressed
  - only 1.2% self-report depression)
- 51% of behavioral health care services are delivered by non-psychiatric physicians
- Primary care physicians write 67% of all psychotropic prescriptions
  - psychiatrists wrote less than 18%.
- 70% of all primary care physicians visits are for psychosocial problems
- Psychologically distressed patients use 2 to 3 times more health care services than non-distressed patients.
Non-Psychiatric Physician Visits in Panic Disorder

Bottom Line

Primary care is the “de facto” mental health service system for 70% of the population

Regier et al., 1993
Mentally ill die 25 years earlier, on average

By Marilyn Elias, USA TODAY

Adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall, a gap that's widened since the early '90s when major mental disorders cut life spans by 10 to 15 years, according to a report due Monday.

"We're going in the wrong direction and have to change course," says Joseph Parks, director of psychiatric services for the Missouri Department of Mental Health. He's lead author of the report from eight states — Maine, Massachusetts, Rhode Island, Oklahoma, Missouri, Texas, Utah and Arizona — that will be released at a meeting of state hospital directors in Bethesda, Md.

About 60% of the 10.3 million people with serious mental
The CATIE Study

At baseline investigators found that:

- **88.0%** of subjects who had dyslipidemia
- **62.4%** of subjects who had hypertension
- **30.2%** of subjects who had diabetes

were NOT receiving treatment.

Joseph Parks, M.D., National Council, 4/14/12
If you have a serious mental illness

Probability of death compared to general population:

- Heart disease 3.4
- Diabetes 3.4
- Accidents 3.8
- Respiratory ailments 5
- Pneumonia, influenza 6.6

Joseph Parks, MD Missouri Department of Mental Health
Mental Disorders and Smoking

- Higher prevalence of cigarette smoking (56-88%) for SMI patients (overall US prevalence 25%).

- More toxic exposure for patients who smoke (more cigarettes, larger portion consumed).

- Smoking is associated with increased insulin resistance.

- 44% of all cigarettes in US are smoked by persons with mental illness.

Joseph Parks, M.D., National Council, 4/14/12

Opportunity

Adults with Mental Health Conditions

29% of Adults with Medical Conditions Also have Mental Health Conditions

68% of Adults with Mental Health Conditions Also Have Medical Conditions

Robert Wood Johnson, 2011 – Mental Health Comorbidity
Remember three numbers
6-17-25

- 6 years - Half life of psychological knowledge
- 17 years - Science to Service Gap
- 25 years - Average loss in life expectancy for SMI
Impact of Behavioral Health

Co-Morbidities on Medicaid Costs

<table>
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<tr>
<th>Condition</th>
<th>Annual Per Capita Costs</th>
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<tbody>
<tr>
<td>Asthma and/or COPD</td>
<td>$8,000</td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>$9,488</td>
</tr>
<tr>
<td>Coronary Heart Disease</td>
<td>$8,788</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$9,498</td>
</tr>
<tr>
<td>Hypertension</td>
<td>$15,691</td>
</tr>
<tr>
<td></td>
<td>$36,730</td>
</tr>
<tr>
<td></td>
<td>$35,840</td>
</tr>
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5% of people account for ~80% of the cost
25% of people account for ~98% of the cost
What does all this have to do with Care Coordination?

- 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 without addressing Behavioral Health
Care Coordination Goal

Improve Care and Efficiency
Primary care integration is the collaboration between behavioral health service providers and primary care providers.

Collaboration can take many forms along a continuum:

- **MINIMAL**
  - At a Distance

- **BASIC**
  - On-Site

- **CLOSE**
  - Partly Int
  - Fully Int

- Coordinated
  - Co-located
  - Integrated

Today’s Disconnected World
The Seven Competencies of a Health Home

• Primary Care Integration
• Care Management
• Care Coordination
• Provider Management
• Claims Processing (State specific)
• Population Health
• Analytics and Decision Support
Individual Pharmacies Soc.

SU

Inpatient MH CMHC PCP

Case Management Utilization Management

Enrollment Assessments Care Plan Referrals

Analytics Consent Authorizations

Outbound Claims

Clinical Registries Provider Registry

HIEs Provider Portal

Treatment Guidelines Population Based Evidence

Clinical Research Medicaid Medicare BC/BS MCO

Local Health Dept.

Patient Decision Support

Clinical Workflow

Financial

Registries

Reporting and Analytics

Provider Network

Inbound Claims Hospital

Clinical Workflow Financial Registries

decision Support

Reporting and Analytics

Patient

Provider Network

Clinical Workflow

Financial

Registries
Netsmart CareConnect Network

- Lab Results
- Lab Orders Out
- Reportable Labs
- CCD & Referrals
- Immunization
- Syndromic Surveillance

Image Source: http://healthit.hhs.gov
Purpose Built Network

Building The Network

5,836 Organizations on Referrals

1,301 Laboratories

5,631 Connections Through HIEs

CareConnect

MAYO CLINIC
Mayo Medical Laboratories

LabCorp
Laboratory Corporation of America

Quest Diagnostics

B&R
Bi-Regional Laboratories Inc.

Cerner

Epic

Allscripts

caradigm

KHIN

SMRTNET

The HIWAY

MiHIN

Shared Services

NORTH CAROLINA HEALTH INFORMATION EXCHANGE

BHIX
Brooklyn Health Information Exchange

KHIE
Kentucky Health Information Exchange

Healthix

INTERBORO RHIO

RHIO

SACVALLEY MESHARE

HealthyConnections
Rhode Island Quality Institute
EHR Agnostic (CareManager and CareConnect)

Operates independent of all Electronic Health Records

Aggregates data using industry standards; Care Manager via CareConnect. (CCD/CDA)

Integrates to HIEs or EHRs to receive ED alerts, Medications, Allergies, and problems
REAL WORLD EXAMPLES
Supports Multiple Populations

- Management of Multiple Chronic Conditions
- Management of the Serious Mentally Ill (SMI) Population
- Integration of Child and Family Services
- Behavioral Health Integration with an ACO
Health Homes of Upstate New York

Provider Network

- BH Provider(s)
- Inpatient MH Facilities
- Social Services
- Hospital(s)
- PCP(s)

Leads and Care Management Agencies

- HHUNY Southern Tier Chautauqua
- HHUNY Western Lake Shore Behavioral Health
- HHUNY Finger Lakes Huther Doyle
- HHUNY Central Onondoga CMS

Health Home

- HHUNY Managing Entity

4

60

3,326
Kansas Health Homes

Health Home Leads
- UHC
- Amerigroup
- Sunflower

Health Home Partners
- CMHC 1
- CMHC 2
- CMHC 26

Downstream Providers
- BH Provider(s)
- Inpatient MH Facilities
- Social Services
- Hospital(s)
- PCP(s)

3 Health Home Leads
26 Health Home Partners
3,397 Downstream Providers
Sharing a Care Plan: NYC

**Behavioral Health**
- Care Coordination
- Care Management Agency
- Care Coordination Plan

**Physical Health**
- Care Coordination
- Care Management Agency
- Care Coordination Plan

**Problems**

**Objectives**

**Interventions**

**Health Information Exchange**

- Supporting workflow of Behavioral Health
- Supporting workflow of Substance Abuse
- Exchanging both Physical and Behavioral Health data
- Exchanging CDA electronically (Care Coordination Plan)

**Transfer of CDA Electronically**
YESS

- Emergency Services and Shelter
- Implementing Netsmart CareRecord (EHR)
- Health Home for Children (Magellan)
Integration Model: LA County

- LACDMH IBHIS
- San Fernando
- Tarzana Treatment Centers
- Referrals CCD Clinical Documents
- Contractors (Netsmart Systems)
- Contractors (Non-Netsmart)
- Valley Pres Hospital
- North Ridge Medical Center
- Referrals CCD Clinical Documents
- ED Alerts Transitions of Care Referrals
- CareConnect™
- Epic
Health Record Integration

- Push Based Referrals and Transitions of Care
- Increase Data to Include Behavioral Health Data
- Implement Point of Care Consents for Query
- Embed Netsmart into their Systems
Fundamental Change in Orientation

Needs of the patient

Support of the individual provider at the point of care

Treatment of chronic disease

Islands of automation

Needs of the population

All providers across the spectrum of care

Management of chronic disease

Integrated information access across providers, settings & activities

“And” not “Or”
There are always surprises
Why Change?

The reason organizations fail is “the assumptions on which the organization has been run no longer fit reality.”

Peter Drucker

The End of Delegation? Information Technology and the CEO. HBR Perspectives Sept-Oct 1995 Reprint Number 95505
BUT...IT’S NOT ABOUT US
In their words…

We believe that the majority of physicians and other health care providers must fundamentally change their approach toward their patients, an approach revealed through the use of that “special voice”…

Bergeson, 2004
…Sadly, far too many professionals have a manner of speaking to us as if we are slightly stupid children....

Bergeson, 2004
...It’s that voice that reminds us that we aren’t really partners in care with our health care providers. . .

Bergeson, 2004
...It’s that voice that reminds us that health care providers still think of themselves as taking care of us, instead of working with us....

Bergeson, 2004
It’s the voice of learned helplessness.
The best time to plant a tree was 20 years ago.

The second best time is now.

– Proverb
STEVE JOBS

“I want to put a ding in the universe.”
Put a ding in the universe