

# Integrated Population Health: Better Health, Better Care, Better Value

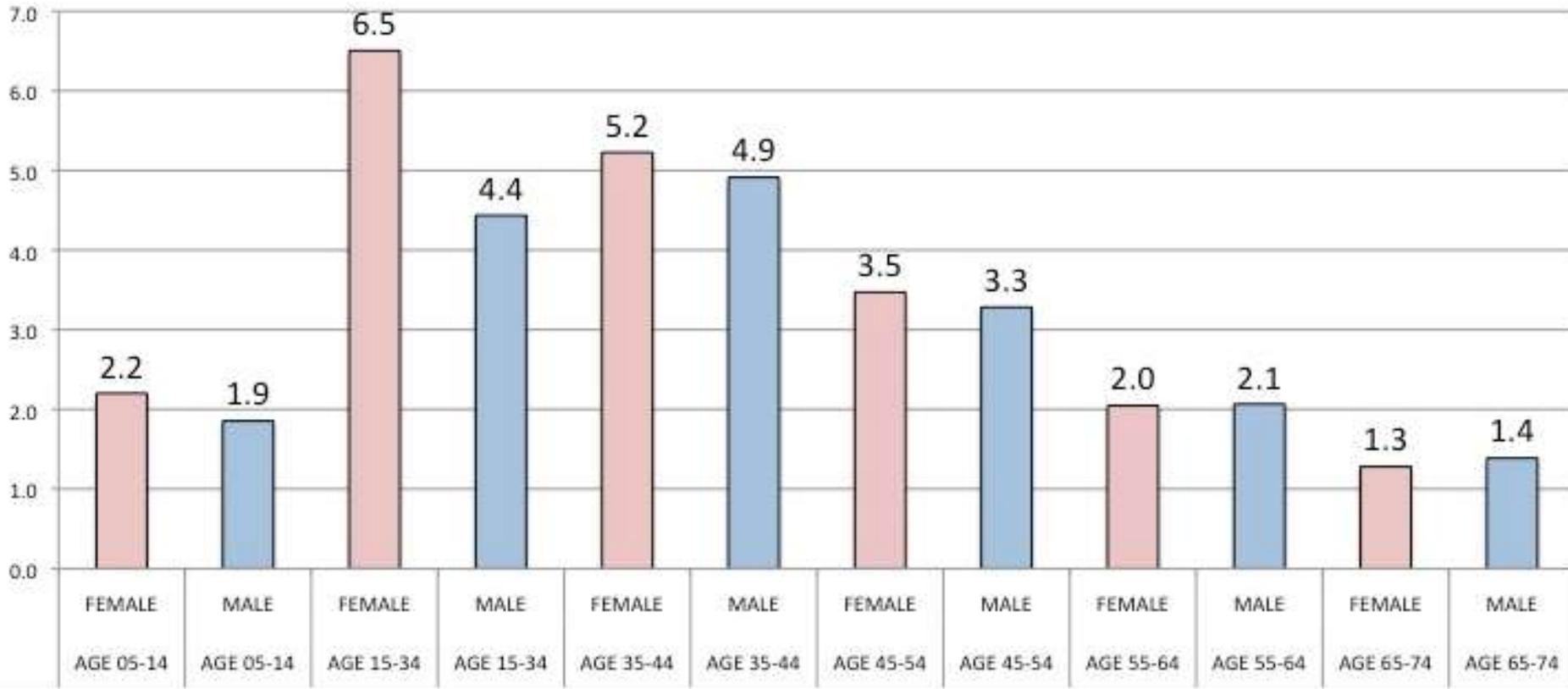
SAMHSA-HRSA CIHS  
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# Primary and Behavioral Health Care Integration

- Improved access to primary care services
- Improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease
- Increased availability of integrated, holistic care for physical and behavioral disorders
- Better overall health status of clients

## Mental Health Client's Increased Mortality Rate Compared to Texas Average



Preliminary analysis of 4,486 deaths, 2006-2008.

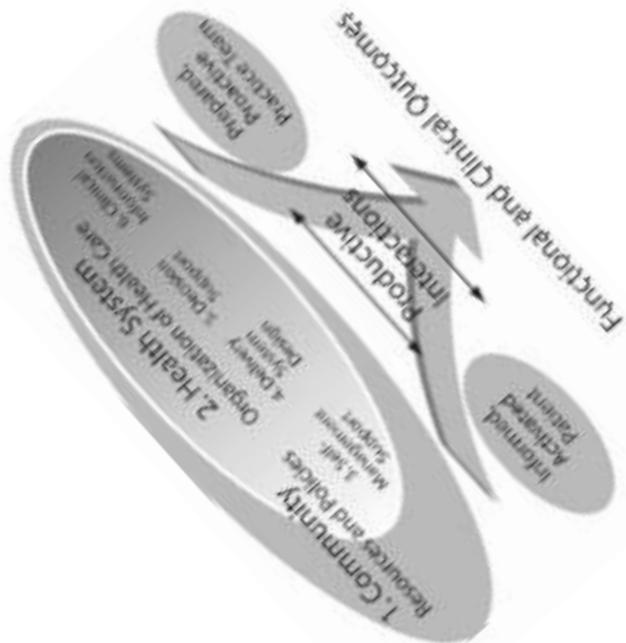
Causes: 25% CVD, 18% accidents, 13% cancer, 9% suicide, 5% respiratory

# Improved Outcomes need Improved Processes and Infrastructure

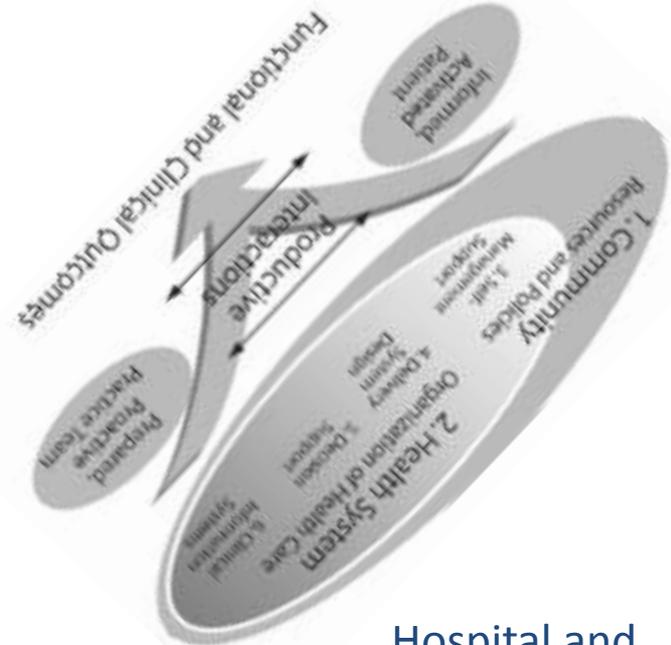


# Primary Care

Chronic Care Model is needed in each provider setting



Specialty (BH or PH) Care



Hospital and Emergency Care

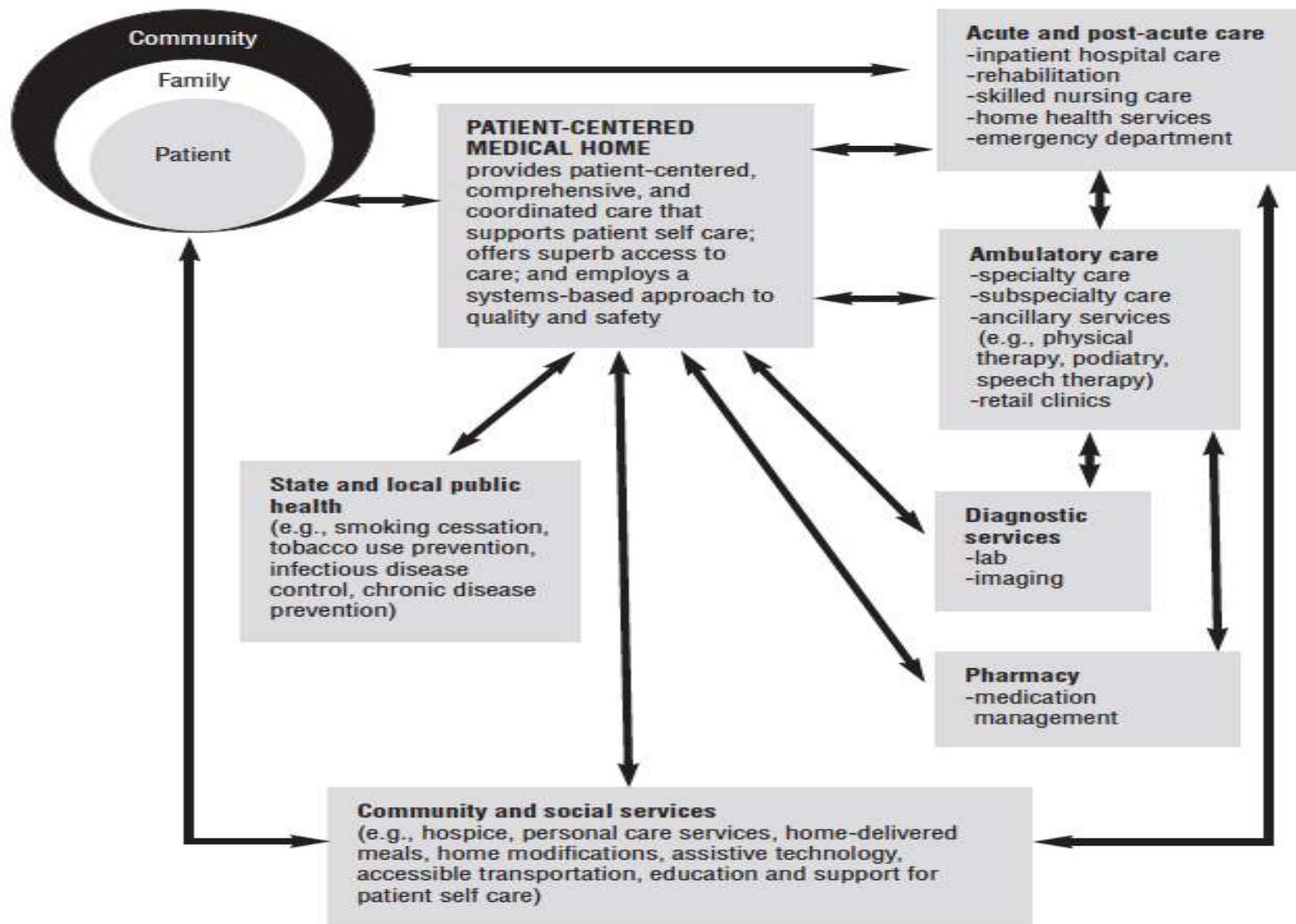
# Enhancing Effective Capacity: Each role operates at the peak of scope of practice

- Primary Care
  - Physician
  - APN, PA
  - RN
  - LVN
  - Medical assistant
  - Admin assistant
- Behavioral health
  - Psychiatrist
  - Doctoral level therapists
  - Master level therapists
  - Care managers
  - Behavioralist assistants

Peers

Client/Consumer/Patient

**Figure 1. Key actors and the flow of information in the medical neighborhood**



# Person-Centered Health Neighborhood

**patient-centered medical neighborhood...**

## PCMH

In Medical facilities:

- Preventive care
- Chronic care
- Acute, episodic care
- Post-acute care

- Public Health
- Home health services
- Pharmacy

Individual assessments

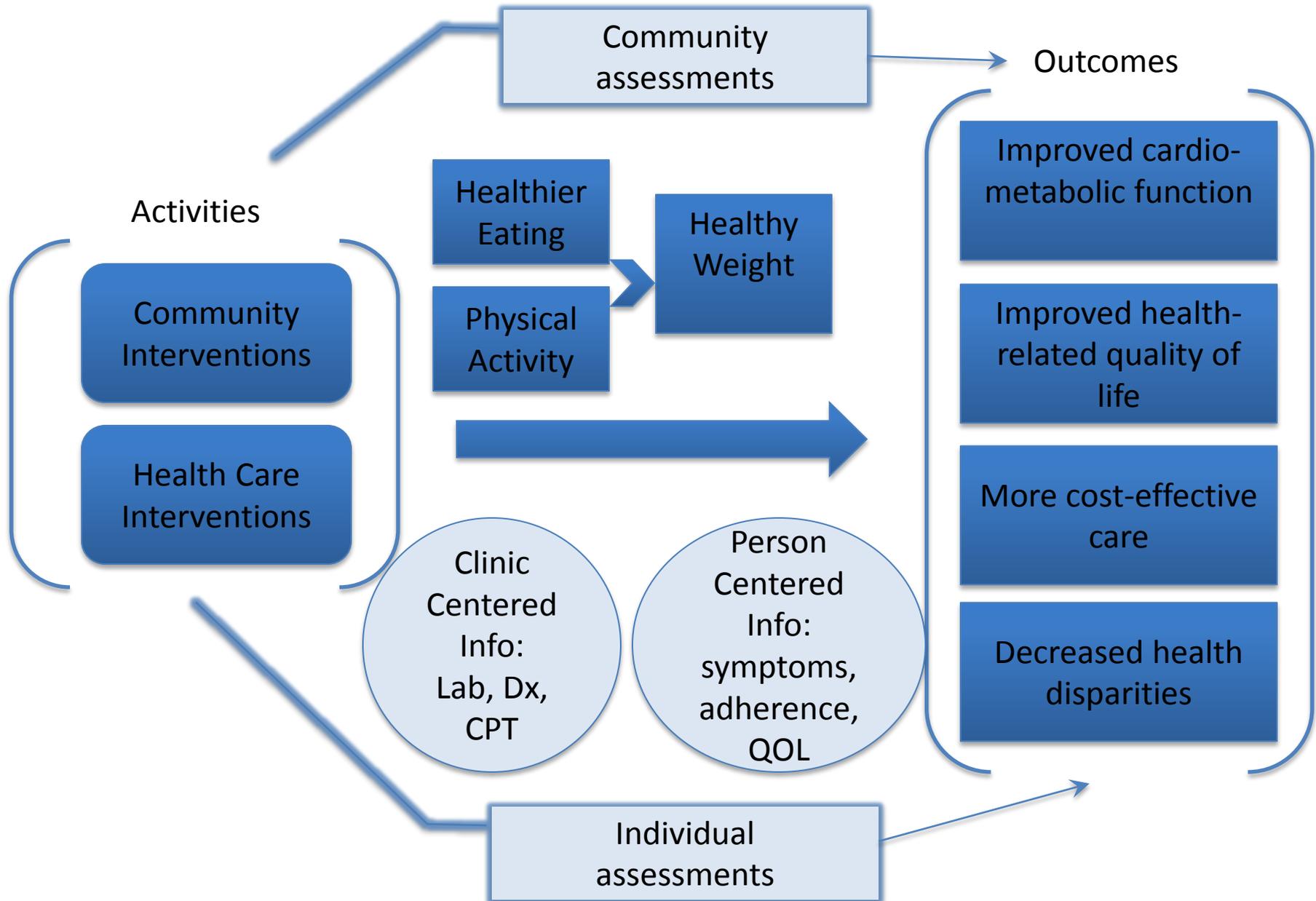
## Community Services

- Societal Services (e.g., Schools, Housing, Transportation, Parks)
- Community Preventive Services (e.g., policy, mass media)

**...and the surrounding community**

Community assessments

# Measuring Prevention and Management



# HIT necessary but not sufficient

- Can't perform PCMH without HIT since need
  - EMR
  - HIE/Registries
  - Aggregate quality and efficiency reports
- But not sufficient
  - Interoperability not required until at least 2014, so CCD alone not that helpful; multiple CCDs problematic
  - HIE/registries lack of completeness is a barrier
  - HIE/registries lack clinical processing
  - No personalized recommendations at point of care

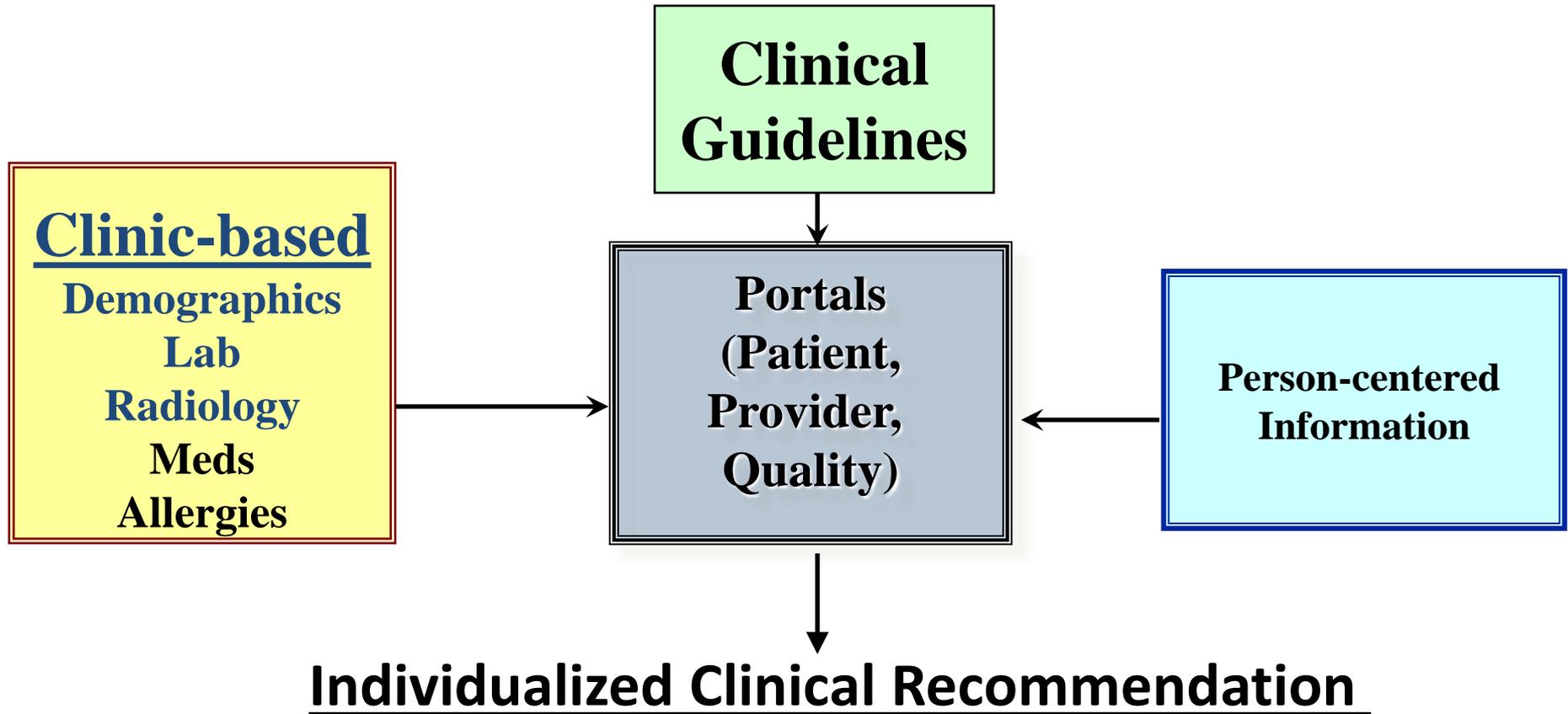
# Enhanced Registry Functionality

- Identify subpopulations with specific chronic care needs: registry. Meeting the **specific individual needs of persons** is critical to the success of PCMH, ACOs, integrated health, etc.: **Enhanced Registry**
  - Preventive services
  - Disease or risk conditions, e.g., **diabetes, cardiometabolic risk**
  - Co-morbid physical and behavioral health
- **Functions built on clinical decision support**
  - **Action reports (exception reports): unmet need**
  - **Performance monitoring**
  - **Clinical decision support @ point of care**
  - **Self-Management support through enhanced patient portal**
- Interoperate with existing IT systems via clinical continuity document (CCD) eventually, but now not required until 2014 at earliest; **CCDs need to be clinically processed**
  - Structured taxonomy
  - Data standards
  - Transmission standards

# Enhanced Patient Portal: dynamic feedback loop

- Patient **uses** information: structured data and information processed into patient language (English or Spanish)
  - Self-management plan (from treatment plan)
    - Non-pharmacotherapy plan and prompts
    - Pharmacotherapy plan and prompts
    - Appointment schedule and prompts
    - What to monitor for (side-effects, complications)
  - Handouts: education, logistic information
- Patient **provides** information
  - Screenings, assessments, and devices (e.g., BP, weight, activity, sleep)
  - Self-report information for holistic view
  - Patient-centered information for CCD
  - Patient-centered feedback on primary results and barriers to adherence
- Patient **controls access** to information: segmented consent

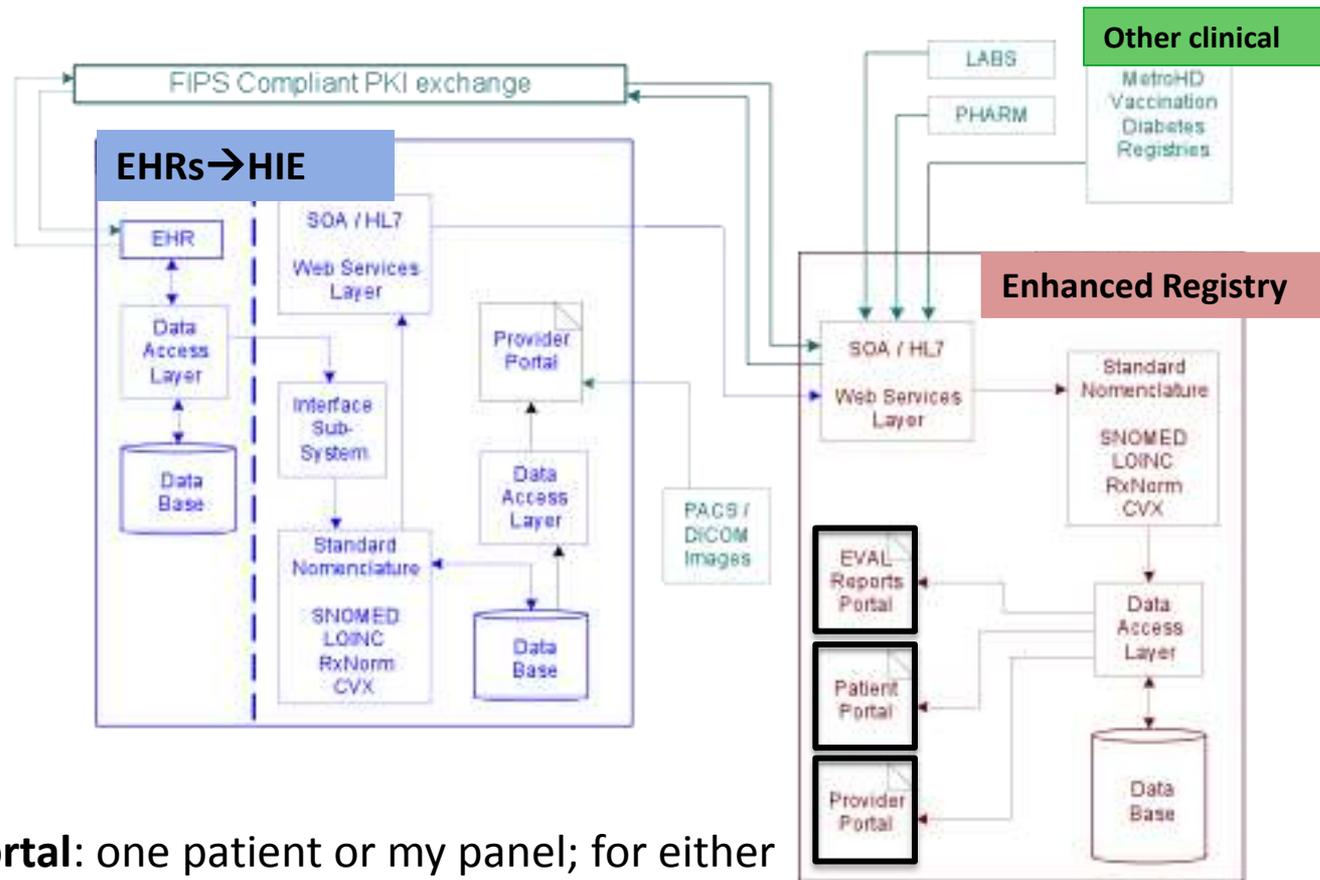
# Information Integration with Enhanced Registry



# Clinical Steps

- **Assess**
  - Health status
    - Health-related quality of life/functional status at baseline
    - Chronic conditions and risk factors at baseline
  - Health needs
    - Clinical preventive services: **all persons**
      - Screen
      - Counsel
      - Immunizations
      - Chemoprophylaxis: aspirin, folate
    - Chronic conditions: **certain persons**
      - Monitoring for primary and secondary outcomes and HR-QOL
      - Delivery of recommended services
      - Monitoring for side effects
- **Engage:** motivational interviewing approach
- **Manage:**
  - Meet the health needs of person and family
  - Support self-management
  - Care coordination

Enhanced Registry: data from multiple sources -> Clinically processed → Portals



**Provider Portal:** one patient or my panel; for either current providers or care coordinator/manager teams

**Evaluation/Reports Portal:** overall population or sub-populations; can click through to individual for care teams

**Patient Portal:** assessments and self-management support

# Summary

- HIE/registry probably not good enough without
  - clinical processing
  - patient-centered information
- Using claim data alone leads to incomplete data since contributing providers probably won't submit claim for non-reimbursable services
- To improve provider acceptability and thus, clinical quality and individual/population health, enhance registry with
  - patient-centered information
  - clinical decision support and
  - personalized clinical recommendations
  - enhanced patient portal with self-management support