Using a Regional Health Information Exchange to support the Behavioral Health Community

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About the Camden Coalition

VISION

A transformed healthcare system that ensures every individual receives whole-person care rooted in authentic healing relationships.

MISSION

Spark a field and movement that unites communities of caregivers in Camden and across the nation to improve the wellbeing of individuals with complex health and social needs.
Clinical observation and data analysis guided the original work of the Camden Coalition of Healthcare Providers, and gave rise to the practice of “healthcare hotspotting.”

- The Coalition determined that the highest need patients had the most frequent emergency room visits and hospital admissions.

- Internal analysis showed that one percent of patients represented 30 percent of hospital costs in Camden.
The Camden Coalition Health Information Exchange

- Stores clinical information for patients who have encounters at participating organizations
- Tool to provide clinical decision-making support to users for their patient populations
- Launched in 2010 and moved to its current platform, CareEvolution, in 2012

Camden Coalition
HEALTH INFORMATION EXCHANGE

- Longitudinal view of a patient's health record
- Population-level reports
- Encounter notifications
- Direct Messaging
- Documentation (Thin EMR) and customized form building
Camden Coalition Health Information Exchange Data

DATA POINTS
- MPI
- ADT
- Lab/Radiology Results
- Discharge Summaries
- Medication List
- Problem List
- Allergy List
- Inpatient Notes
- OBGYN Notes
- Progress Notes
- Radiology Notes
- Medicaid Prescription
- Perinatal Risk Assessments
- Incarceration
- Claims

MCOs  ➔  DATA ➔  Labs  ➔  NJ Medicaid  ➔  DATA

DATA

FQHCs  ➔  DATA  ➔  PCPs
Community Partners
Faith in Prevention

DATA

Hospitals  ➔  DATA  ➔  Camden Coalition  ➔  Other Connected HIEs  ➔  Local Jail
Linking healthcare, criminal justice, and other sector data demonstrates the complexity of individuals in Camden who cycle through multiple systems.
Practice Engagement

- Getting data about their patient population in front of clinicians
- Convening them to share about what is and isn’t working
- Working with individual sites on pilots, while moving forward as a community
- Coordinating around patient care
Historical Use of the HIE
Triage

- Triage team uses the HIE and other data sources to identify patients that meet criteria for Coalition programs.
- Triggers workflows for bedside engagement, home visits and goal planning with a multidisciplinary team of nurses, social workers and community health workers.

<table>
<thead>
<tr>
<th>Patient Overview</th>
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<tbody>
<tr>
<td>Coalition History</td>
</tr>
<tr>
<td>Utilization History</td>
</tr>
<tr>
<td>Triage History</td>
</tr>
<tr>
<td>Inpatient Admission: 6 in the last 6 months</td>
</tr>
<tr>
<td>Engagement History</td>
</tr>
<tr>
<td>ED Visit: 6 in the last 6 months</td>
</tr>
</tbody>
</table>

- Identifying Events
- Insurance
- Step One
  - All Program Rule Outs
  - Camden Core (Beacon Triage)
  - Camden Delivers
- Step Two - Past Medical History
- Step Three - Barriers and Complexity
- Triage Outcome
HIE Role

- **Identifying patients**
- Supporting **clinical decision-making**
- Linking hospital admissions and recorded 7-day follow up appointments

Data Activation and support

- Provided a space for providers to address barriers to reconnection and suggest patients for a high-touch intervention with the Camden Coalition team
- **Evaluate** the success of the program in terms of direct impact, existing barriers and scalability
Motivators to expand behavioral health work

- Findings of panel assessment
- Lessons from ED reconnection work
- Link between behavioral health and chronic disease mortality
- Changing landscape
  - Opportunities for additional investment in behavioral health data collection and IT
  - Movement around opioid crisis
Behavioral Health Data in our internal programs
Every story is unique: Meet Peter

- 51-year old African American male
- COPD exacerbation, Acute Asthma Exacerbation, Hypertension, GERD
- Generalized Anxiety Disorder, Major Depressive Disorder
- In remission from Substance Disorder Dependence from Alcohol
- Homeless (1+ year in shelter)
- Limited income (~$200/month)
Monitoring hospital utilization of patients who receive a housing voucher through the Housing First program.
Our Camden Delivers intervention focuses on mothers diagnosed with a substance use disorder.

- Our care teams collaborate with the Addiction Medicine Program at Cooper Hospital and other providers to link patients to the services they need to manage their medical and social needs during and after pregnancy.

### Demographics

<table>
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<tr>
<th>Demographics</th>
<th>No. (%)</th>
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<tr>
<td>Average age (years)</td>
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<tr>
<td>Race</td>
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</tr>
<tr>
<td>Black/African American</td>
<td>4 (31)</td>
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<tr>
<td>Hispanic/Latino</td>
<td>4 (31)</td>
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<td>White/Caucasia</td>
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<td>Other</td>
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### Health Stats

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<tr>
<th>Health Stats</th>
<th>No. (%)</th>
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<tr>
<td>Chronic Medical Conditions</td>
<td>12 (92)</td>
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<tr>
<td>Mental Health Conditions</td>
<td>13 (100)</td>
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<tr>
<td>Mood Disorders</td>
<td>12</td>
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<tr>
<td>Anxiety Disorders</td>
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<tr>
<td>Psychotic Disorders</td>
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<tr>
<td>Personality Disorders</td>
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<tr>
<td>Suicidal/homicidal Ideations</td>
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<tr>
<td>Substance Use</td>
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<tr>
<td>Opioid</td>
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<tr>
<td>Cocaine</td>
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<tr>
<td>Cannabis</td>
<td>4</td>
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<td>Alcohol</td>
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<tr>
<td>Benzodiazepine</td>
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<td>PCP</td>
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<td>Amphetamine</td>
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</tr>
<tr>
<td>K2</td>
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<tr>
<td>Dual diagnosis MH/SUD</td>
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# Encounter Notification report

## 7 Day ED Pregnancy/Substance Abuse

As of 10/14/19 1:33 PM

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB and Age</th>
<th>Gender</th>
<th>MRN</th>
<th>Pregnancy</th>
<th>Substance Abuse</th>
<th>Zipcode</th>
<th>Emergency Location</th>
<th>Emerg Admit Date</th>
<th>Emerg Discharge Date</th>
<th>Inpatient Location</th>
<th>PPA Creation Date</th>
<th>PPA Updated Date</th>
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<tr>
<td>Demoski, C L</td>
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<td>F</td>
<td>XXXXXX</td>
<td>10/07/2019 (Pregnancy with inconclusive fetal viability, not applicable or unspecified)</td>
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<td>None</td>
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<td>CAMH CER 04 04</td>
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Activating Relevant Data for Behavioral Health
How are we bring behavioral health providers in primary care setting

- Building on internal triage process to create automated flags
  - current admissions
  - previous diagnoses

- Building on 7 day pledge
  - Targeting lists for behavioral health related, or impacted conditions
  - bringing social workers in meetings
  - discussing bh strategies and dual approach
Partnering with Oaks Integrated Care

<table>
<thead>
<tr>
<th>Name</th>
<th>DOB</th>
<th>Age</th>
<th>Gender</th>
<th>Visit Type</th>
<th>Admit Date</th>
<th>Discharge Date (Day)</th>
<th>Facility</th>
<th>Inp (12mo)</th>
<th>ED (12mo)</th>
<th>Last Used Insurance (12 mo)</th>
<th>Labs Last 30d</th>
<th>Radiology Last 30d</th>
<th>Patient ID</th>
<th>Encount ID</th>
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<tbody>
<tr>
<td>Demoski, T J</td>
<td>XX/XX/XXXX</td>
<td>39 yo M</td>
<td>E</td>
<td>2019-10-07</td>
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<td>CUH</td>
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<td>AMERIGROUP</td>
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<tr>
<td>Demoski, V</td>
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<td>HORIZON MERCY</td>
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Supporting Quality Metrics and Reporting

- Look up individual patient outcomes around utilization, future episodes of care, etc
- Building on the panel designations to track overall metrics for population
- Exploring workflow alignments with quality metrics around reconnection to care
Piloting workflow support

- Piloting transitions between care settings
  - 1st - using HIE to prep for visit
  - 2nd - panel tracking so that two agencies can coordinate
  - 3rd - piloting electronic referral
  - 4th - tracking outcomes of referral process to automate measurement of referral success
Integrating Behavioral Health data into the HIE
Steps we are taking to move forward increased BH data sharing

Landscape Assessment
● Interviewed Arizona, Oregon, New York, Kansas and Alaska HIEs
● Using high levels of consent and focus on stakeholder engagement, communities are using HIEs to share behavioral health data

Regional convenings
● Goal is to provide a space for both groups to discuss data-sharing opportunities and barriers
● Summer 2019- attended by regional medical and behavioral health providers
● Fall 2019- reviewing patient rights around data sharing and brainstorming a community model
In small groups, discuss the following questions:

1. What is your vision for improving access to behavioral health information in your city/county/region?

1. Are there specific use cases where you think improved access to behavioral health data would be especially helpful?

1. What are the minimum set of data points that would help support a priority use case?

1. What are some of the obstacles/barriers you see to sharing behavioral health data?

1. Which stakeholders should be involved in these discussions?
Key Takeaways from Discussions

**Vision**
- To increase access and availability of both behavioral health and medical information across behavioral health and medical providers
- Desire from behavioral health providers to have increased access to medical information
- Having an informed consent by patients

**Use Cases**
- Share behavioral health diagnosis, medication list, and encounters list,
- Share program tagging for behavioral health services with medical providers
- Additional data points with interest were case notes, lab information, screening results and SDOH/other services information, including availability of services

**Barriers**
- Concerns about the stigma/discrimination that may result from sharing this information
- Concerns around the consent process and how that would work
- Concerns about how the data is being used