Holistic Person-Centered Care: Collaborative Approaches in Delivering Physical and Behavioral Health Services

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Integrated Care: The Map Needs Multiple Routes

Keys to Success

- Member Voice
- Flexibility
- Provider Collaboration
- Data
- The “Special Sauce”
Member Voice

- The most important piece of integration is the willingness of the member to participate.

- No matter your strategy, if the member is not interested, there will be no integration.

- Member’s decisions on their care need to be first and foremost.

- Feedback and partnership is a requirement for success.
Flexibility

- Make a plan for progress
- Recognize this is new and there is no perfect plan – yet
- Be willing to learn from your mistakes and adapt to the needed change
- Consistently review options and be open to feedback
Provider Collaboration

- Evaluation of the network

- Solicit interest and discuss thoughts for integration specific to providers

- Know the “musts” but work with providers to be creative within the absolutes

- Think outside the box – this is not all physical health and not all behavioral health

- Find interested partners
Data

- Develop mechanisms to support the sharing of data
- Be open to suggestions on evaluation measurements
- Work in partnership with all options to support the provider to make the most change
- Recognize more care may be needed in the beginning to see change – be patient
- Develop creative strategies for value based strategies
The “Special Sauce”

- Know there is no “Special Sauce”

- Each partnership brings different challenges and different opportunities – none will be the same

- Recognize the ultimate goal and be willing to find the best way to better health outcomes for the members served

- Continue to review, analyze, modify and partner
ABOUT US

- Began as Outpatient Behavioral Health provider serving 3,800 SMI Adults in 2009

- An alternative to traditional mental health services for adults with SMI emphasizing:
  - Choice
  - Whole person wellness
  - Voice & involvement
  - Integration of best clinical practices and compassionate professionals with the wisdom of individuals receiving services and their family members
Serving 8,000 T19/NT19 adults with SMI at 7 clinic locations
- 5 Integrated Health Homes
- 1 Medical ACT Team (stand-alone clinic)
- 1 rural FQHC partnership

June 2018 - 1,430 in PIR Integrated Health Homes (31% T19 penetration)

Targeted Investments Program (TIP)
- Behavioral health - 7 sites
- Primary care - 5 sites

CMS Transforming Clinical Practice Initiative (TCPI) participating agency
T19 Members Seeing PIR PCPs - June 2018

- Arrowhead - Aug 2016: 54% (771)
- MACT Team - Oct 2016: 100% (100)
- Gateway - September 2017: 55% (732)
- Metro - December 2017: 36% (1200)
- West Valley - April 2018: 10% (968)
QUESTIONS TO CONSIDER

 Is it our mission?
 Do we as, a provider, add value?
 Should we partner for success or go it alone?

 How much will it cost?
   Technology & data management
   Changing workforce roles
   Integrated healthcare facilities

 How do we continue to engage the voice of service participants and providers as architects and designers of the system of care?
Our Why of Integration

- High rates of premature mortality among SMI
  - Disease burden magnified by manageable health conditions (smoking, obesity, sedentary, SUDs)

- Focus on high cost/high need (Familiar Faces)
  - Who are the 10% most at risk?

- Allows for a learning model unique to populations with cognitive impairments
  - Direct access to healthcare on site
  - Small doses over long periods of time
  - Relationship based health advocacy
  - Meeting people where they are on their road to health
## Chronic Disease Burden

<table>
<thead>
<tr>
<th>Condition</th>
<th>2016 AZ General Pop. (n= 6,392,017)*</th>
<th>PIR Arrowhead (n=1,020)</th>
<th>PIR Gateway (n=976)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>30.8%</td>
<td>34%</td>
<td>43%</td>
</tr>
<tr>
<td>Respiratory/Asthma</td>
<td>15.7%</td>
<td>54.3%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>10.1%</td>
<td>14%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>3.8%</td>
<td>32.6%</td>
<td>35.8%</td>
</tr>
<tr>
<td>Obesity/BMI</td>
<td>28.4%</td>
<td>58.7%</td>
<td>56.8%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>14%</td>
<td>55.3%**</td>
<td></td>
</tr>
</tbody>
</table>
# High Cost/High Need ED Utilization - 12 Mos Ending Nov 2017

<table>
<thead>
<tr>
<th># of ED Visits</th>
<th>% of Total Visits</th>
<th># of Patients</th>
<th>Total Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>10+</td>
<td>31.6%</td>
<td>181</td>
<td>2,837</td>
</tr>
<tr>
<td>5-9</td>
<td>25.2%</td>
<td>388</td>
<td>2,266</td>
</tr>
<tr>
<td>3-4</td>
<td>20.4%</td>
<td>580</td>
<td>1,771</td>
</tr>
<tr>
<td>2</td>
<td>11.8%</td>
<td>565</td>
<td>1,059</td>
</tr>
<tr>
<td>1</td>
<td>11.5%</td>
<td>1,116</td>
<td>1,030</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>2,797</td>
<td>8,963</td>
</tr>
</tbody>
</table>

Data Source: Mercy Care
In 2011, PIR began experimenting with different models of delivering primary care and physician extender services

- Co-location by a local FQHC (Mesa, Phoenix)
- Physician group practice contracted for co-located primary care (Peoria)
- First SMI clinic dually-licensed as a health home added in 2013 (Glendale)

Under the Integrated SMI RBHA, the pace of change has accelerated!
2015- PIR launched Arizona’s first Medical ACT Team
- High contact ACT Team offers perfect platform for chronic disease management by embedding PCP within the teams
  - Multi-disciplinary positions (Employment, Housing, Living Skills) target multiple social determinants and needs
  - Targets SMI adults with most intractable MH symptoms and multiple chronic health conditions - 100 total members on team
  - Single care team with full responsibility for all aspects of care
  - 24-7-365 response
2016-2017 - Opened our first whole health and wellness center

- Primary care & psychiatry in same medical suite
- Shared record and standing consultation meetings between providers
- Weekly integration meeting with providers, PCP and care coordinators
- Wellness as an engagement strategy
SMI Integrated Health Home
Behavioral Health, Primary Care, Pharmacy & Robust Wellness Services
Engaging People on their Journey to Health
PIR’s “teaching kitchen” develops skills in food safety, selection and preparation.

Supervised by a master’s level nutritionist
GATEWAY FITNESS CENTER

Certified fitness trainers provide classes in equipment safety, yoga, weights, step and chair activities

Drop in or PCP referral
Are we there yet?

- Nope!
- 2017-2018
  - Added 3 more Integrated Health Homes
  - Developing a rural FQHC partnership
- Focus on Health IT
  - Social determinants screening tool
  - Health Current ADT Program
  - Care Management - New!
  - Population health platform - New!
**PIR’s Integrated Care Approach**

- **Structures** that support integration, not co-location
  - Facility design
  - Clinical team roles, including care coordination & care management
  - Service offerings
  - Technology

- **Processes** that support integrated workflow & member outcomes
  - Technologies that support information sharing and patient management based on risk indicators
  - High risk interventions
MEMBER ENGAGEMENT AS SECRET SAUCE

- Hard-wired into PIR mission & governance structure
- Focus on fun & wellness programs, WRAP
- Integrated General Consent
- Health fairs
- BHMP involvement
- Integrated care as the “new normal”
PCP clinic within the behavioral health facility in same space as psychiatry

Multiple services in one setting facilitated by a Collaborative Care Team
- Psychiatry and Medication Management
- Case Management & Health Navigation
- Rehabilitation and Vocational Services
- Primary Care & Care Coordination
- Peer/Family Support & WRAP

Comprehensive wellness & disease management program using peer health coaches
## Wellness as a Core Service

<table>
<thead>
<tr>
<th>Wellness Strategies Targeting:</th>
<th>Through:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity</td>
<td>Nutritional Counseling</td>
</tr>
<tr>
<td>Sedentary Lifestyle</td>
<td>Fitness, Stress &amp; Exercise Management</td>
</tr>
<tr>
<td>Poor Nutrition</td>
<td>Teaching Kitchen</td>
</tr>
<tr>
<td>Life Stress</td>
<td>Peer Health Coaching</td>
</tr>
<tr>
<td>Smoking &amp; Other Substance Use</td>
<td>Life Skills/Health Promotion Services</td>
</tr>
</tbody>
</table>
Caseloads of approx 1:50
Referred by PCP to work with people with more severe health conditions
- HRA
- CO2, A1c monitoring
- BP, weight monitoring

Self-management focus
- Diet, nutrition education w/ nutritionist
- Teaching people to use BP machines
- Support in smoking cessation
- Follow-up with PCP
Care Management
- 1:100
- High risk registry focus

Care Coordinators
- 1 per PCP
- 1:20 assigned caseload
- High utilizer/chronic condition management

Case Management
- Supportive/Connective teams
- Preventive care management
- Coordination of care
- Psychosocial supports
Single EMR & Shared Care Plan

Health Information Exchange

Patient Portal & Engagement Plan

Population Health Management
Diagram of Admission, Discharge, and Transfer Notifications Workflow
Using data to target clinical interventions
- High risk - utilization
- Care gaps - prevention
- Improving BH/PH outcomes - care management
HIGH RISK INTERVENTIONS - REDUCING UTILIZATION

- High Risk Registry for Familiar Faces
- Establish clinic-based teams to focus specifically on these individuals
- Root cause analysis
  - Record review
  - Member outreach, natural supports
- Individualized assessment & strategy
  - Medications, Dx, baseline
  - Health literacy
  - Reason for visit (stomach ache, headache)
- Goal is to provide alternatives to high cost settings
ACT ED High Risk Intervention - 2018

HR Intervention Group
Non HR Group

356 patients @ 0.7 visits pmpm
18 patients @ 4.2 visits pmpm
-64%
Managing/negotiating value-based contracts

- Reduce Psych Hospital Admits & ED visits by 20%
- Physician Follow Up Psych Discharge within 2 days for 85% of discharges
- HbA1c test in past 12 months for 57% of diabetic population
### FY17 ACT Value-Based Metrics

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal</th>
<th>Omega</th>
<th>Varsity</th>
<th>West Valley</th>
<th>MACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Hospital</td>
<td>-20%</td>
<td>-38%</td>
<td>-14%</td>
<td>-36%</td>
<td>-29%</td>
</tr>
<tr>
<td>Acute Hospital</td>
<td>-20%</td>
<td>-13%</td>
<td>-42%</td>
<td>-55%</td>
<td>-25%</td>
</tr>
<tr>
<td>ED Visits</td>
<td>-20%</td>
<td>-25%</td>
<td>-20%</td>
<td>-4%</td>
<td>-42%</td>
</tr>
<tr>
<td>Employed</td>
<td>+5%</td>
<td>128%</td>
<td>49%</td>
<td>-13%</td>
<td>100%</td>
</tr>
<tr>
<td>PCP Visits</td>
<td>+10%</td>
<td>26%</td>
<td>23%</td>
<td>57%</td>
<td>24%</td>
</tr>
<tr>
<td>Jail</td>
<td>-10%</td>
<td>22%</td>
<td>-40%</td>
<td>10%</td>
<td>2%</td>
</tr>
<tr>
<td>A1c Test</td>
<td>57% of pop</td>
<td>57% of pop</td>
<td>57% of pop</td>
<td>57% of pop</td>
<td>50%</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>49% of pop</td>
<td>49% of pop</td>
<td>49% of pop</td>
<td>49% of pop</td>
<td>75%</td>
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</table>
Long-term commitment to integration is vital - It’s Who We Are
Investments in health IT
Willing to change your practice in fundamental ways
It won’t work if your staff are not on-board
Member engagement as secret sauce
Arizona Care Network – Physical Health Partner
Arizona Care Network

- Began operations in 2013
- Joint venture between Tenet Healthcare (Abrazo Community Health Network) & Dignity Health in 2014
- Affiliation with Phoenix Children’s Care Network for pediatric services
- Over 5,000 clinicians caring for nearly 250K adult and pediatric lives in value-based agreements supporting:
  - Governmental Payers (Medicare & Medicaid)
  - Commercial Health Plans (United, Aetna, Cigna, etc.)
  - Medicare Advantage Plans
  - Self Funded Employers
13 DIVERSE VALUE-BASED CONTRACTS

- Medicare
- Medicaid
- Commercial
- Direct to Employer

5,602 Providers

1,840 Care locations statewide

250,000

1,109 Primary Care
3,964 Community Specialists
529 Facility/other

$18 Million Total Medical Cost Savings

Quality outcomes achieving Value-Examined Lives

7/24/2018 PRIVILEGED AND CONFIDENTIAL
ACN and MMIC partnered to create this model adapted from the *Teamlet Model developed by Dr. Thomas Bodenheimer, University of California - San Francisco
Members of the Virtual Health Home:
• Serious Mental Illness (SMI) Diagnosis
• Federal/State entitlement program (Title XIX)
• Medical Services received from participating PCP
• Behavioral Health services received from a participating PNO

Health Coach Virtual Health Home Model:
• Embedded health coach in PCP offices during hours of operation.
• Experienced behavioral health worker
• Trained to promote cardiovascular risk reduction
• Completes an evaluation at baseline and every six months
Patient & Primary Care Physician: Pre-Enrollment with a Health Coach

Patient’s experience before entering the VHH:

• Uncontrolled chronic conditions
• Varying treatment plans from physical and behavioral without coordination
• Seeking a trusted partner in the physical health world

PCP Experience before:

• Unable to get patients to regularly attend
• Unable to get patients to adhere to treatment plan
• Not updated with the behavioral health treatment plan, new and changing
• Inability to regulate the patient’s focus and provide necessary education
Patient & Primary Care Physician: Post-Enrollment

Post Enrollment:

- Patient engaged in program; 187 enrolled and 79 un-enrolled
- Patient healthcare experience improved
- Provider can efficiently and effectively tend to panel of patients
- Chronic conditions improved, specifically HgA1c (Patient Example: HbA1c 13.4 to 7.7 steadily decreasing)

- [https://www.youtube.com/watch?v=9YDp23zUWLU](https://www.youtube.com/watch?v=9YDp23zUWLU)
Questions

Thank you

mercy care