INTRODUCTION TO OUR HEALTHCARE SYSTEM
“We expect consolidation to continue as pressure on state budgets increases, privatization of behavioral healthcare services grows and facilities seek economies of scale.”
(December 2016)

"On June 5, 2017, Governor Doug Ducey issued his first public health emergency declaration, which called for a statewide effort to reduce opioid deaths in Arizona. An Enhanced Surveillance Advisory following the declaration resulted in 280 suspected opioid deaths and 2,361 suspected overdoses reported since June 15th."
(September 2017)

"Drug Deaths in America Are Rising Faster Than Ever. Drug overdose deaths in 2016 most likely exceeded 59,000, the largest annual jump ever recorded in the United States."
(June 5, 2017)

"Arizona failed to provide the number of beds considered necessary to provide adequate treatment for people with mental illness; 50 per 100,000 people is the standard. In 2016, there were 4.4 beds per 100,000 people, ranking Arizona 48th in beds per capita."
(March 20, 2017)

"The opioid crisis is an emergency, and I’m saying officially right now it is an emergency. It’s a national emergency. We’re going to spend a lot of time, a lot of effort and a lot of money on the opioid crisis."
(August 10, 2017)
MENTAL HEALTH FACTS IN AMERICA

1 in 5 adults in America experience a mental illness.

Nearly 1 in 25 (10 million) adults in American live with a serious mental illness.

One-half of all chronic mental illness begins by the age of 14; three quarters by the age of 24.

49.9 million adults with any type of mental illness in the past year

18.1% (42million) adults live with ANXIETY disorders

15% (900,000) Pregnancies result in POSTPARDUM disorder

8% (24.4million) Americans have PTSD

6.9% (16million) adults live with major DEPRESSION

2.6% (42million) adults live with BIPOLAR disorder

1.2% (3.2million) adults live with SCHIZOPHRENIA

1% (2.2million) Americans have OCD

56% adults with MENTAL ILLNESS did NOT receive treatment


*updated to 2016 figures based on ratios above and adult USA population of 249,485,000. 2014 FIGURES: https://www.samhsa.gov/newsroom/infographics?page=1
Substance Use & Mental Illness in U.S. Adults

**Consequences**

**10.2m**
Approximately 10.2 million adults have co-occurring mental health and addiction disorders.¹

**26%**
Approximately 26% of homeless adults staying in shelters live with serious mental illness.¹

**24%**
Approximately 24% of state prisoners have "a recent history of a mental health condition".²

**Impact**

**1st**
Depression is the leading cause of disability worldwide, and is a major contributor to the global burden of disease.³

**-$193b**
Serious mental illness costs America $193.2 billion in lost earning every year.⁴

**90%**
90% of those who die by suicide have an underlying mental illness. Suicide is the 10th leading cause of death in the U.S.²

*updated to 2016 figures based on ratios above and adult USA population of 249,485,000

2014 FIGURES AND RATIOS: https://www.samhsa.gov/newsroom/infographics?page=1
https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
The Need for Services that can Meet the Need

EMERGENCY ROOM VISITS FOR MENTAL HEALTH CONDITIONS

1:8 ER visits involve a mental health and/or substance use condition

Mood disorders account for more than 40% followed by anxiety disorders and alcohol-related conditions

People needing mental health care wait on average almost 2 hours longer in ER than people needing general medicine

1:5 emergency physicians said they have patients waiting 2+ days for in-patient psychiatric beds

The number of psychiatric hospital beds in US dropped more than 96% since 1950s and more than 17% since 2010

Average ER cost per psychiatric patient is more than $2,000 in addition to general medical care, with additional typical ER costs around $6,000+

District Court decision filed April 2015, says that Washington State violates the constitutional right of inmates with mental health issues who wait longer than seven days for evaluation and treatment

ARIZONA’s Mental Health Crisis

Arizona ranked **42th** (adults) in the nation for the state’s high prevalence of mental health illness and low access to mental healthcare.

92% of Arizona market that is currently under-served for beds necessary to treat mentally ill.

4th most common reason for ER visits in Maricopa County was mental health as a primary diagnosis.

716,704 Emergency room visits and discharges of inpatients with mental disorders.

197,963 Discharges of Inpatients with mental disorders.

518,741 Emergency room visits for mental disorders.

Arizona’s Opioid Epidemic

ADHS Emergency Response

431 MILLION opioid pills prescribed in Arizona in 2016. That’s equal to 62 pills for every man, woman and child in the state.

2+ PER DAY number of opioid overdose deaths in Arizona in 2016

75% INCREASE in the number of overdose deaths in Arizona since 2012

COMMUNITY EMERGENCY

• The Mesa Fire and Medical Department Community Care Initiative is a $12.5 million cooperative agreement with the Centers for Medicare and Medicaid (CMS) that seeks to improve community healthcare in Mesa by linking traditional clinical care services with community-based interventions.

• This endeavor derives from the 911 system and aims to improve efficiency, cost, savings, and patient health.

• The program teams up a captain-paramedic and a licensed behavioral health counselor, which provides system flexibility to 911 based patients experiencing non-medically necessitated behavioral health issues.

• This allows patients to receive definitive and appropriate care including a mental health assessment and transportation directly to an inpatient behavioral health facility – for instance the one Integro Health Systems offers.
“Everything in life has a price. $20,152,088. That’s the price of waiting. Recent estimates suggest that Arizona’s healthcare system foregoes over $20 million annually due to prolonged emergency department (ED) waiting times for behavioral health patients. “

“psychiatric boarding cases compared to nonpsychiatric ED admissions, the average boarding case leads to a direct loss of $1,198 to EDs. When factoring in additional opportunity costs of psychiatric boarding (e.g., loss of revenue associated with potential bed turnover), the average case costs EDs $2,264.13. By applying these figures to Arizona’s psychiatric boarding data, estimates reveal that the average psychiatric boarding case costs upwards of $6,220, leading to a total statewide cost of $20,152,088 per year”
Studies showing average psychiatric patient in medical emergency departments boards for an average of between 8 and 34 (!) hours.

2012 Harvard study: Psych patients spend an average of 11.5 hours per visit in ED; those waiting for inpatient beds average 15-hour stay.

2012 CHA Study: After decision made for psychiatric admission, average adult waits over ten hours in California EDs until transferred.

Boarding is a costly practice, both financially and medically.

Average cost to an ED to board a psychiatric patient estimated at $2,264.

Psychiatric symptoms of these patients often escalate during boarding in the ED.

Higher Readmission Rates

- Readmission rates after 30 days of hospital discharge are high for behavioral health
  - Patients with mood disorders is 15 percent
  - Patients with schizophrenia is 22.4 percent
  - Patients with opioid and prescription drug abuse
- These numbers may be higher in Maricopa County
Solution

General recommendations

• Identifying and addressing root causes
• BH 101 online curriculum for ED docs, nurses and staff
• ADT alerts including Health Current
• More effective levels of care that address specific patient needs, eg, co-morbid BH and PH problems
• Addressing our archaic involuntary law that creates blockages in the crisis system.

Integro Regional Model

• A new, innovative continuum of crisis services for patients with co-morbid medical and behavioral health problems.
• Three levels of care that can be flexibly adapted to patient needs
  • Urgent care/observation unit
  • Inpatient/subacute
  • IOP
• Connected to crisis and BH provider network to ensure throughput
• Overcomes IMD issue
• Designed to optimize outcomes for patients and their families
• Designed to be efficient and cost-effective
Solution

General recommendations

- **Telepsychiatry Services** – This solution is important in increasing access to a psychiatrist in a more timely fashion. There are various private companies offering this service across the country.

- **Psychiatric Observation Units and Treatment Protocols** – Specific psychiatric emergency department and/or observation units are utilized to pull psychiatric patients out of the general ED once they are stabilized or medically cleared.

- **Protocols** to care for the patient during their lengthened observation stays are often helpful.

- **Patient Navigation/EMS Involvement** – This can be approached from several aspects. One increasingly common approach is “Community Paramedicine Programs” in which paramedics help patients navigate the often cumbersome health care environment. Additionally, some EMS agencies are clearing patients medically in the field and transporting them directly to psychiatric hospitals. Lastly, social workers and case managers can serve as important navigators for patients.

- **Mobile Crisis Units** – These are usually teams of multidisciplinary mental health professionals that respond to individuals in the community requiring assistance with a psychiatric crisis. The team may include social workers, nurses, psychiatrists, psychologists, addiction specialists, mental health technicians, and peer counselors. The mobile crisis team can provide a range of services that can include assessment, crisis intervention, information, referrals, and supportive counseling.

- **Regional/State Health Registries** – A streamlined state or regional dashboard showing bed availability coupled with available transfer mechanisms are helpful in reducing the time and effort it takes to get patients to definitive care.

- **Emergency Department Evaluation, Treatment, Re-evaluation**

- **Protocols for Safe Discharge** – Evidence-based decision tools can be helpful in allowing an emergency physician to safely discharge a patient with a mental health disorder.

- **Lessons Learned Case Studies**

Integro Regional Model

- **Stand-alone Psychiatric/Medical Services (PES)**
  - **Advantages:**
    - Staffed around the clock with psychiatric nurses and other mental health professionals
    - More prompt diagnosis, treatment
    - Extended observation capability, 23:59hr
    - Can significantly reduce admission rate (70-80%)
    - Allows for quick decompression of EDs reduced adv ED time from over 10hr to less than 2hr
    - Immediate proximity to medical
  - **Central Charting:** *Cerner*
  - **AEMS approve for direct hand off**
  - **$500+/-$9485: $350) vs $2,264. ($5894/ED visit 2014: 75,587 ED visits with MH as a primary)**

Maricopa county 2014 in-patetion discharges with MH as primary Dx had total charges of $953,221,301 if Integro and partners treated 50% of this admissions potential results in a reduction (70%) in charges of $333,627,361 or $185,348,534 Savings
Integro Health Services is a freestanding behavioral health system. Our team of health experts from all over the spectrum of medicine work together with hospitals, communities, foundations, doctors, and urgent services to help clients with behavioral management.

The place where the priority is members with behavioral health and co-morbid medical problems. Patients get stable safely and quickly. Evaluation and treatment from trained professionals who understand behavioral health, and provide comprehensive and compassionate care.

More acute cases are easily moved to rooms on site for the intensive, round the clock care they require. (Non-IMD)

Continued Care is a must for keeping patients stable. Ongoing individual and group therapy transforms patients into functioning, loving, and happy, members of their family and community.
## Solution

<table>
<thead>
<tr>
<th>License (License)</th>
<th>License # (License)</th>
<th>Capacity (License)</th>
<th>Provider Type (License)</th>
<th>Revenue Codes (BH Covered Services Manual)</th>
<th>AHCCCS Rate (BH FFS Codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Tx Center/Counseling</td>
<td>OTC8606</td>
<td>15 BH Obs/Stablz Chairs Up to 24 hrs</td>
<td>77</td>
<td>HCPCS Codes: S9484, S9485</td>
<td>$63.33/hr up to 5 hrs $350.51 per diem</td>
</tr>
<tr>
<td>IP – Sub Acute</td>
<td>IFBH8604</td>
<td>16 beds</td>
<td>85</td>
<td>Revenue Codes: Psychiatric: 0114, 0124, 0134, 0154 Detox: 0116, 0126, 0136, 0156</td>
<td>$613.58 $655.21</td>
</tr>
<tr>
<td>Outpatient Tx Center/Counseling</td>
<td>OTC8603</td>
<td>60 members Includes IOP: 2 – 5hrs/day 3 – 5 days/wk</td>
<td>77</td>
<td>As per the Covered Services Manual CPT and HCPCS codes</td>
<td>FFS Behavioral Health Outpatient Rates</td>
</tr>
</tbody>
</table>
HOW WE ARE DIFFERENT

Urgent Care
Client is seen by a behavioral provider, and their medical and behavioral issues are stabilized.

Client referred from hospital or provider

Client discharged from hospital

Admission to Hospital
Client begins customized therapy protocol based on their needs (estimated range of 3 days – 3 weeks)

IOP / OP
Client is discharged and begins outpatient treatment (estimated range of 8-12 weeks IOP with 12m follow up treatment)

All-in-one approach
Client meets their counselors within the Integro Network for Inpatient and Intensive Out Patient treatment

Client referred from hospital or provider

Integrated medical and psychiatric approach to care

• One unified treatment team
• One Medical Record
• Reduction of wait times
• Improved results
We are currently in discussion with all health plan providers, including federally and state funded plans.
INTEGRO’S FLAGSHIP LOCATION

1501 E. Orangewood Ave., Phoenix, AZ

URGENT CARE FACILITY PROVIDING EMERGENCY SERVICES
• 6 medical exam rooms
• Observation room with 15 observation recliners

BEHAVIORAL HEALTH INPATIENT FACILITY (BHIF)
• 16 bed medically integrated Non-IMD care facility*
• Can add additional 16 bed units and/or Psychiatric Hospital beds, depending on need

2728 N. 24th St., Phoenix, AZ

INTENSIVE OUT PATIENT FACILITY
• 8,000 ft. one-to-one meeting rooms
Group Meetings  |  Counseling  |  Labs  |  Med check & Follow-up
Catered luncheons  |  Education Training

*Bed expansion based on patient census, with capacity of 126 beds
Integro has invested in ligature resistance furniture so that in a time of mental instability, clients cannot harm themselves or others.
INTEGRO EXPANSION

PHASE I (4-6 months)
• Add additional 16 bed non IMD units and/or Psychiatric Hospital beds depending on need
• Commercial contracts
• Network development with ACN
  • Developing a system of care with BH
  • Integrated
  • Can take and manage risk

PHASE II (2nd year)
• Based on need
• Considering opening 16 bed non IMD units with urgent care and IOP facilities in Key locations in Valley
Advantages with Integro

• A continuum of crisis and acute services for members with co-morbid BH and PH problems
• Reduction in transportation and ED visits and costs
• Inpatient is subacute non-IMD
• Focused on moving member through continuum to optimize member outcomes
• Reduced LOS and costs vs competition
• Can work with ACN and Mercy Care to develop cost-effective and value based reimbursement models
• Case managers work with each patient to post-discharge to ensure discharge plan is implemented
• Same EHR with Cerner
• Want to work with ACN and Mercy Care as partners and meet their needs
ADDITIONAL RESOURCES

https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers
https://www.google.com/amp/s/www.m-scribe.com/blog/intensive-outpatient-program-iop-billing-guidelines-explained%3fhs_amp=true
http://www.recovery.org/topics/how-much-does-rehab-cost/
http://azbigmedia.com/ab/arizona-can-improve-mental-health-care
Costs, Charges, and Payments for Inpatient Psychiatric Treatment in Community Hospitals

Hospital

- AVERAGE LENGTH OF STAY FOR DISCHARGES: All conditions 4.5 Mental disorders 8.2
- 2014 in-patient discharges with MH as primary Dx 4.2614 had average charges of $22.369 or collectable $14912($1864/day) if bill medical DRG $2500

Arizona

- State/local government hospitals — $2,089
- Nonprofit hospitals — $2,474
- For-profit hospitals — $2,035

Here are average costs per inpatient day in 2013, organized by hospital ownership type, in all 50 states and the District of Columbia, according to the latest statistics from Kaiser State Health Facts.

Integro

- Transfer medical patients with MH/SA: IV Abx, PICC Lines, Wounds, ...

- Los 8
  - Non-IMD
    - LOS 8
      - B5  $613.58
        - $4908.64
        - $5889 +/-
  - Psychiatric Hospital
    - 71  $816.39
    - $6,531.12
$189 BILLION
Mental healthcare spending

$51.1 BILLION
Retail drug prescription spending

$65.5 BILLION
Outpatient care

NCHS reported in 2014

Shift in Patient Management from Inpatient to Outpatient Management

Distribution of national mental health expenditures

Note: Based on data from the Behavioral Health Spending and Use Accounts.
Source: National Center for Health Statistics

Specialty Hospitals Have Reported a Reduction in Cost and Overhead...Integro Health System’s model incorporates all facets.
INTENSIVE OUT PATIENT

- Readmission rates for patients with mood disorders is higher than any other mental health condition, with 15 percent readmitted within 30 days of hospital discharge and up to 22.4 percent of patients with schizophrenia being readmitted.
- Less than 14 days inpatient has readmit rate 10.8% @ 30 days and 22% @ 180 days.
- IOP's lower readmission to 3%.
- Lower rates of emergency department utilization.
- Decreased costs.

- Services typically covered in IOPs:
  - Individual psychotherapy
  - Group psychotherapy
  - Family psychotherapy
  - Multi-family psychotherapy
  - Psycho-educational services
  - Medical monitoring

- According to CMS guidelines, in order to be eligible for reimbursement, all IOP services must:
  - Be supervised by the attending provider.
  - Be consistent with an individual treatment plan that addresses the problems requiring the admission and consistent with clinical best practices.
  - Be reasonably expected to improve the patient's presenting problem within a reasonable amount of time, typically between 12 and 16 weeks.