Creating Sustainable Medical Neighborhoods
On the Path to Integration
AGENDA

Introductions

Objective #1
Understand different Models of Integrated Care

30 mins

Objective #2
Define the Medical Neighborhood

30 mins

Objective #3
Identify the Role of Health Information Technology in supporting the care of high risk members

30 mins
Introductions

Practice Innovation Institute (Pii)

- Don Fowls, MD Psychiatrist, Pii Clinical Advisor
- Keith Parker, MBA, Pii Executive Sponsor
- Giselle Mikel, MS, Pii Practice Transformation Consultant
- Mily Schroeder, MS EdD, Pii Government Relations & Compliance Administrator
PII is....

- Arizona’s Practice Transformation Network (PTN)
  - a collaboration among Health Current and Mercy Care
  - funded under the national CMS Transforming Clinical Practice Initiative (TCPI)
This presentation will:

• Review our experience with Clinicians, focusing on different Models of Integrated Care with particular attention paid to developing a Medical Neighborhood

• It will provide an overview of different types of Medical Neighborhoods, review what factors contribute to developing successful models, and present practical information on how to create and sustain one

• Identify the role of Health Information Technology in supporting the care of high risk members
### Objectives

<table>
<thead>
<tr>
<th>Objective #1:</th>
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Continuum of Integration

Coordinated Care

Screening
Navigators
Care & Case Managers
Colocation

Co-located Care

Health Homes
System Level Integration

Integrated Care
# Stages of Integration

<table>
<thead>
<tr>
<th>Function</th>
<th>Coordinated</th>
<th>Co-located</th>
<th>Integrated</th>
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<tr>
<td><strong>Patient Center Care Team</strong></td>
<td>Care is referral triggered with periodic exchanges between Behavioral health and Physical health staff. Tx plan are mostly separate. Clinics workflows usually exist without common information tools such as registries. Most physical and behavioral care services are delivered in separate settings.</td>
<td>Physical and Behavioral Care services are delivered in the same setting, promoting communication and spontaneous, interdependent consultations. This model reduces barriers to patient access and follow through but does not consistently coordinate treatment by the care team. Often information tools such as registries or automated coordinating functions are used.</td>
<td>A patient care model exists, integrating the treatment plans developed by behavioral health clinicians and others medical stand. Capacity is developed by building consultations as needed for total care. Patients are tracked in a registry.</td>
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| **Shared Population and Mission** | Physical and Behavioral health clinicians understand the concepts of the whole person model of care and total health outcomes but take responsibility primarily for their or own aspects of patient's care. | All clinicians embrace the goal of the whole person care model and understand that it is their responsibility for the total health outcomes of their patients. Additionally, some systems monitor and report treatment plan and total health outcomes to providers and staff. | All Clinicians most understand and embrace the whole person care model, take responsibility for the total health outcomes and carry out and adjust care for their entire patient population. This model has expanded connections within the community. |

| **Systematic Clinical Approach** | There are some protocols and shared workflows but they are mostly informal or driven differently from provider to provider. | Many protocols and shared workflows are established, but not for all processes of integrated care, and they are not consistently implemented. | Protocols and shared workflows are established for nearly all processes of integrated care and in most cases are implemented consistently. |

*Source: Adapted from the Agency for Healthcare Research and Quality Behavioral Health Lexicon, 2011*
How Integrated is BH in Your Practice?

Self - Assessment

LEVEL 0
Pre-Coordinated

LEVEL 1 & 2
Coordinated

LEVELS 3 & 4
Co-located

LEVELS 5 & 6
Integrated

No Collaboration

Basic Collaboration at a Distance

Close Collaboration Onsite with Some Systems Integration

Approaching Integrated Practice

Full Collaboration Transformed Practice

Objective #1: Model 1

Kaiser Family Foundation

• Universal Screening
• Navigators
• Co-location
• Health Homes
• System-Level Integration of Care
Objective #1: Model 2

State Options for Integrated Care

- Managed Care Organization as Integrated Care Entity (MCO)
- Primary Care Case Management Program as Integrated Care Entity (PCCM)
- Behavioral Health Organization as Integrated Care Entity (BHO)
- MCO/PCCM and BHO Partnership Facilitated by Financial Alignment
Objective #1: Model 3

The Four Quadrant Clinical Integration Model

Quadrant I
- BH ↓ PH ↓
- PCP (with standard screening tools and behavioral health practice guidelines)
- PCP-based behavioral health consultant/care manager
- Psychiatric consultation

Quadrant II
- BH ↑ PH ↓
- Behavioral health clinician/case manager w/ responsibility for coordination w/ PCP
- PCP (with standard screening tools and guidelines)
- Outstationed medical nurse practitioner/physician at behavioral health site
- Specialty behavioral health
- Residential behavioral health
- Crisis/ED
- Behavioral health inpatient
- Other community supports

Quadrant III
- BH ↓ PH ↑
- PCP (with standard screening tools and behavioral health practice guidelines)
- PCP-based behavioral health consultant/care manager (or in specific specialties)
- Specialty medical/surgical
- Psychiatric consultation
- ED
- Medical/surgical inpatient
- Nursing home/home based care
- Other community supports

Quadrant IV
- BH ↑ PH ↑
- PCP (with standard screening tools and guidelines)
- Outstationed medical nurse practitioner/physician at behavioral health site
- Nurse care manager at behavioral health site
- Behavioral health clinician/case manager
- External care manager
- Specialty medical/surgical
- Specialty behavioral health
- Residential behavioral health
- Crisis/ED
- Behavioral health and medical/surgical inpatient
- Other community supports

Persons with serious mental illnesses could be served in all settings. Plan for and deliver services based upon the needs of the individual, personal choice and the specifics of the community and collaboration.
Where do you practice?

- Private Practice Primary Care
- Community Clinic
- Federally Qualified Health Center
- Tri-Care or CHAMPUS
- Specialist Office
- Hospitalists
- Other
Exploration Activity

• Please write down your top 1-2 questions about BH Integration

• What is your hot topic?
  – Where to start?
  – Billing?
  – Value-based care?
  – How to build/improve?
  – Something else? (chances later)
Why integrate NOW?

• Evidence of Effectiveness
  • Increasing Health Care Coverage, including BH
  • Decreasing the Total Cost of Care
  • Managing a Population Health

• Patient and Family Engagement

• Restore Joy in Practice
Where do you start?

- Identify Gaps in care
- Identify Pathway to change
- Implementing Change
Assessing the Effectiveness of BH Integration

- Improve Population Health
- Reduce Per Capita Cost
- Improve Patient Experience of Care
Integrating BH into a care delivery changes a care setting by:

- Increasing providers knowledge, expertise, and capacity
- Promoting understanding across the entire care continuum
- Providing more comprehensive and better coordinated care
- Identifying BH concerns early
- Facilitating communication, collaboration, and treatment between providers
- Allowing physical health providers to use the expertise of trained BH specialists
- Improving Patient education and satisfaction

Key Elements to consider when moving toward integration:

- Standard BH screening
- Unified Treatment Plans
- Actionable screening results
- Protocol-base care delivery
- Common electronic health records
- Patient Centered care (treating mind and body)
Engaged Practice - Primary Care Case

- 17 year old with anorexia nervosa, multiple admissions, inpatient admissions, Irritable Bowel Syndrome, Hypothyroidism, electrolyte abnormalities, osteoporosis, neutropenia, and anemia

- Mom - house cleaner; Dad – construction worker
Health IT & Behavioral Health Integration

- Practice management
- Practice dashboards
- Utilization and cost data including pharmacy
- Identifying the high needs, high cost members
- ADT alerts
- Integration of plan and provider data

*Line density represents the frequency and degree of structure in the communication. Adapted from figures by Oxman and Rubenstein.*
What is a Medical Neighborhood?

“A Medical Neighborhood is an expanded patient-centered care model where primary care and specialty providers, hospitals and other clinicians work together in partnership to provide complete and coordinated care”

- Southern New England PTN, 2017
The Medical Home Neighborhood

NCQA RECOGNITION PROGRAMS
- Patient-Centered Medical Home
- Patient-Centered Specialty Practice
- Patient-Centered Connected Care™

PRIMARY CARE (PCMH)
 Patients

- Urgent Care
- Behavioral Health
- Retail Clinics
- On-Site Clinics
- School-Based Clinics
- Other Providers
- Specialists
Patient Centered Specialty Practice (PCSP)

**Provide Access and Communication**
- (Electronic) Access
- Specialty Practice Responsibilities
- Culturally and Linguistically Appropriate Services
- Practice Team

**Plan and Manage Care**
- Care Planning and Support Self-Care
- Medication Management
- E-Prescribing

**Track and Coordinate Referrals**
- Referral Processes and Agreements
- Referral Content
- Referral Response

**Identify and Coordinate Patient Populations**
- Patient Information
- Clinical Data
- Coordinate Patient Populations

**Track and Coordinate Care**
- Test Tracking and Follow-Up
- Referral Tracking and Follow-Up
- Coordinate Care Transitions

**Measure and Improve Performance**
- Measure Performance, Patient and Family Experience
- Implement and Demonstrate Continuous Quality Improvement
- Report Performance
- Use of Certified EHR Technology
Barriers to Information Flow and Accountability in the Medical Neighborhood:

- No (or few) financial incentives or requirements for care coordination
- Lack of staff and time for investment in coordination
- Limited PCC involvement in inpatient care
- Fragmented, diverse services rather than integrated delivery system
- Limited financial integration across most providers
- Limited health IT infrastructure and interoperability
- Practice norms that encourage clinicians to act in silos rather than coordinate with each other
- Complexity of coordination for patients with high levels of need and/or frequent self-referrals
- Patient self-referrals about which the PCMH is unaware
- Misperceptions regarding HIPAA provisions and limits to information exchange
Opportunities

Activities to Improve the Medical Neighborhood

- Dedicated care coordination staff in the PCMH
- Systematizing care coordination activities within the PCMH
- Getting PCCs more involved in inpatient care
- Referring to good neighbors
- Appropriate referrals
- Referral tracking systems
- Establishing care coordination agreements
- Patient education (through print or other materials) on medical home approach, referral process, etc.
- Discussions with patients about their responsibilities in the PCMH
- Use of decision aids about treatment options
- Incorporating patient perspectives in the medical neighborhood
The Future of Healthcare – Medical Neighborhoods

Providing the right care at the right time to each patient!

- Integrated Community Services
- Patient Accountability
- Proactive Approach
- Reduce Costs
- Comprehensive Care
- Patient Centered Specialty Practices
Objective # 3

Role of Health Information Technology in Supporting the Care of High Risk Members

• **Point of Care**
  – EHR/Practice management system

• **Care Coordination**
  – Care pathways/Care triggers
    • HIE
    • Integrated or stand alone pathway system

• **Population Health / Analytics**

• **Integration & Data Management**
EHR/Practice Management system

• Understanding functionality and use
• Initial data entry
• Represent
  – Longitudinal record
  – Limited Record
• Standardization and use
  – Electronic filing system vs structured data base
• Registry, Analytics, Practice Management, etc...
Care Coordination

- Purpose and goals determine applications
  - Population supported
- Integration and data sources
  - Determine what data sources will be used
- Use of current system
- Separate application
Population Health & Analytics

Understanding:

• Measures & Performance
• Cost and utilization
• Risk stratification
• Patient panel identification and use
Interoperability (HIE)

Health Current is Arizona’s HIE

Imagine fully informed health.
Interoperability (HIE)

Health Current Services

• Health Information Service Provider (Direct secure)
• Alerts and Notifications
• HL7 V2 bi-directional data delivery
• CCDA, XML bi-directional data delivery
• Supporting Data Management Data Trustee Role
Health Current Data Segmentation Structure

Patient information is stored in 1 of 2 sections of the database referred to as “sites”

- **Non-Part 2 site contains:**
  - General medical, dental and mental health data from providers who **are not** 42 CFR Part 2 providers, or if a Part 2 provider, **can** separate the Part 2 data from non-Part 2 data

- **Part 2 site contains:**
  Substance abuse diagnosis and treatment data from Part 2 providers **only** and may contain general medical, dental and mental health data from integrated Part 2 providers who **can’t** separate Part 2 data from non-Part 2 data
Pulling It All Together

Data types
- Clinical
- Claims (CCLF, 834,835)

Data formats
- HL7 V2, V3
- CCD, C-CDA
- X12, EDI
- Custom delimited

Point of care

Data transport and management across health care continuum
QUESTIONS ?
Practice Innovation Institute

– Website: http://piiaz.org/
– Email: info@piiaz.org