Practice Transformation and Integrated Care Pathways

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Agenda

Introductions 5 mins

Who are we? 5 mins

Description & Purpose 10 mins

Objectives 60 mins

Q/A 15 mins
Introductions

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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:

- Share the importance of *practice transformation* and highlights the work done by one of Pii’s Participants, **Southwest Behavioral and Health Services (SB&H)**.

- Identify the specific care needs with attention paid to developing a *Medical Neighborhood*.

- Review the importance of *practice transformation* and the *integration of care pathways* through sharing the relevant referral process from the Medicaid behavioral health system practices to *Southwest Autism Center of Excellence (SACE)*.
Objectives

**Objective #1**
Understand the importance of Practice Transformation

**Objective #2**
Identify the specific care needs with attention paid to developing a Medical Neighborhood

**Objective #3**
Integrate care for patients who are diagnosed with co-occurring medical conditions

**Objective #4**
Understand the effectiveness of care pathways
Objective # 1
The Importance of Practice Transformation

- Care coordination between providers of services
- Community-based health teams to support chronic care management
- Improved quality care/reducing barriers to care/patient/family engagement
- Reduction of cost
- Advanced Payment Models/Value based payments
Transformation is a Verb

- Culture change
- Population Management
- Data use
- Evidence Based Medicine & Care Planning
- Patient and family engagement as the drive to transformation
- Continuous process improvement
Transformation Beneficiaries

• **Patients**
  - partners in their own care
  - integrated care – whole health treatment plans

• **Providers**
  - capability to analyze and document value
  - efficiency of operation
  - joy in the workplace

• **Cost Savings for everyone**
  - reduction of ED/Hospital Use
  - reduction in unnecessary testing
“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
Our current model won’t get us there.... inability to meet patient needs.....

“....present efforts resemble a team of engineers trying to break the sound barrier by tinkering with a Model T Ford. We need a new vehicle....”

(Chassin et al.,1998)
The Medical Neighborhood

NCQA RECOGNITION PROGRAMS

- Patient-Centered Medical Home
- Patient-Centered Specialty Practice
- Patient-Centered Connected Care™

PRIMARY CARE (PCMH)

- Urgent Care
- Behavioral Health
- Retail Clinics
- On-Site Clinics
- School-Based Clinics
- Other Providers
- Specialists

PATIENTS
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
Improvement Framework

- People and Process
  - Operational Improvement
    - Improvement Goals
    - Outcome Measures
    - Workflow Design and Training
    - Key Performance Indicators
    - Reliable Data Capture
    - Dashboards

- Data, Tools, Technology
  - Leadership and Strategy

Proprietary
The ITPOSIMO Dimensions of Health Information System Design–Reality Gaps
What are the Barriers?

- 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
What are the Opportunities?

- 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 - Integrate care for patients who are diagnosed with co-occurring medical conditions

Current State

Primary Care Clinician

Patient

Mental Health or Chemical Dependency Specialist

Current State
Continuum of Integration

Coordinated Care

Co-located Care

Integrated Care

Screening

Navigators

Care & Case Managers

Colocation

Health Homes

System Level Integration
Graduating towards coordinated care

- High risk registry
- Warm hand offs
- Schedule appointments together (collocated)
- Develop combined plan of care
- Identify member/peer/family engagement
- Post ER/Hospital visit plans
- EHR strategy
Objective # 4 - Identifying unmet needs and service gaps in the Medicaid system of care for members with Autism
Practice Transformation through a comprehensive approach to care
SACE Model and specific referral process through the Medicaid Behavioral Health system
SACE Model and specific referral process through the Medicaid Behavioral Health system

- Referral Identification
  - Medicaid Enrolled
  - High Registry
  - Primary Care
  - Co-locations
  - Warm Hand Offs
  - Behavioral Health
  - Commercial Insurance
  - Private Pay
Barriers to care and lessons learned

- Access to care coupled with community need/education
- System stakeholder education and defining a “Center of Excellence”
- Developing medical neighborhood and interdisciplinary relationships
- Staffing levels for specialty disciplines (BCBA)
- Upstart funding and sustainability
- Quality Management and training
- Medicaid reimbursement for ABA Therapy
- AHCCCS Initiative and ABA Policy implemented in AMPM
Questions?
Contact Information

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