INTEGRATED CARE 101- PART 2:

BUILDING THE BUSINESS CASE AND SUPPORTING INTEGRATED CARE

PRESENTED BY:
Jean Glossa, MD,MBA, FACP and Lori Raney, MD

HMA ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

Wednesday, February 10, 2021
1:00-2:00 pm EST

The Integrated Care Technical Assistance Program (ICTA) is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). This project is supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $4,616,075.00 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, or an endorsement by, CMS/HHS, or the U.S. Government.

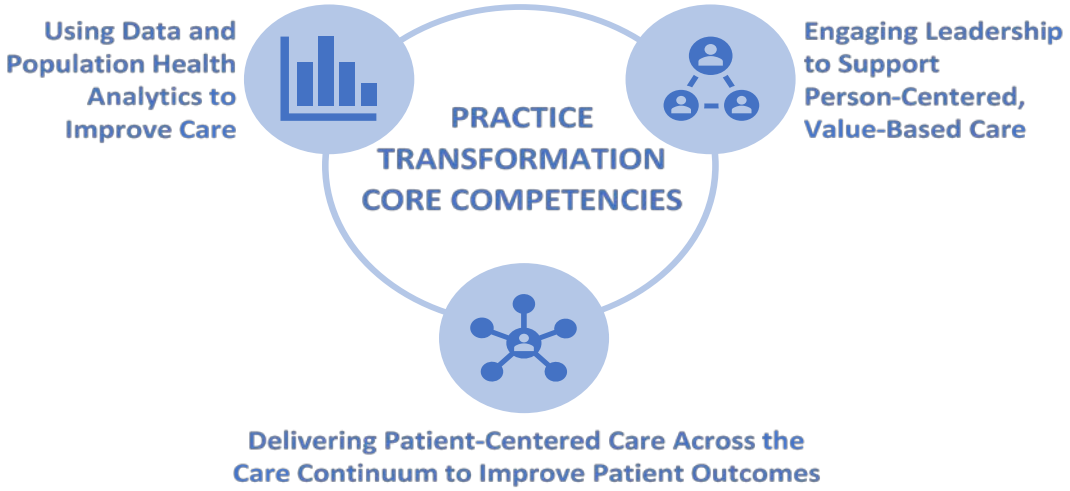
WHAT IS THE ICTA PROGRAM?

ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

The Integrated Care Technical Assistance Program (ICTA) is a five-year program aimed to enhance Medicaid providers' capacity and core competencies to deliver whole person care for physical, behavioral health, SUD and social needs of beneficiaries.

The ICTA Program is managed by the DC Department of Health Care Finance (DHCF) in partnership with the DC Department of Behavioral Health (DBH). Health Management Associates will provide the training and technical assistance.

The goal is to improve care and Medicaid beneficiary outcomes within three practice transformation core competencies:



ICTA TECHNICAL ASSISTANCE

The program offers several components of coaching and training. Material is presented in various formats. The content is created and delivered by HMA subject matter experts with provider spotlights.

All material is available on the project website Integratedcaredc.com

Educational credit is offered at no cost to attendees for select elements.

ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

HEALTH MANAGEMENT ASSOCIATES

PRESENTERS

Lori Raney, MD
HMA: Principal
TA Coach/SME
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Jean Glossa, MD, MBA, FACP
HMA: Managing Director, Delivery System
ICTA Project Director
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Jennifer Joyce, LICSW, MBA
Community Connections: Senior Director of Integrated Services Department of Behavioral Health Provider

DISCLOSURES

Faculty	Nature of Commercial Interest
Lori Raney, MD	Dr. Raney discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. She has no relevant disclosures.
Dr. Glossa, MD, MBA, FACP	Dr. Glossa discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients. She has no relevant disclosures.
Jennifer Joyce, LICSW, MBA	Ms. Joyce is an employee of Community Connections, a not-for-profit mental health agency providing mental health services, addiction treatment, and residential care to DC Residents, as a Department of Behavioral Health provider. She has no relevant disclosures.
Elizabeth Wolff, M.D., MPA	Dr. Wolff discloses that she is an employee of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

Integrated Care 101 – Part 2: Building the Business Case and Supporting Integrated Care

ICTA INTEGRATED CARE TECHNICAL ASSISTANCE

HEALTH MANAGEMENT ASSOCIATES

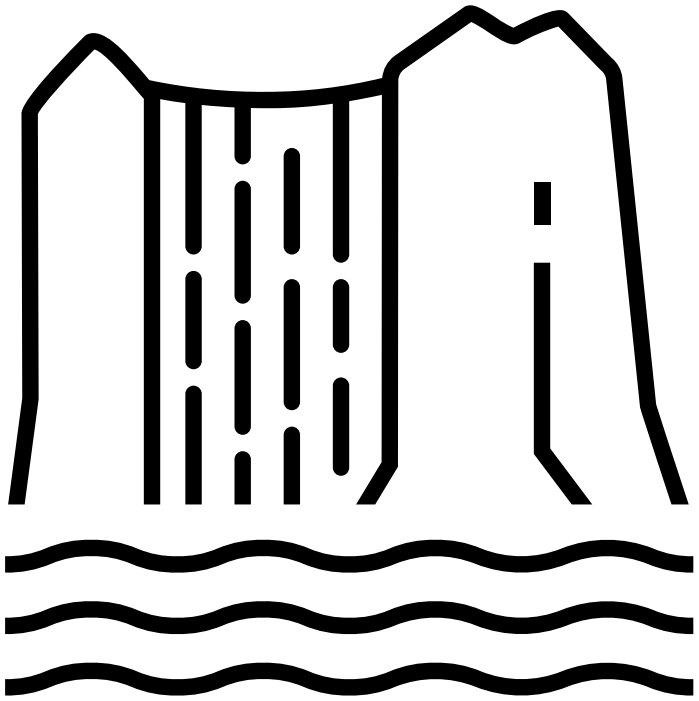
AGENDA

- Welcome and Program Announcements
  - Topic Pre-Question
- Define key results from successful integrated care initiatives including:
  - Physical and behavioral health outcomes
  - Implementing a population health approach through registries
- How to build and support integrated care through:
  - Internal champions and education
  - Effective enhanced referrals and workflows
  - Identification of stumbling blocks and solutions among care teams
- Department of Behavioral Health Provider Testimonial – Community Connections
- Closing Remarks/Q&A

OBJECTIVES

1. Define 3 key outcomes of integrating care in both primary care and behavioral health settings
2. Explain the main processes crucial to effective enhanced referral
3. Outline workflow practices important to screening and outcome measurement
4. Summarize the key features and stumbling blocks of effective team care

Image permitted by DC Department of Health Care Finance



Chatterfall

What do you think are the benefits of integrated care?

- Wait to press enter

WORKFLOWS

CLINICAL WORKFLOWS

Support for Holistic Self-Management and Recovery with Peers or MH Clinicians who:

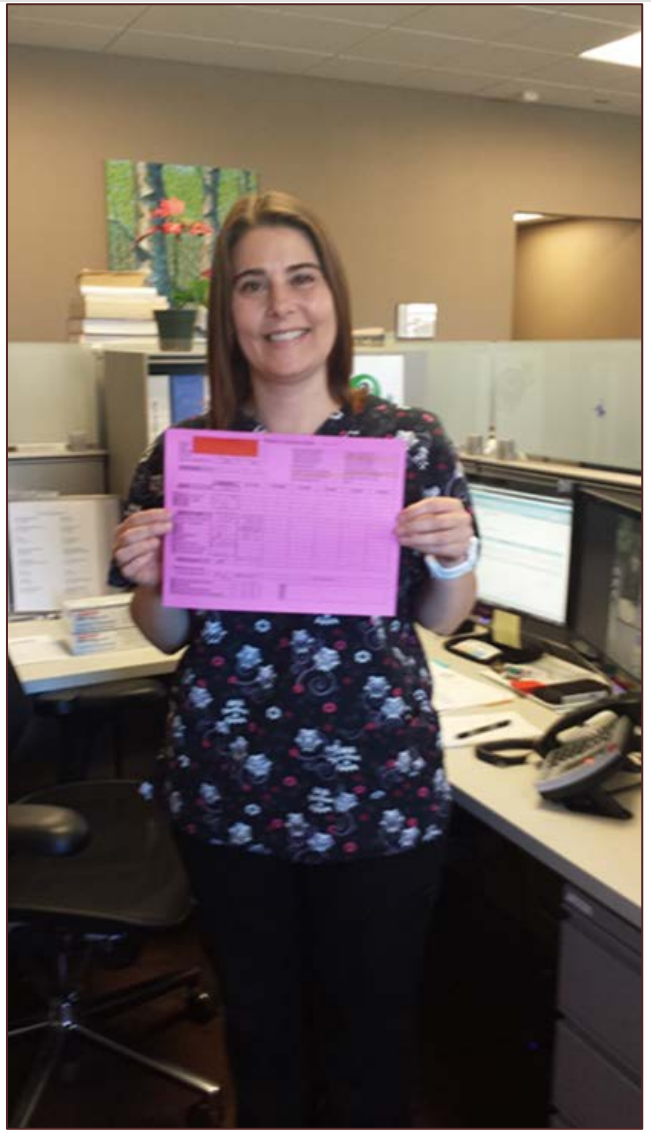
Work with consumers to identify goals that are inclusive of physical, behavioral, spiritual, personal, or professional goals.

Use evidence-based interventions such as the Illness Management and Recovery Program (IMR) or Chronic Disease Self Management.

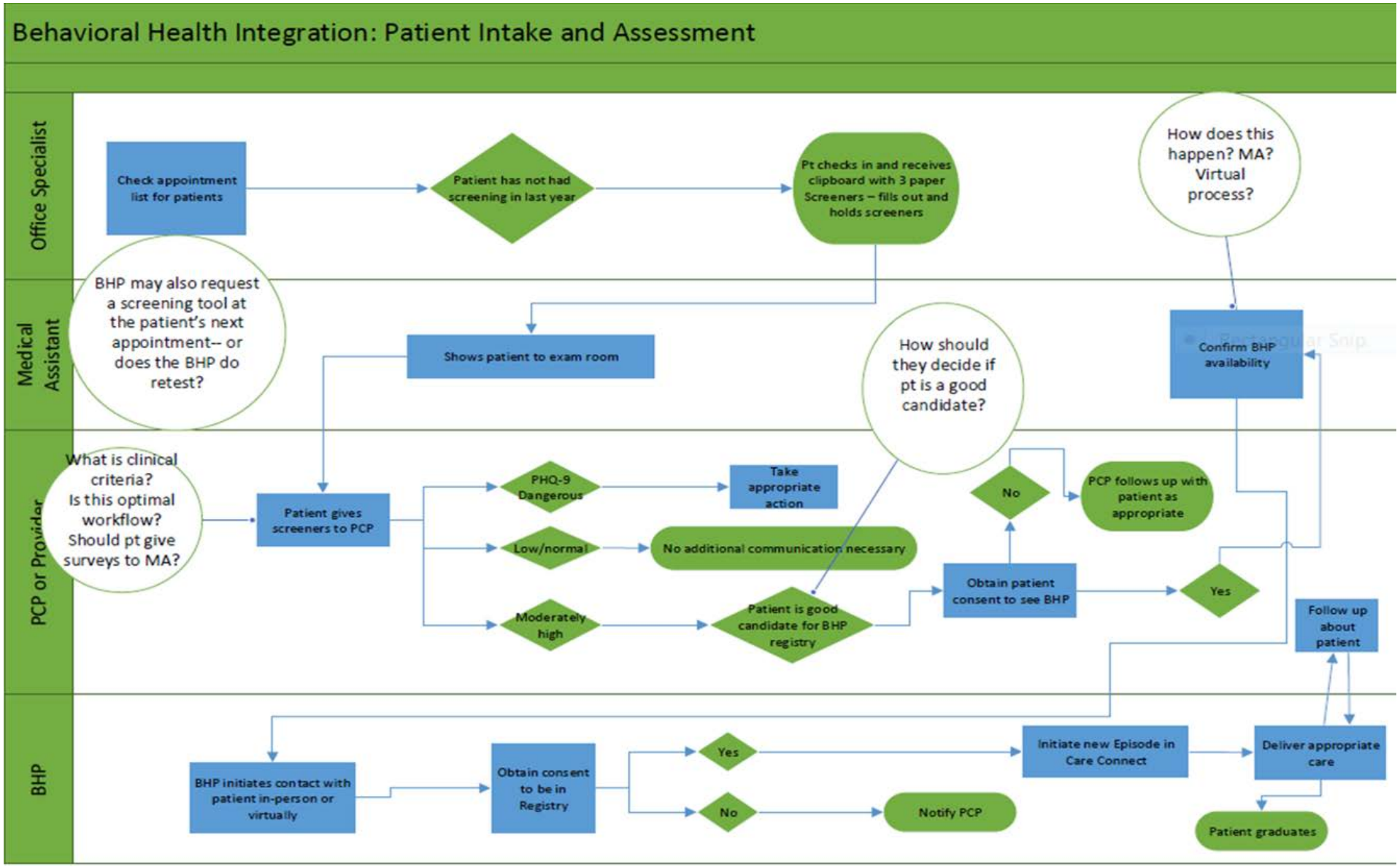
Use health screenings to identify and respond to the most pressing health needs of the population. Include trauma.

Offer wellness activities at the community mental health center and/or partner with other organizations to offer wellness activities to members, e.g. yoga, nutrition and cooking classes.

ROLE CLARITY: WHAT *ROLE* IS GOING TO DO WHICH TASKS?



PRIMARY CARE WORKFLOWS



Source: Courtesy OhioHealth

Image permitted by DC Department of Health Care Finance

What concerns have you encountered with workflows for integrated care in your organization?

PERFORMANCE METRICS FOR INTEGRATED CARE

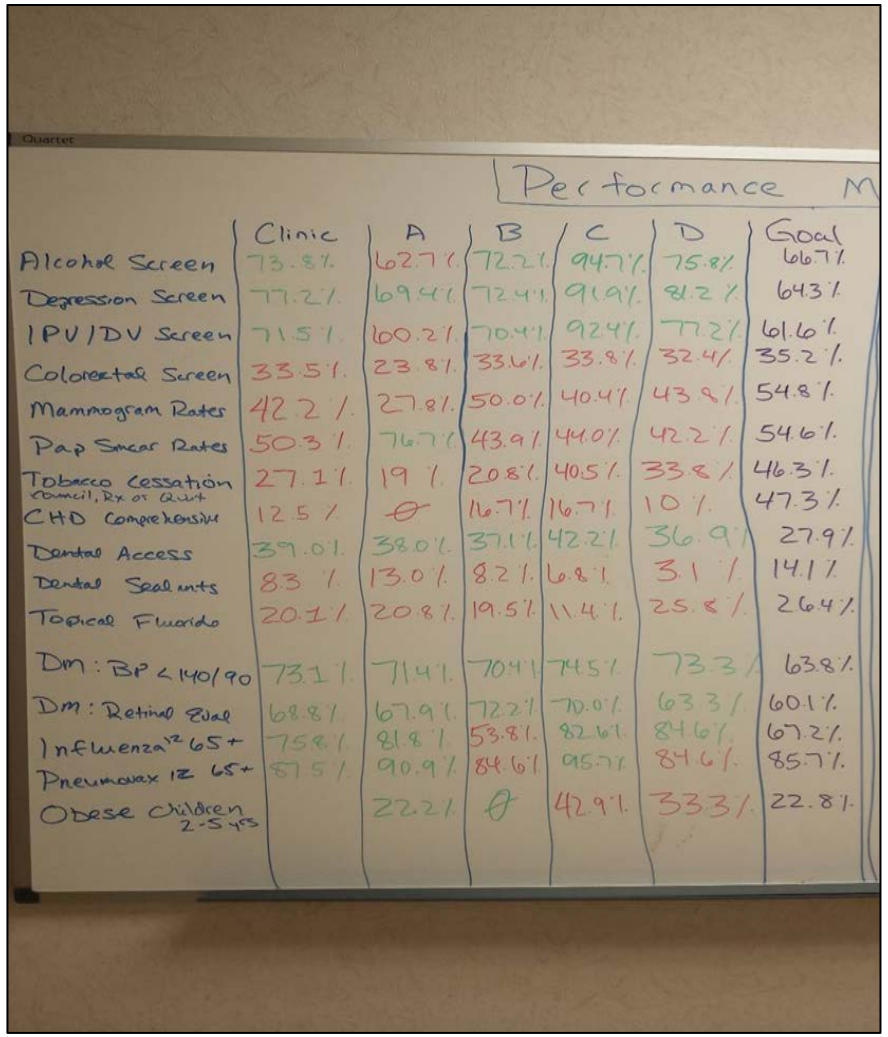
POPULATION BASED CARE:
REGISTRY TO TRACK, MEASURING CHANGE AND ADJUST TREATMENT

			Behavioral Heatlh													
			Treatment Status					PHQ-9				GAD-7				
MRN	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Number of Follow-up Contacts	Weeks in Treatment	Average # Contacts per month	Initial PHQ-9 Score	Last Available PHQ-9 Sco	% Change in PHQ-9 Score	Date of Last PHQ-9	Initial GAD-7 Score	Last Available GAD-7 Sco	% Change in GAD-7 Score	Date of Last GAD-7
1234501	Active	Bryson Clay	2/28/2018	10/1/2018	9	30	1.20	21	9	-57.1%	10/1/2018	10	4	-60.0%	10/1/2018
1234502	Active	Kayla Ho	3/15/2018	9/30/2018	8	28	1.14	13	17	30.8%	9/30/2018	5	5	0.0%	9/30/2018
1234503	Active	Reed Snow	2/7/2018	9/3/2018	9	29	1.24	10	4	-60.0%	9/3/2018	18	14	-22.2%	9/3/2018
1234504	Active	Princess Hull	4/22/2018	9/17/2018	9	21	1.71	18	18	0.0%	9/17/2018	19	18	-5.3%	9/17/2018
1234505	Active	Ignacio Tanner	4/17/2018	10/1/2018	9	23	1.57	14	8	-42.9%	10/1/2018	16	14	-12.5%	10/1/2018
1234506	Active	Jan Jacobson	2/20/2018	10/2/2018	8	32	1.00	11	4	-63.6%	10/2/2018	19	18	-5.3%	10/2/2018
1234507	Active	Eddie Wu	2/19/2018	9/17/2018	8	30	1.07	16	8	-50.0%	9/17/2018	10	18	80.0%	9/17/2018
1234508	Active	Ulises Rosales	7/30/2018	9/15/2018	4	6	2.67	17	16	-5.9%	9/15/2018	4	3	-25.0%	9/15/2018
1234509	Active	Freddy Keith	7/21/2018	10/15/2018	13	12	4.33	22	18	-18.2%	10/15/2018	5	3	-40.0%	10/15/2018
1234510	Active	Grayson Mcgee	12/19/2017	10/15/2018	7	42	0.67	14	4	-71.4%	10/15/2018	7	17	142.9%	10/15/2018

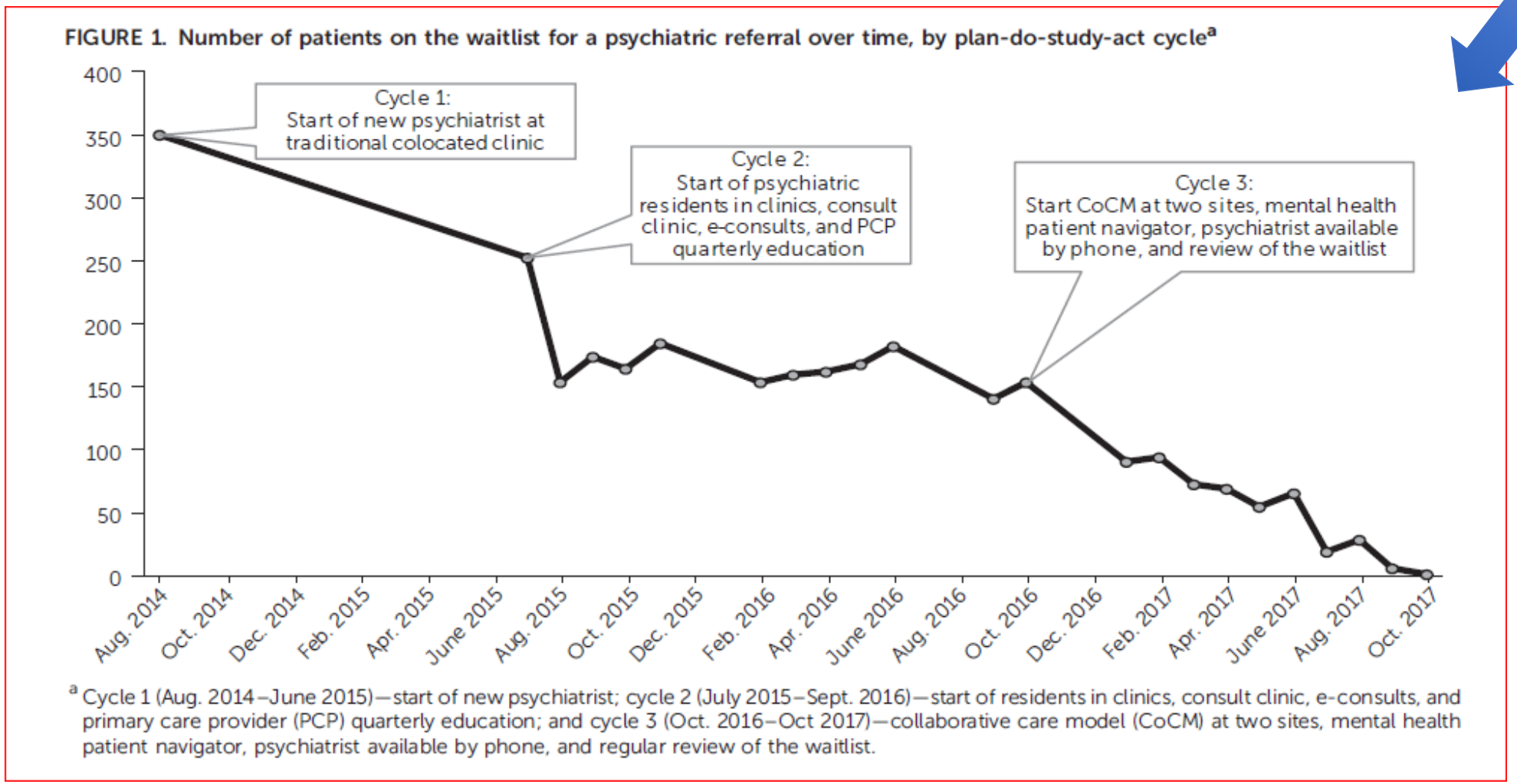
Two crucial data points:
50% reduction PHQ-9
Remission (PHQ 9 < 5)

PERFORMANCE MEASURES: ACCOUNTABILITY

- **Process Metrics:**
  - Percent of patients screened for depression
  - Percent with follow-up with behavioral care manager within two weeks
  - Percent not improving that received case review and psychiatric recommendations
  - Percent treatment plan changed based on advice
  - Percent not improving referred to specialty BH
- **Outcome Metrics**
  - Percent with 50% reduction PHQ-9 – Clinical Response
  - Percent reaching remission (PHQ-9 < 5) NQF 710 and 711
- **Satisfaction** – patient and provider
- **Functional** –work, school, homelessness
- **Utilization/Cost**
  - ED visits, 30 day readmits, med/surg/ICU, overall cost



WAITLIST REDUCTION FOR PSYCHIATRIC SERVICES WITH COLLABORATIVE CARE MANAGEMENT

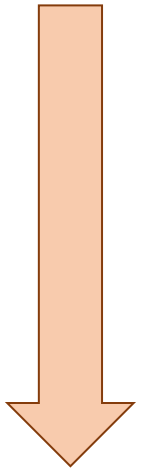


Source: Kinnan, Emerson et al. Psychiatric Services in Advance 2019 (doi: 10.1176/appi.ps.201900222)

BUSINESS CASE: REDUCES HEALTH CARE COSTS OVER TIME (18-24 MONTHS)

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	**31,082**	29,422	32,785	**-$3363**

SAVINGS



ROI
$6 : $1

Source: Unützer et al., Am J Managed Care 2008

SET GOALS

Medical Treatments Targets

- Glucose control
- Blood pressure
- Cardiac risk reduction

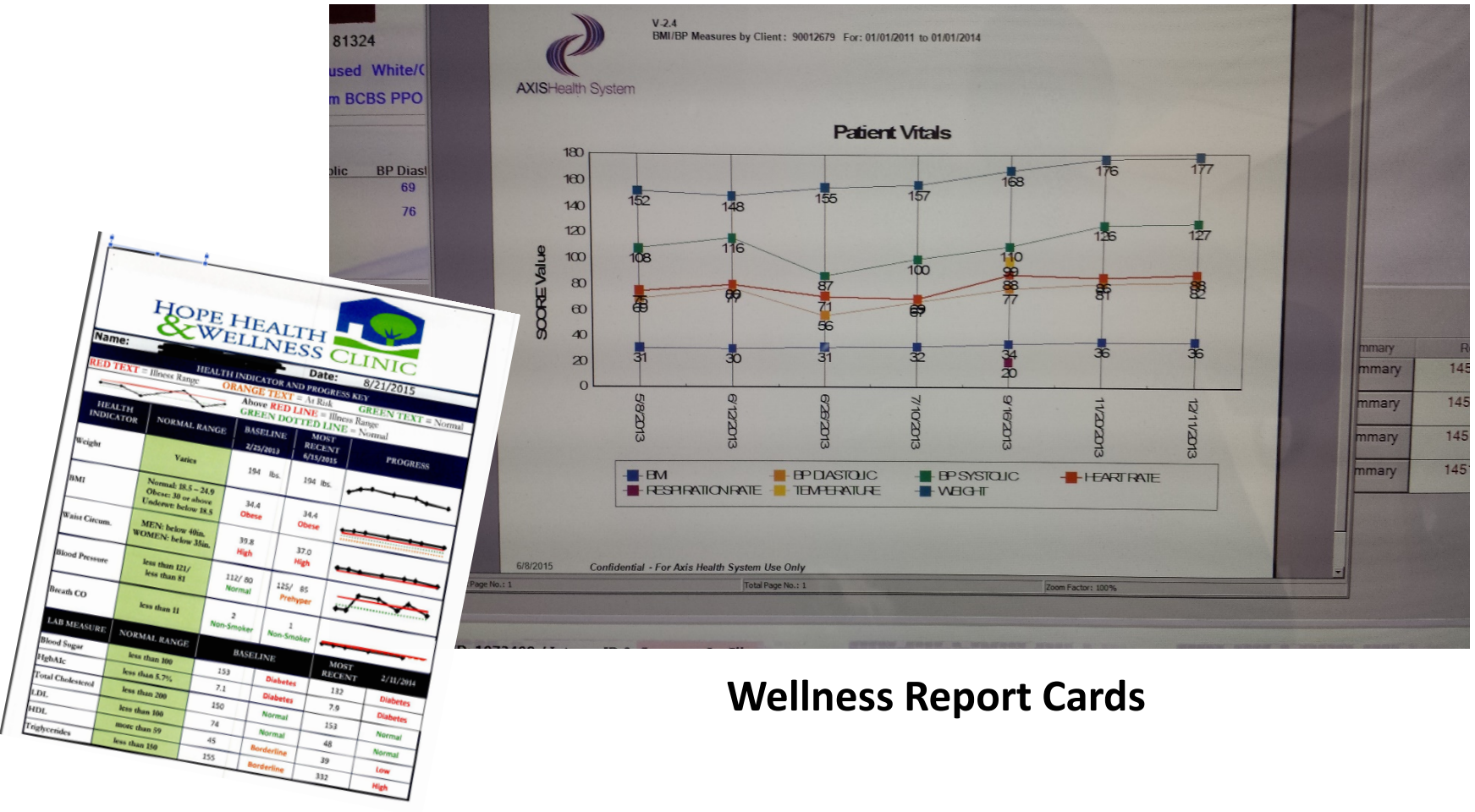
Health Behavior Change Targets

- Inactivity
- Smoking cessation
- Improving dietary habits

COMMIT TO TARGETS

Goal	Target
Improve tracking of health outcomes	90 % of eligible clients will have documented BMI, Hgb A1c, LDLc, and blood pressure in the last 6 months.
Improve health outcomes	Reduce by 25 % the number and % of eligible clients with a Hgb A1c > 7, a blood pressure > 140/90, or LDLc > 100.
Improve health behaviors	1. Reduce by 25 % the number and % of clients who are smoking.
	2. Increase by 25 % the number and % of clients who are physically active (30 minutes or more of aerobic activity such as walking at least 4 times/ week)

USING DASHBOARDS FOR PATIENT EDUCATION

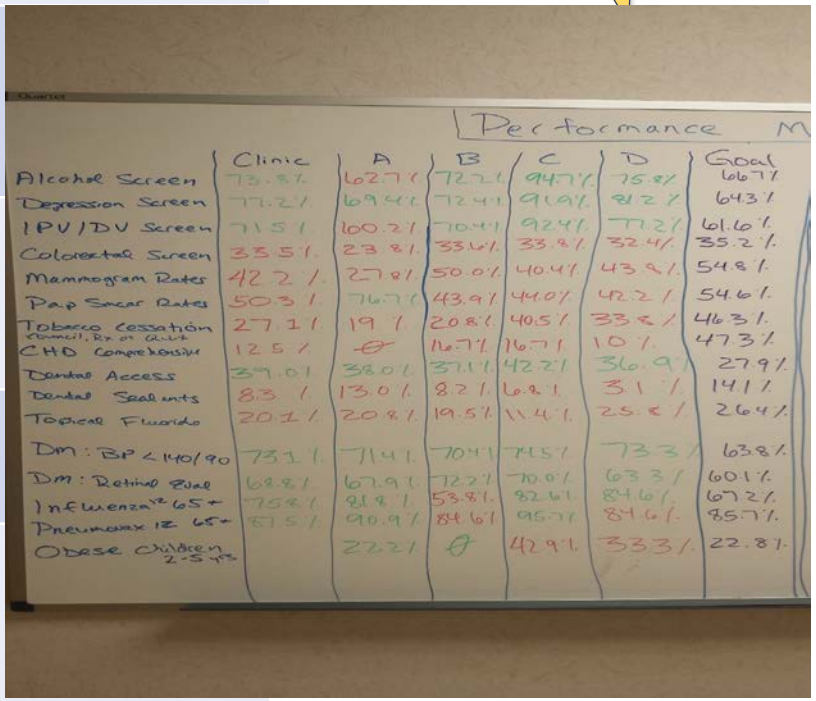


Wellness Report Cards

PERFORMANCE BASED MEASURES AND VALUE BASED PAYMENT

Standard	National Quality Forum Number
BMI Screening and Follow-up Adults	NQF 0421
BMI Screening and Follow-up Children	NQF 0024
Controlling High Blood Pressure	NQF 0018
Tobacco Use Screening and Cessation Intervention	NQF 0028
Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications	NQF 1932
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	NQF 2607
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NQF 1933
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NQF 1933

Celebrate Successes!



Discussion

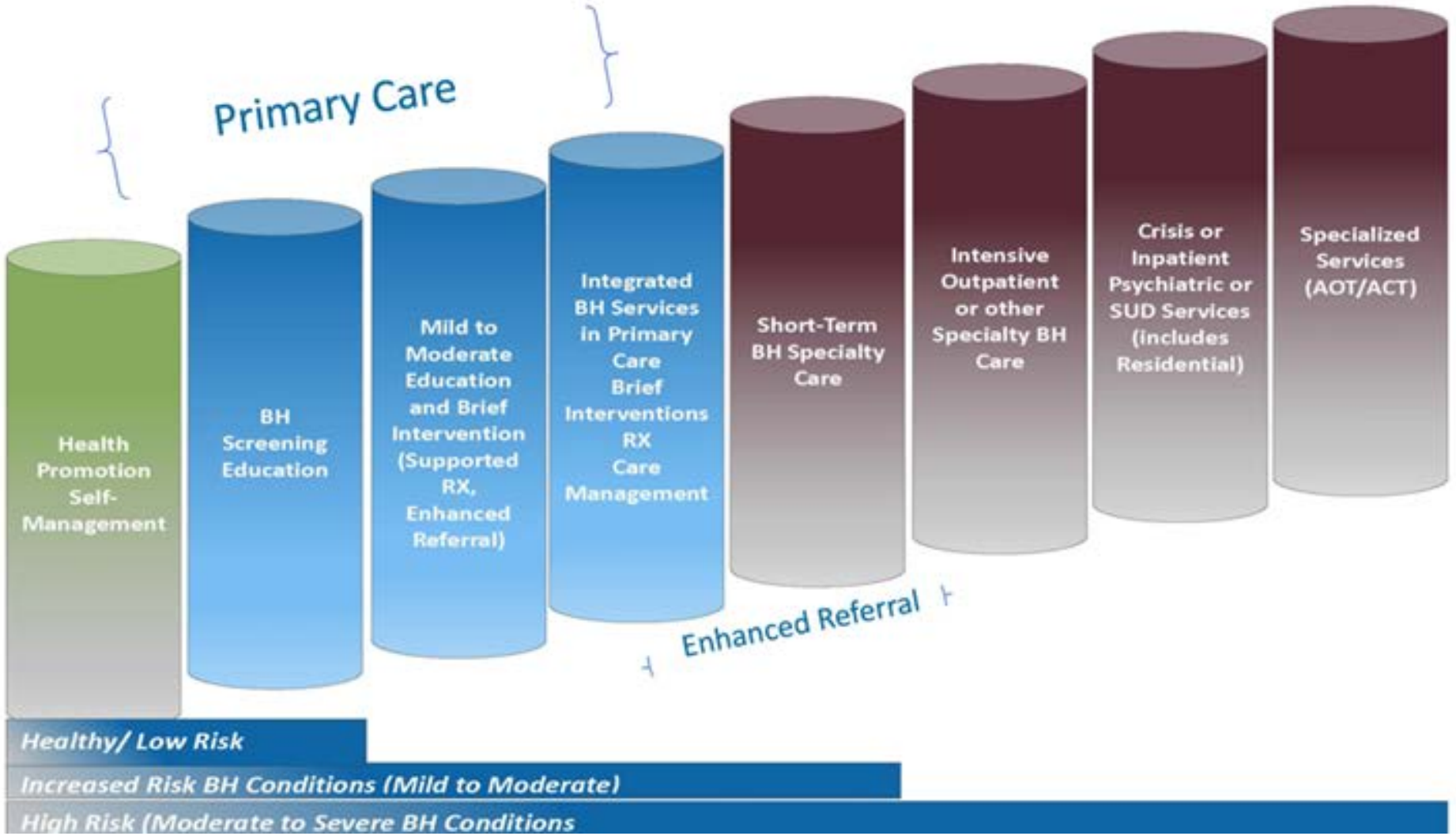
How can you help your team (e.g., therapists, care managers, HIT and administrators) embrace measurement-based care as a means of better tracking outcomes?

ENHANCED REFERRAL PROCESS

Enhanced Referrals

Formal agreements (MOUs, BAAs) that define coordination/transitions of care, sharing of information, & available services resources among providers.

WHERE DOES ENHANCED REFERRAL FIT IN THE CONTINUUM OF CARE?



POLLING QUESTION:

Do you have existing enhanced referrals with other providers?

- ❑ Yes: We have multiple enhanced referrals (more than 3 providers)
- ❑ Some – 1-2 enhanced referrals with providers
- ❑ None

CORE STEPS OF ENHANCED REFERRAL PROCESS

Purposeful and thoughtful design of the referral process can improve the quality of the referral:

- ✓ Improved Patient Experience
- ✓ More consistent communication with partner
- ✓ Higher rate of referral success

IDENTIFYING NEED FOR REFERRAL

Discuss the process for identification of need and map out steps of this element of the workflow.

COMMUNICATION ABOUT THE REFERRAL

Consider all the individuals (internally and externally) who may need to be told about the referral process.

ENGAGING THE INDIVIDUAL

Referrals often leave the individual out of the process—consider methods for enhanced engagement and keeping the person at the center of the process.

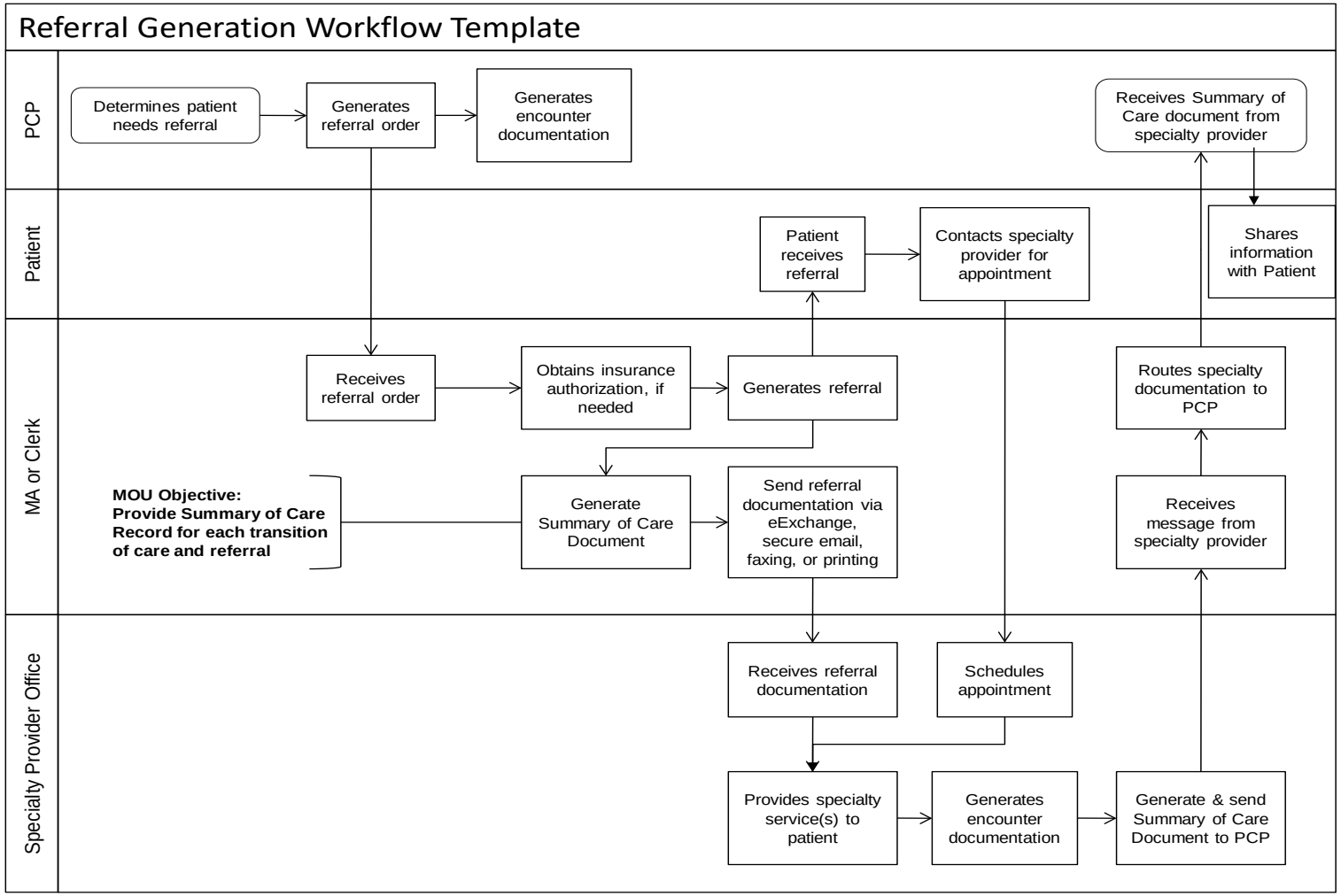
REFERRAL TRACKING AND COMMUNICATION AFTER REFERRAL

After the referral is made, there are essential steps to maintain communication and track outcomes.

MONITORING PERFORMANCE

Consider the workflow required to monitor and improve upon the process internally and with your partners.

WORKFLOW FOR ENHANCED REFERRAL



FORMALIZING THE PARTNERSHIP WITH MEMORANDUM OF UNDERSTANDING (MOU) OR CARE COMPACT

Provides an avenue for addressing legal issues such as HIPAA and often incorporates a memorandum of understanding (MOU) or a business associates agreement (BAA) for sharing of data and other information.

Care compacts may address other operational elements such as information technology or payment considerations.

11. Colorado Systems of Care/Patient Centered Medical Home Initiative: Colorado Primary Care - Specialty Care Compact.

Source: https://www.pcpcc.org/

REFERRAL TRACKING IMPORTANT TO SUCCESS AND METRICS

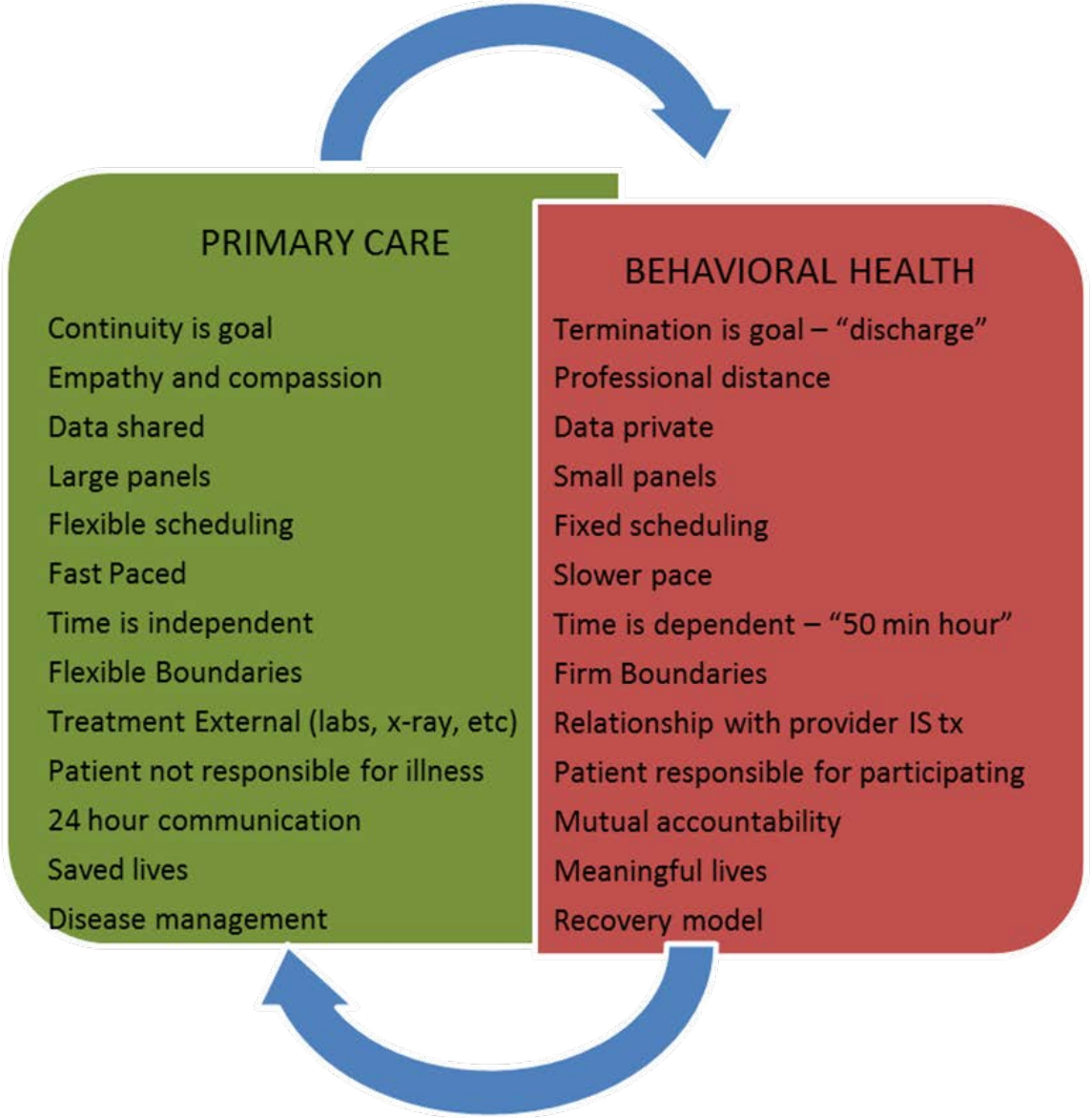
EXAMPLE OF REFERRAL TRACKING TEMPLATE

Use: create a simple tool to monitor the completion of referrals for all patients/ clients. This tool can be used to track performance of a specific referral relationship/ organization, track performance by provider, and to any measures of success defined by the organizations.

Patient Identifier	Provider	Organization/ Provider Referred To	Date Referral Sent	Referral Received	Patient No-Showed Appointment	Return Communication Received	Medications and Care Plan Updated

HIGH FUNCTIONING TEAMS

TWO CULTURES: ONE PATIENT



EFFECTIVE IMPLEMENTATION: NINE FACTORS

Table 1. Factors Considered Important for Implementation of DIAMOND

Ranking	Implementation Factor	Definition
1	Operating costs of DIAMOND not seen as a barrier	The clinic has adequate coverage or other financial resources for most patients to be able to afford the extra operational costs.
2	Engaged psychiatrist	The consulting psychiatrist is responsive to the care manager and to all patients, especially those not improving.
3	Primary care provider (PCP) "buy-in"	Most clinicians in the clinic support the program and refer patients to it.
4	Strong care manager	The care manager is seen as the right person for this job and works well in the clinic setting.
5	Warm handoff	Referrals from clinicians to the care manager are usually conducted face-to-face rather than through indirect means.
6	Strong top leadership support	Clinic and medical group leaders are committed and support the care model.
7	Strong PCP champion	There is a PCP in the clinic who actively promotes and supports the project.
8	Care manager role well defined and implemented	The care manager job description is well defined, with appropriate time, support, and a dedicated space.
9	Care manager on-site and accessible	The care manager is present and visible in the clinic and is available for referrals and patient care problems.

DIAMOND indicates Depression Improvement Across Minnesota—Offering a New Direction.

ELEMENTS OF HIGH FUNCTIONING INTEGRATED TEAMS

Source: Lardieri, Lasky, Raney, SAMHSA-HRSA CIHS, 2014

COMMUNICATION PLAN

- Elevator Speech – clear, few sentences, relentless
- LISTEN, LISTEN, LISTEN, encourage feedback
  - Why do this (before how)?
  - How to do this?
  - Who will do this?
  - When will it happen?

MAKE IT FUN and CELEBRATE THE WINS

PR, PR, PR, PR…….

Regional Primary Care Initiative

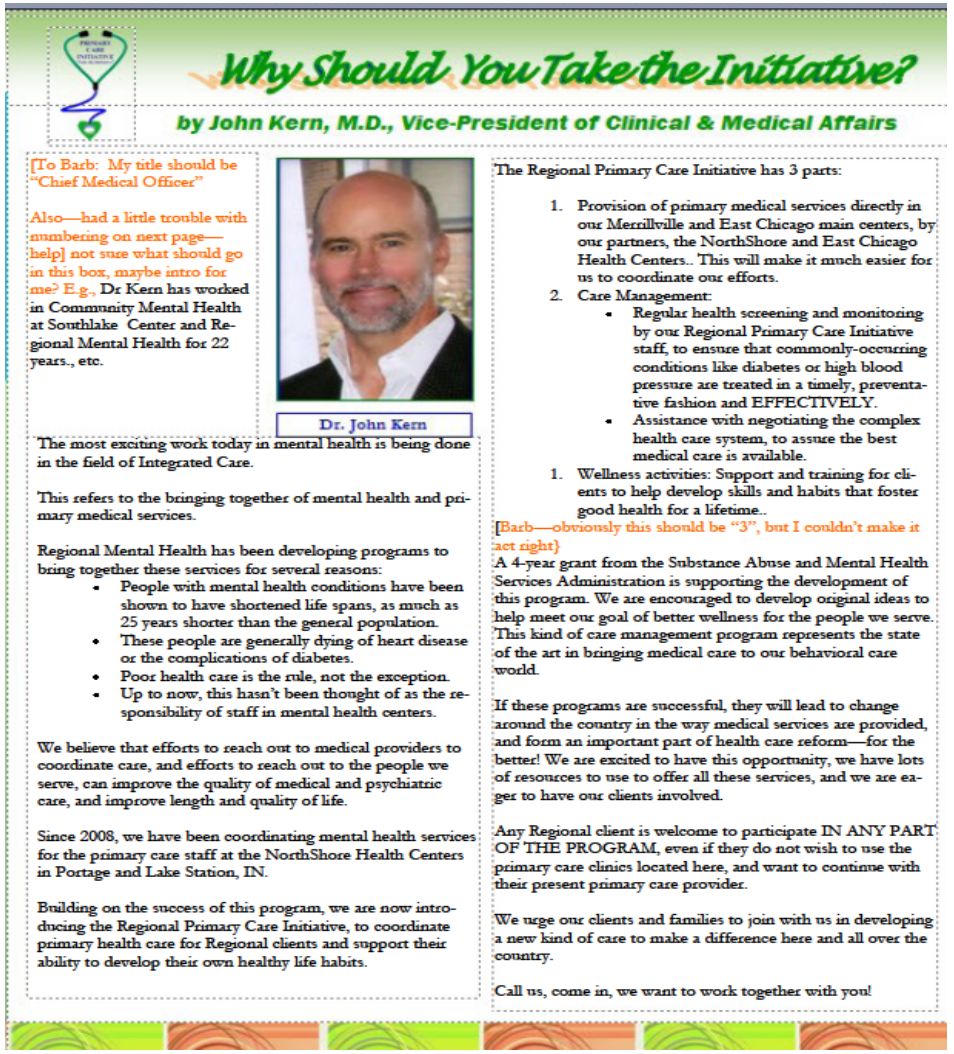
Persons with mental illness die up to **25 years too soon** due to preventable health conditions.

Regional Primary Care Initiative now offers a nationally recognized program to bring needed primary medical services to our clients, right in our Merrillville and East Chicago centers.

- General medical care **at the Regional office.**
- Assistance for consumers in
  - Medication management,
  - Healthy eating,
  - Stress management,
  - Healthy activities,
  - Stopping smoking,
  - Help negotiating the medical system..

Talk to your clients and peers about engaging in this program to live longer and healthier!

Sign up **today** by calling Olga at 219-99999



Why Should You Take the Initiative?

by John Kern, M.D., Vice-President of Clinical & Medical Affairs

[To Barb: My title should be "Chief Medical Officer"

Also—had a little trouble with numbering on next page—help] not sure what should go in this box, maybe intro for me? E.g., Dr Kern has worked in Community Mental Health at Southlake Center and Regional Mental Health for 22 years., etc.

Dr. John Kern

The most exciting work today in mental health is being done in the field of Integrated Care.

This refers to the bringing together of mental health and primary medical services.

Regional Mental Health has been developing programs to bring together these services for several reasons:

- People with mental health conditions have been shown to have shortened life spans, as much as 25 years shorter than the general population.
- These people are generally dying of heart disease or the complications of diabetes.
- Poor health care is the rule, not the exception.
- Up to now, this hasn't been thought of as the responsibility of staff in mental health centers.

We believe that efforts to reach out to medical providers to coordinate care, and efforts to reach out to the people we serve, can improve the quality of medical and psychiatric care, and improve length and quality of life.

Since 2008, we have been coordinating mental health services for the primary care staff at the NorthShore Health Centers in Portage and Lake Station, IN.

Building on the success of this program, we are now introducing the Regional Primary Care Initiative, to coordinate primary health care for Regional clients and support their ability to develop their own healthy life habits.

The Regional Primary Care Initiative has 3 parts:

1. Provision of primary medical services directly in our Merrillville and East Chicago main centers, by our partners, the NorthShore and East Chicago Health Centers.. This will make it much easier for us to coordinate our efforts.
2. Care Management:
   - Regular health screening and monitoring by our Regional Primary Care Initiative staff, to ensure that commonly-occurring conditions like diabetes or high blood pressure are treated in a timely, preventative fashion and EFFECTIVELY.
   - Assistance with negotiating the complex health care system, to assure the best medical care is available.
1. Wellness activities: Support and training for clients to help develop skills and habits that foster good health for a lifetime..

[Barb—obviously this should be "3", but I couldn't make it act right}

A 4-year grant from the Substance Abuse and Mental Health Services Administration is supporting the development of this program. We are encouraged to develop original ideas to help meet our goal of better wellness for the people we serve. This kind of care management program represents the state of the art in bringing medical care to our behavioral care world.

If these programs are successful, they will lead to change around the country in the way medical services are provided, and form an important part of health care reform—for the better! We are excited to have this opportunity, we have lots of resources to use to offer all these services, and we are eager to have our clients involved.

Any Regional client is welcome to participate IN ANY PART OF THE PROGRAM, even if they do not wish to use the primary care clinics located here, and want to continue with their present primary care provider.

We urge our clients and families to join with us in developing a new kind of care to make a difference here and all over the country.

Call us, come in, we want to work together with you!

Courtesy John Kern, M.D.

DISCUSSION

+ ***Where do you see opportunities to improve relationships and communication in your care team?***

DEPARTMENT OF BEHAVIORAL HEALTH PROVIDER TESTIMONIAL – COMMUNITY CONNECTIONS

Jennifer Joyce, LCSW, Community Connections: Senior Director of Integrated Services

CONTACT US

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