# Coordinated Care Management:

## Public Health & Behavioral Health Creating an Integrated Community

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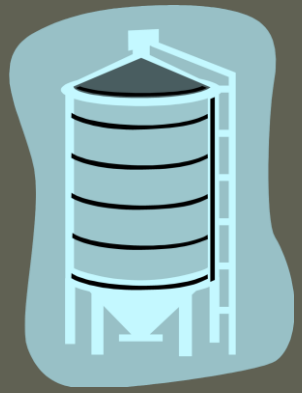
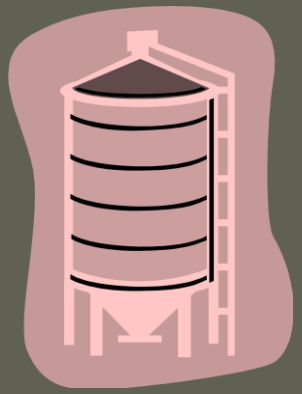
*19th Annual NACM Conference – October 2nd, 2013*

# It's All About Global Budget

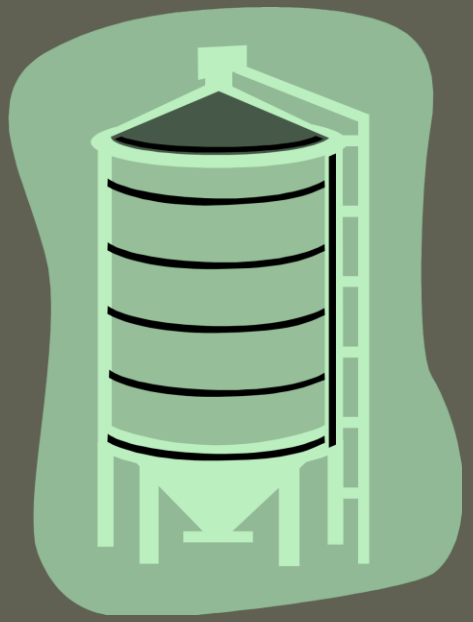


Behavioral Health



Physical Health

Dental Health



All Health

# But to a Small Healthcare Neighborhood, it felt a little like this….

# Planning for Change

- Oregon Health Authority (2010)
- HB 3650 – Health System Transformation
- HB 1580 –Implementation of Integrated and Coordinated Care Delivery System
  - Physical Health
  - Behavioral Health (MH, SA)
  - Dental Health
- Oregon's Medicaid Waiver
- Coordinated Care Organizations (2012)

HB 3650:
http://www.leg.state.or.us/11reg/measpdf/hb3600.dir/hb3650.en.pdf
SB 1580:
http://www.leg.state.or.us/12reg/measpdf/sb1500.dir/sb1580.en.pdf

# Local Mental Health Authority

Lifeways, Inc.

# Local Health Authority

## Malheur County Health Department (MCHD)

# Malheur County

# Malheur County


- 9,926 square miles
- Population of 31,630 (2012)
- Rural, frontier
- Local economy – agriculture and farming
- 94% rangeland
- Geographic isolation
- Low socioeconomic status
- Low educational achievement
- Transportation

# Behavioral Health's Tribal Knowledge & Myths

- Early 1980's: DSM III
- Dx is King
- Personality Disorders Untreatable
- Schizophrenia & Cognitive Improvement are Incompatible
- Thought, Mood, Anxiety Disorders - Separate & Distinct
- Housing is gained in stages
- Families Less Important
- No EBP's
- Congregate care is best

# Characteristics of Provider Practice

Single facility - Unconnected to other behavioral health or PCP providers

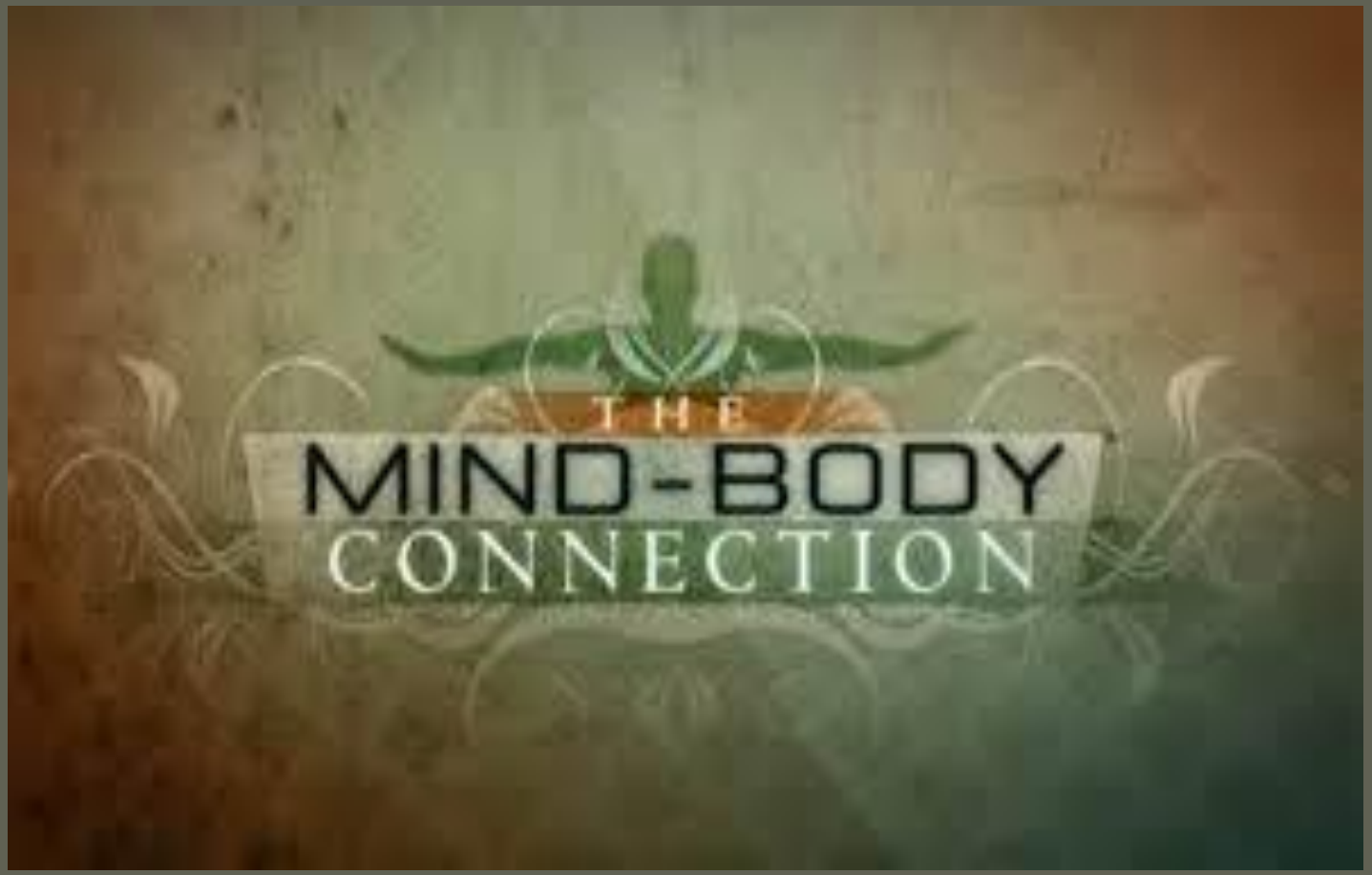
- Limited use of technology and data
- Clinical judgment of single practitioner
- Singular patient focus
- Limited experience in shared financial risk
- Reporting services provided and patient encounters
- Single episode dependent… "Illness" approach

Linked Levels of Care - Formal or virtual integration into a care system

- EMR & Technology
- Multidisciplinary integrated teams
- Population management approach
- Shared financial risk (global budget)
- Requirement for quantitative demonstration of clinical effectiveness and efficiency
- Incorporate more efficient long term treatment techniques… "Recovery" focus

**Old to New….**

# The New Paradigm…



# Why Change?

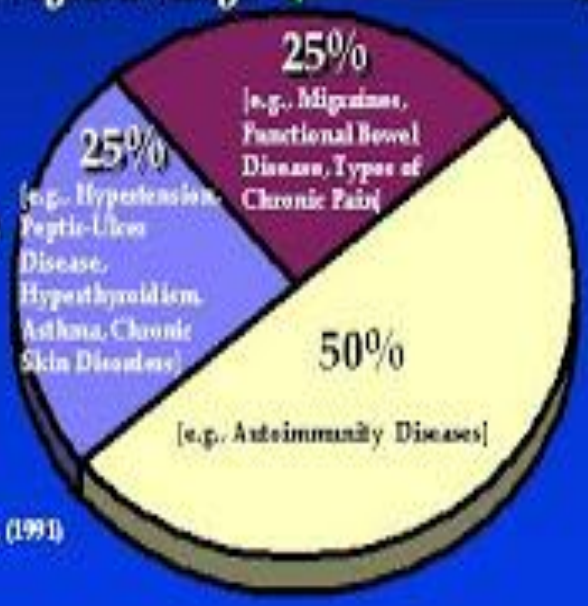
- People with Serious Mental Illness die 25 years earlier than general population
- While suicide and injury account for about 30-40% of excess mortality, 60% of premature deaths in persons with schizophrenia are due to medical conditions such as cardiovascular, pulmonary and infectious diseases

(NASMHPD, 2006)

# Percentage of Outpatient Visits
## *for Psychosomatic Disorders*

*Physiological* Disturbances related to *Psychological* Factors

**Without** End-Organ Damage ← *May Occupy a* **Full 50%** *of the Clinician's Time*

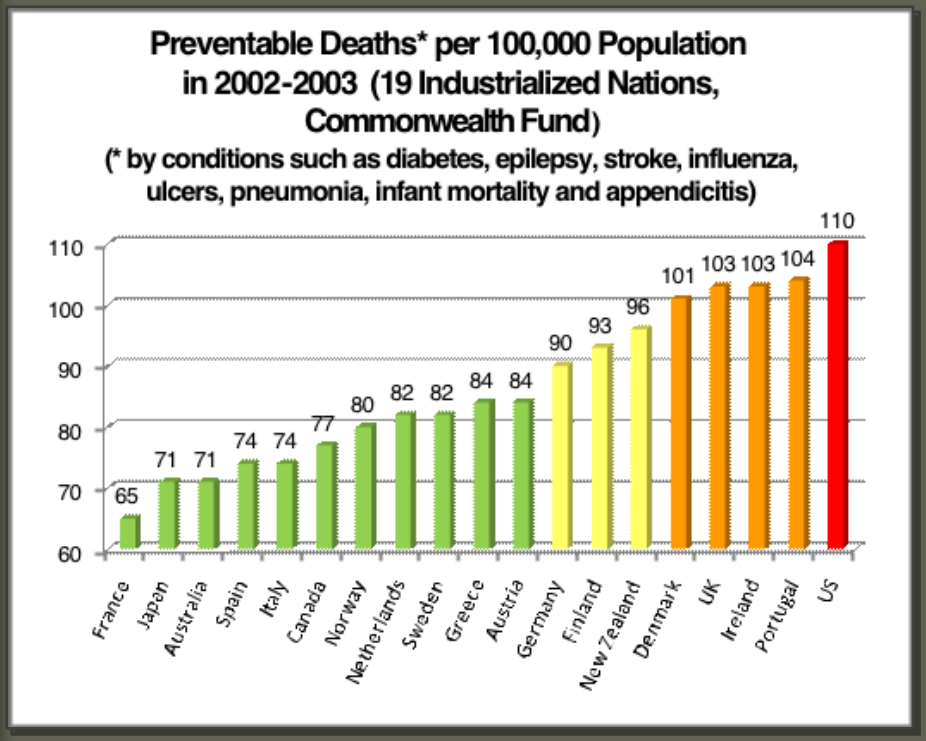



**With** End-Organ Damage

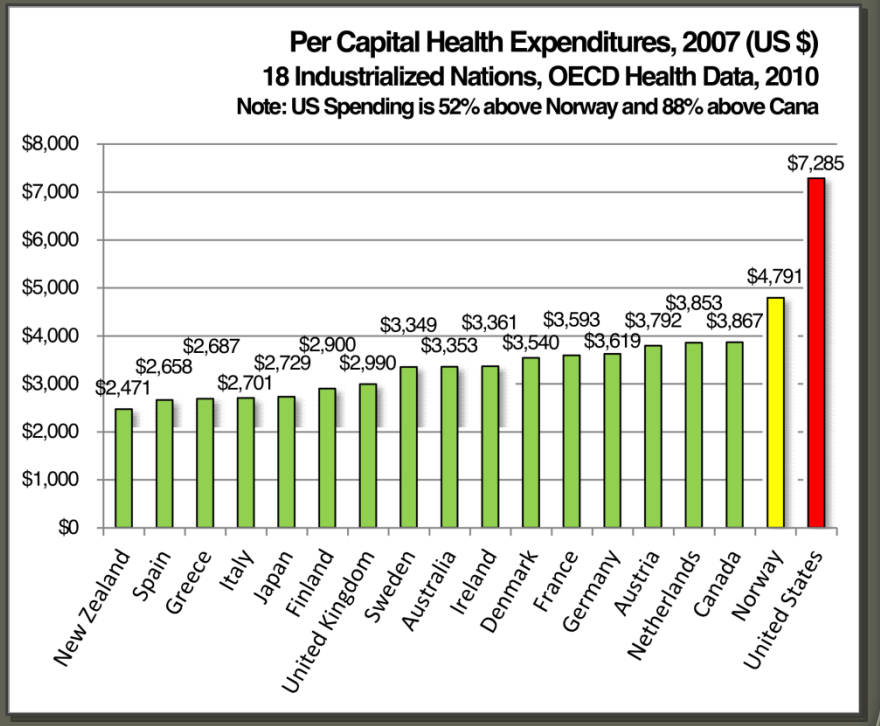
Other Physiological Disturbances that tend to Flare Up with Life-Stress

Resource: Thomas Pauker, M.D. (1991)

# Preventable Deaths & Costs




**110 Preventable Deaths per 100,000**



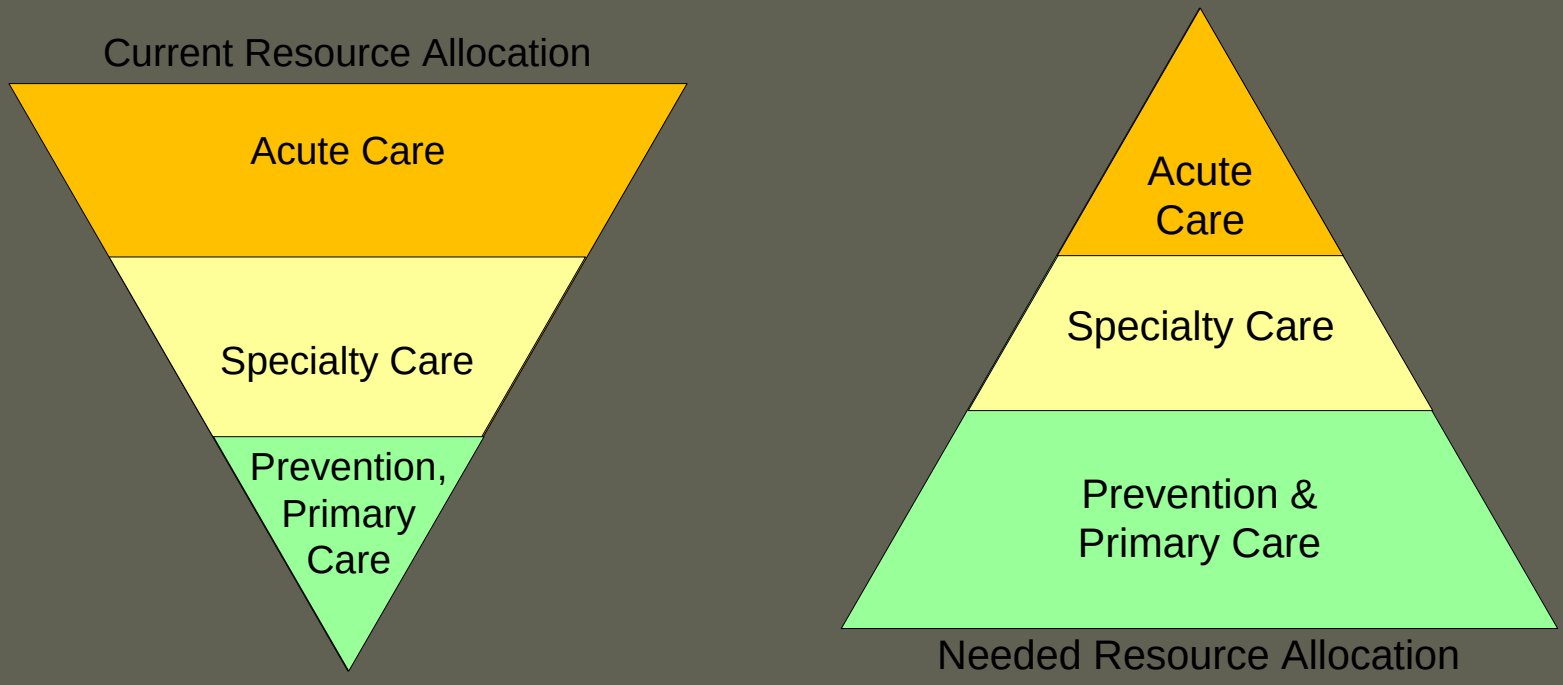

**$7,285 Per Capita Health Expenditure**

# Healthcare Access

- ***Underuse of Healthcare:***
  - Fewer routine preventive services
  - Lower rates of cardiovascular procedures
  - Worse diabetes care (Desai 2002, Frayne 2006)
- ***Misuse of Healthcare:***
  - During medical hospitalization, persons with Schizophrenia are about twice as likely to have infections due to medical care

# Solutions

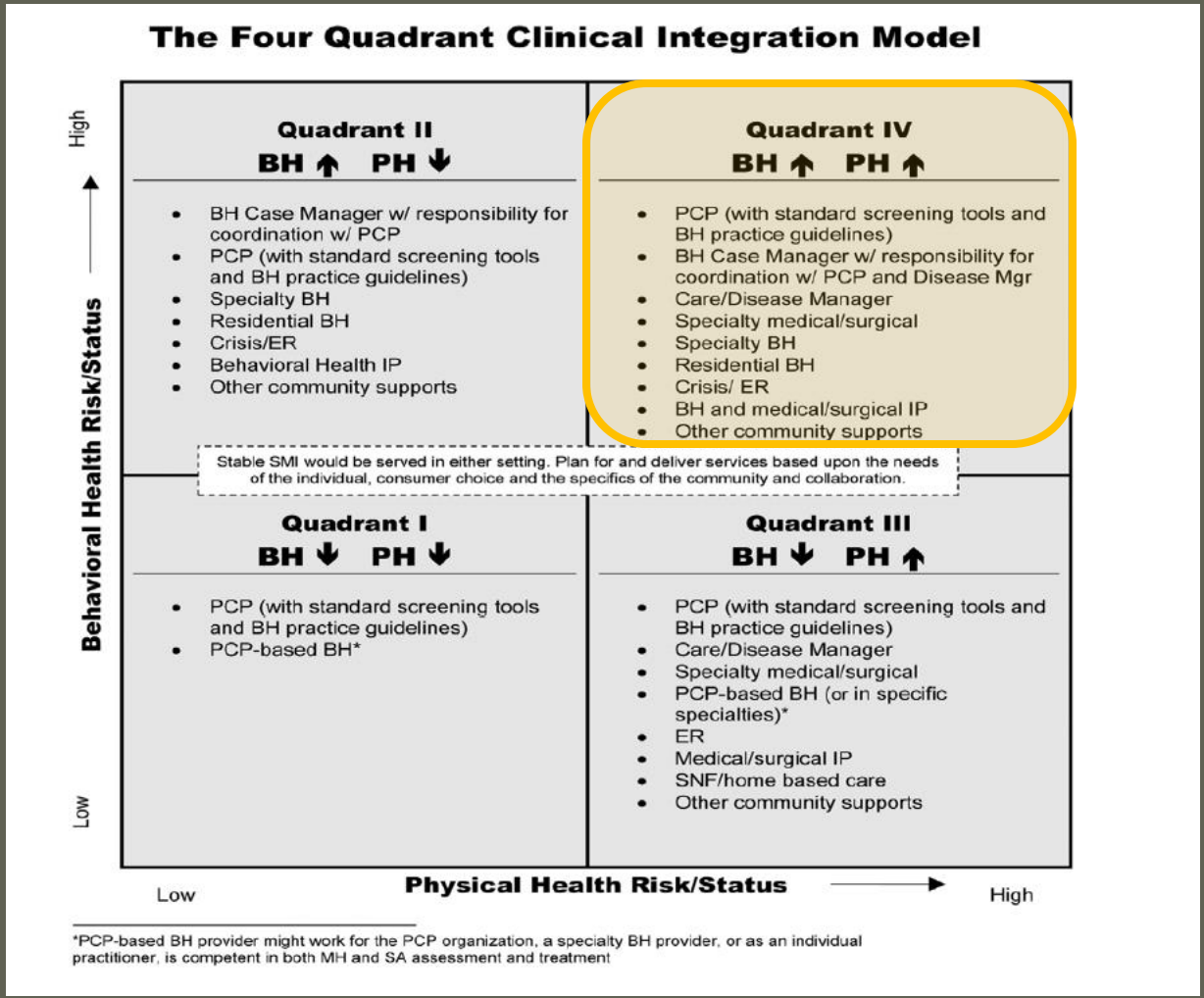
- Need to invert the Resource Allocation Triangle
- Prevention Activities must be funded and widely deployed
- 80/20 Phenomenon



# Case Spotting

- Coordinated Case Management is Built on Appropriate Use of Case Spotting
- Best "Bang for the Buck"
- Focus on Multiple Chronic Conditions
- Contact at Least Quarterly with PCP
- Release of Information & HIPAA
- Increased Care Coordination Promotes Improved Access to Physical Health Services & Prevention

# So What Do We Do Now?



# Care Coordination

- Primary Care Physicians

- Behavioral Health Care Managers

# Is Care Coordination Billable?

- That Depends…
  - SMI connects to a **functional limitation or symptom** related to accessing healthcare
  - Identified in **assessment** as related to SMI
  - Justified as **medically necessary** in service plan

- Then, YES!

# Finding Partnerships to Develop Preventative Health Services

- Sick Care versus Well Care (EASA, Drug Free Community Coalition)
- Where do people access health services in a rural community?
  - Population based health interventions
  - Prevention
- Where does basic community outreach start in our local health care system?
  - Prenatal care/Maternal health
  - Early Intervention
  - Immunizations
  - Vital statistics

# What is Public Health?

- Assessment
- Policy Development
- Assurance

# What is Public Health?

**Top 10 Achievements in Public Health**

1. Vaccination
2. Motor-vehicle safety
3. Safer workplaces
4. Control of infectious diseases
5. Decline in deaths from coronary heart disease and stroke
6. Safer and healthier foods
7. Healthier mothers and babies
8. Family planning
9. Fluoridation of drinking water
10. Recognition of tobacco use as a health hazard

# What is Public Health?

# What is Public Health?

## 10 Essential Public Health Services

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.

# What is Public Health?

## 10 Essential Public Health Services, cont.

6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

# Community Health Assessment

Looking at the baseline of population health in Malheur County.

-Socioeconomic Factors

-Health Outcomes

-Health Factors

# Key Findings & Areas of Concern…Socioeconomic Factors

- Large Hispanic and non-English speaking population
- Low high school and college graduation rates
- High poverty rate
- Unemployment
- Juvenile crime
- Domestic violence and child abuse

# Key Findings & Areas of Concern…Health Outcomes

- High % of adults reporting poor or fair health
- Alzheimer's disease
- Infant mortality
- Teen birth rate
- Late or no prenatal care
- Colorectal and prostate cancer mortality
- Diabetes
- Stroke Mortality
- Sexually transmitted diseases
- Suicide rate

# Key Findings & Areas of Concern…Health Factors

1. Access to primary care and oral health
2. Lack of health insurance
3. Physical inactivity
4. Inadequate fruit & vegetable consumption
5. Obesity
6. Tobacco use

# Key Findings & Areas of Concern…Health Factors

7. Access to healthy food outlets and recreational facilities
8. Lack of cholesterol screening
9. Mammography rate
10. Colonoscopy rate
11. Chronic disease management
12. Mental health & substance abuse services
13. Prescription drug affordability

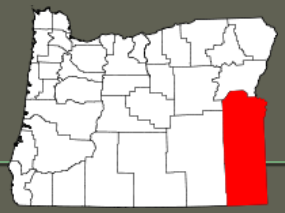
# Health Equity

- Health Equity
  - Access to quality health care
  - Social determinants of health
    - High Opportunity Neighborhoods

# Health Disparities

- Race/Ethnicity
- Sex
- Sexual identity
- Age
- Disability
- Socioeconomic status
- Geographic location

# Malheur County



- As mentioned previously, Malheur County has low income rates, low educational attainment, as well as being a rural frontier community that is geographically isolated with significant transportation challenges.
- Malheur County is an agricultural area with a seasonal migrant population
- The population in Malheur County is one-third Hispanic

# Malheur County Continued

- When looking at addressing health disparities in Malheur County, we must address
  - Providing information and tools to clients that are culturally appropriate and patient-centered
  - Ensure equitable access – need to address transportation challenges within the community
  - Eliminate linguistic and cultural barriers to communication
  - Develop advocacy measures and policies to address correcting health disparities

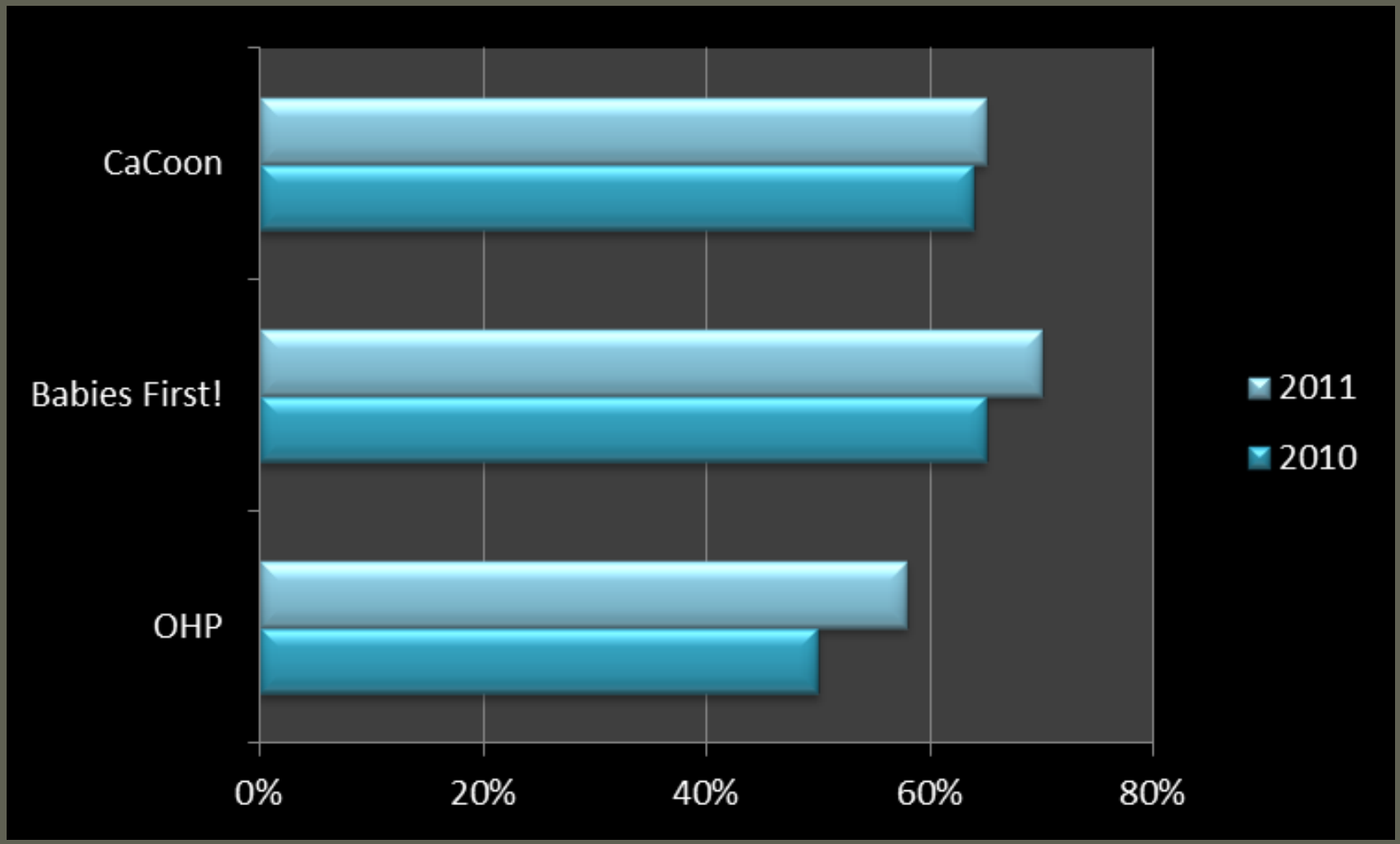
# MCHD and Care Coordination

- Experience in care coordination activities with:
  - Expectant mothers
  - Families with young children
  - Families with children with special needs (up to age 21)

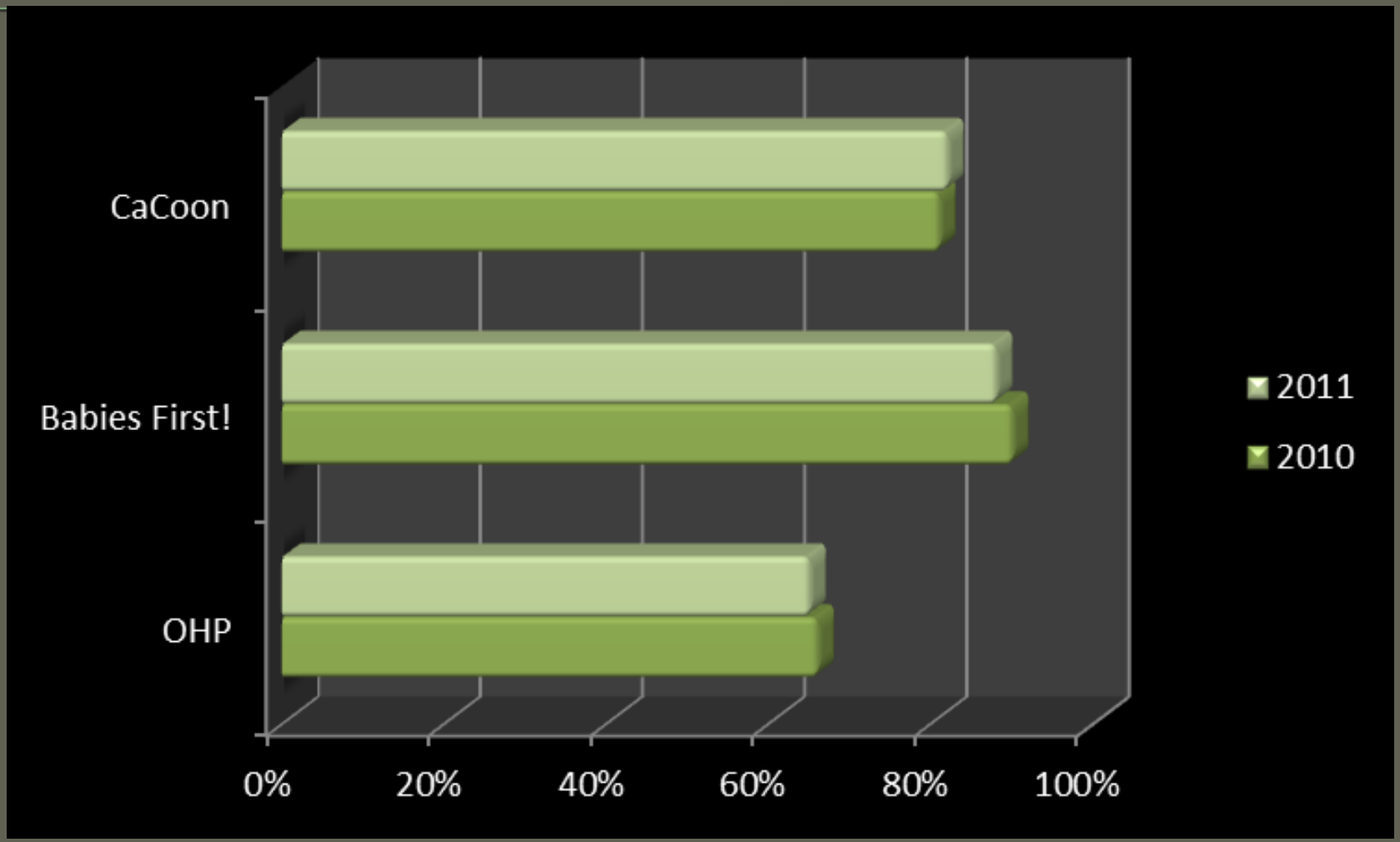
# MCHD and Care Coordination

- Improved outcomes
- Reductions in risk factors that lead to chronic conditions
- Reductions in costs due to ED visits
- Better patient compliance with medical care provider appointments and instructions
- Improvements in HEDIS and other quality metrics

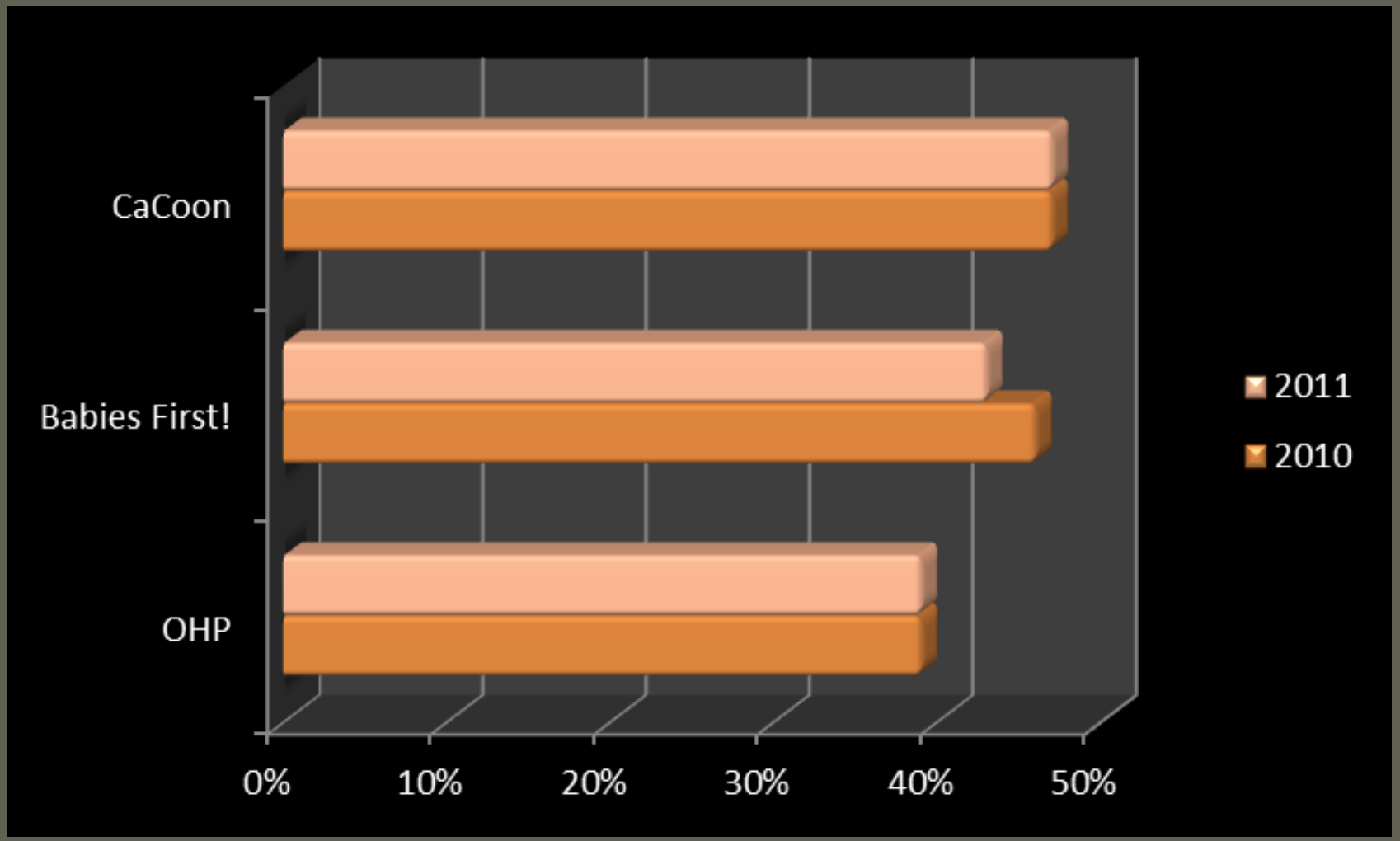
# Immunization Rates at 2 years



# Annual Well-Child Visits Birth to 6 years



# Annual Dental Visits 2-3 year olds



# MCHD & Non-Traditional Health Workers

- Goals:
  - Increase access to and utilization of health and related services
  - Increase cultural competence of care providers and health systems
  - Decrease health disparities

# Non-Traditional Health Workers

- The Role of (Non) Traditional Health Workers (N)THW in Oregon's Health Care System
  - House Bill 3650
  - OAR 333-002-0300 thru 333-002-0380
  - Oregon Health Authority NTHW Steering Committee

# NTHW Definitions

- Community Health Worker
- Peer Wellness Specialist
- Personal Health Navigator

"The Role of Non-Traditional Health Workers in Oregon's Health Care System": www.oregon.gov/oha/oei/docs/nthw-report-120106.pdf

# NTHW Scope of Work

- Outreach and mobilization
- Community and Cultural Liaising
- Case Management, Care Coordination and System Navigation
- Health Promotion and Coaching

# NTHW Success Stories

- Community Health Workers
  - Improved prevention and chronic disease management
  - Cost shifting
  - Indirect savings

# NTHW Success Stories

- Peer Wellness Specialist
  - Shortened length of stays
  - Decreased frequency of admissions
  - Reduction in overall treatment costs
  - Improved treatment adherence
  - Reduction of overall need for services over time

# NTHW Success Stories

- Personal Health Navigators
  - Improved access
  - Better care
  - Reduction of cost

# We're Still Confused What We Can Do…

# Current State of Care

## CHALLENGES

- Barriers that are systemic or sometimes cultural
- Examples
  - HIPPA Misinformation
  - Lack of communication between MH - ER - PCPs
  - Duplication of labs
  - Inconsistent or conflicting patient advice
  - Assumptions about roles, services, and limitations of different providers in BH and PH care settings

## ASSETS

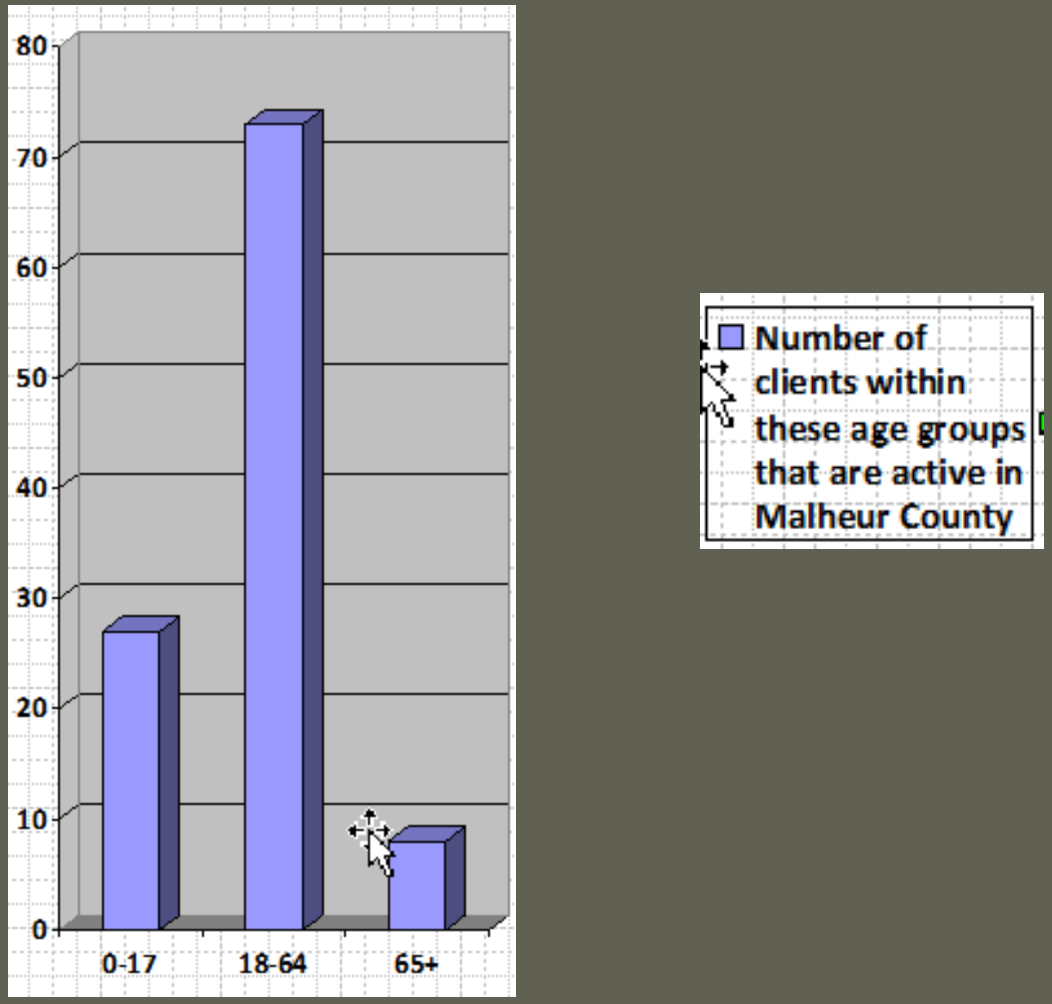
- Existing processes that support positive outcomes
- Examples
  - Wraparound model used for child MH services
  - MH Care coordination staff & training capabilities
  - Community based staff used by BH & HD
  - Population based interventions by HD
  - HD expertise in gathering population based health data
  - Credible EMR

# Malheur Case Spotting

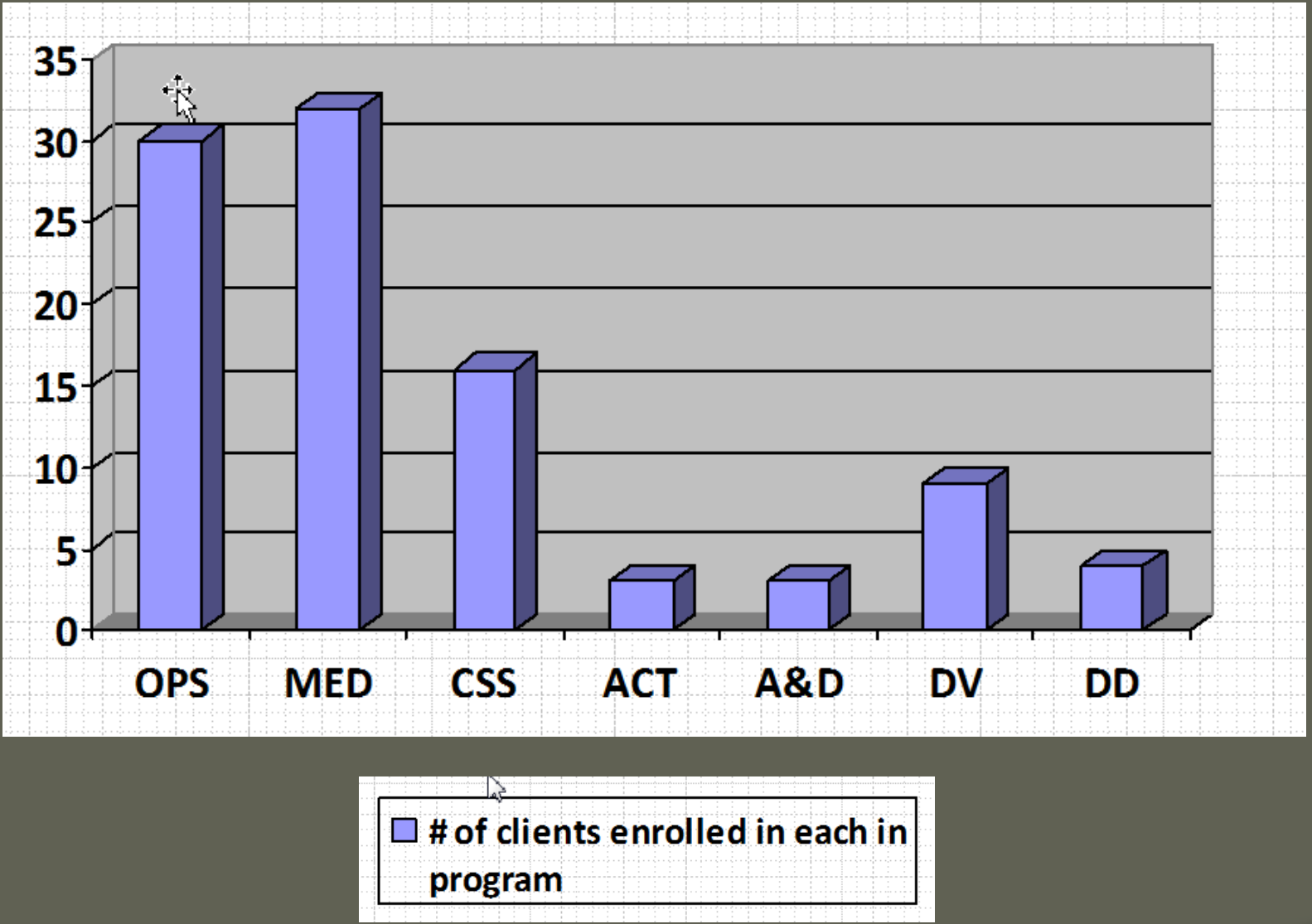
- 1,246 Adults & Children Identified
  - Divided into 3 Tiers
  - Priority Clients Placed in Tier 1
- 109 Clients with 2 or more Chronic Conditions (PHMH)

- Most Clients are known to us and open in our EMR
- Medical Hx is often sketchy and dated
- Record of Correspondence between MH Primary and PCP is minimal

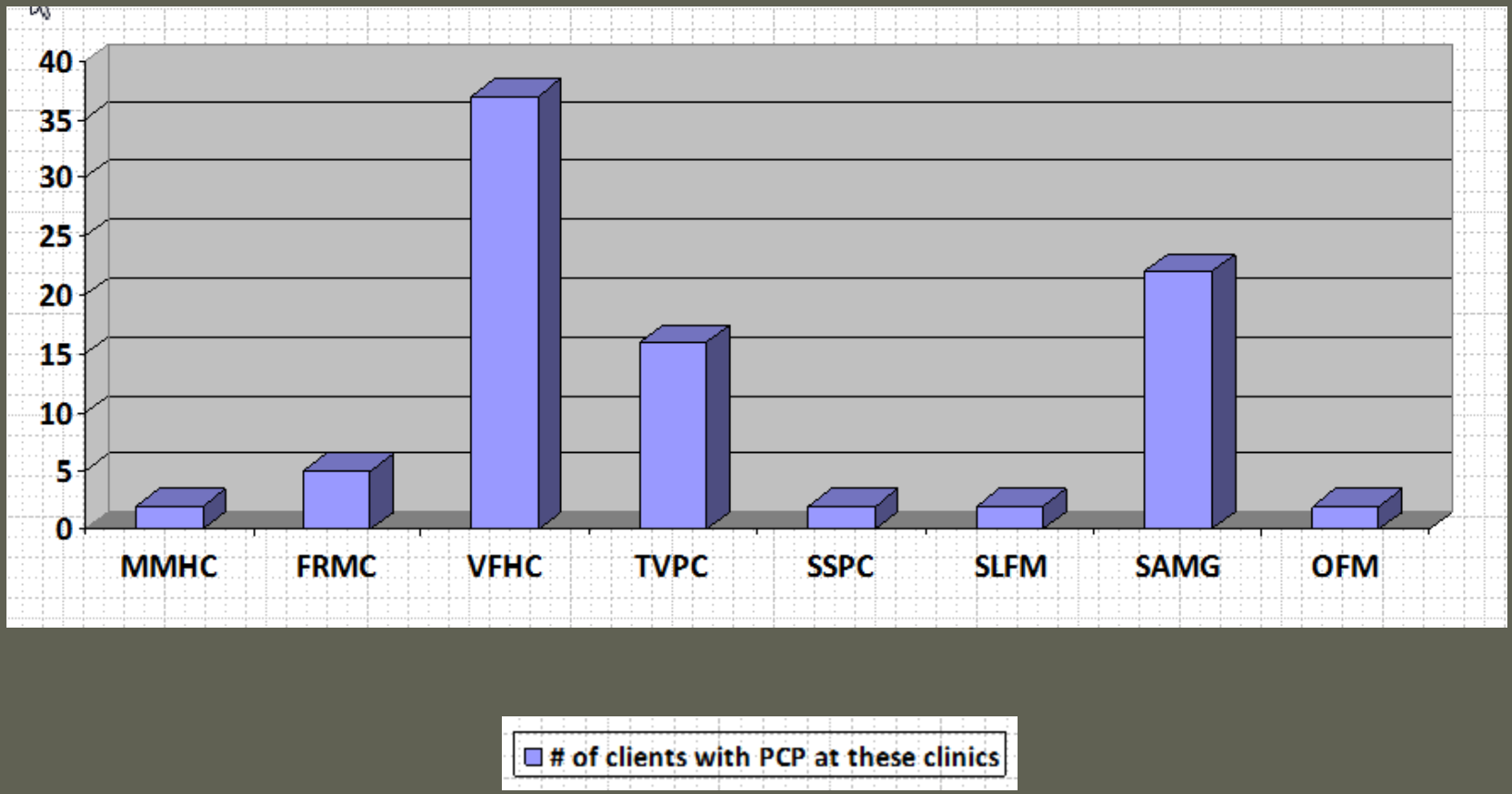
# Priority Clients by Age



# Program Distribution



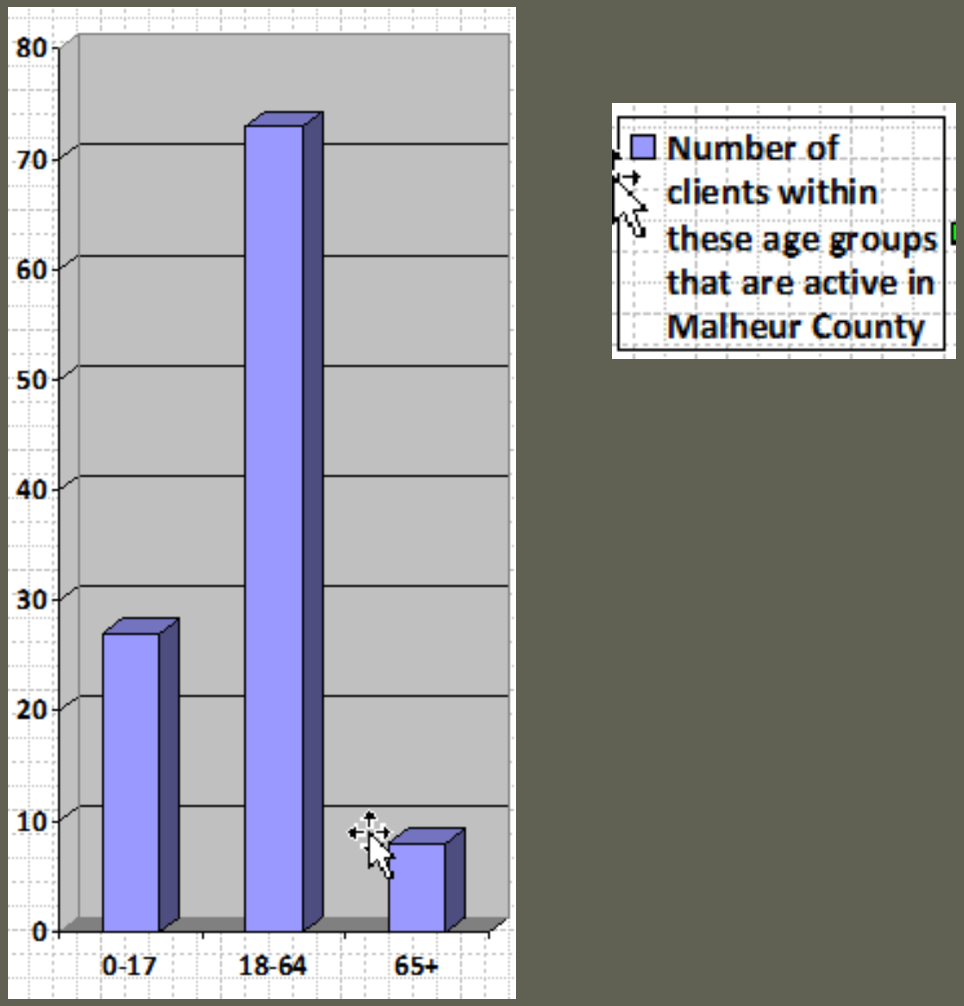
# Priority Client Distribution



# 1. Define the Problem

- Leadership acknowledged emerging research about health disparities as a larger problem and frequent comorbidity of chronic health conditions in our clinic populations
- Education to all staff about healthcare transformation and the profile of clients most affected
- Internal Case spotting used
  - EMR identified local health providers to partner with
  - MHO utilization data to narrow client pool
- Facilitated discussion of front line workers about common challenges (and assets) to addressing both physical and behavioral health in SPMI population

# Priority Clients by Age



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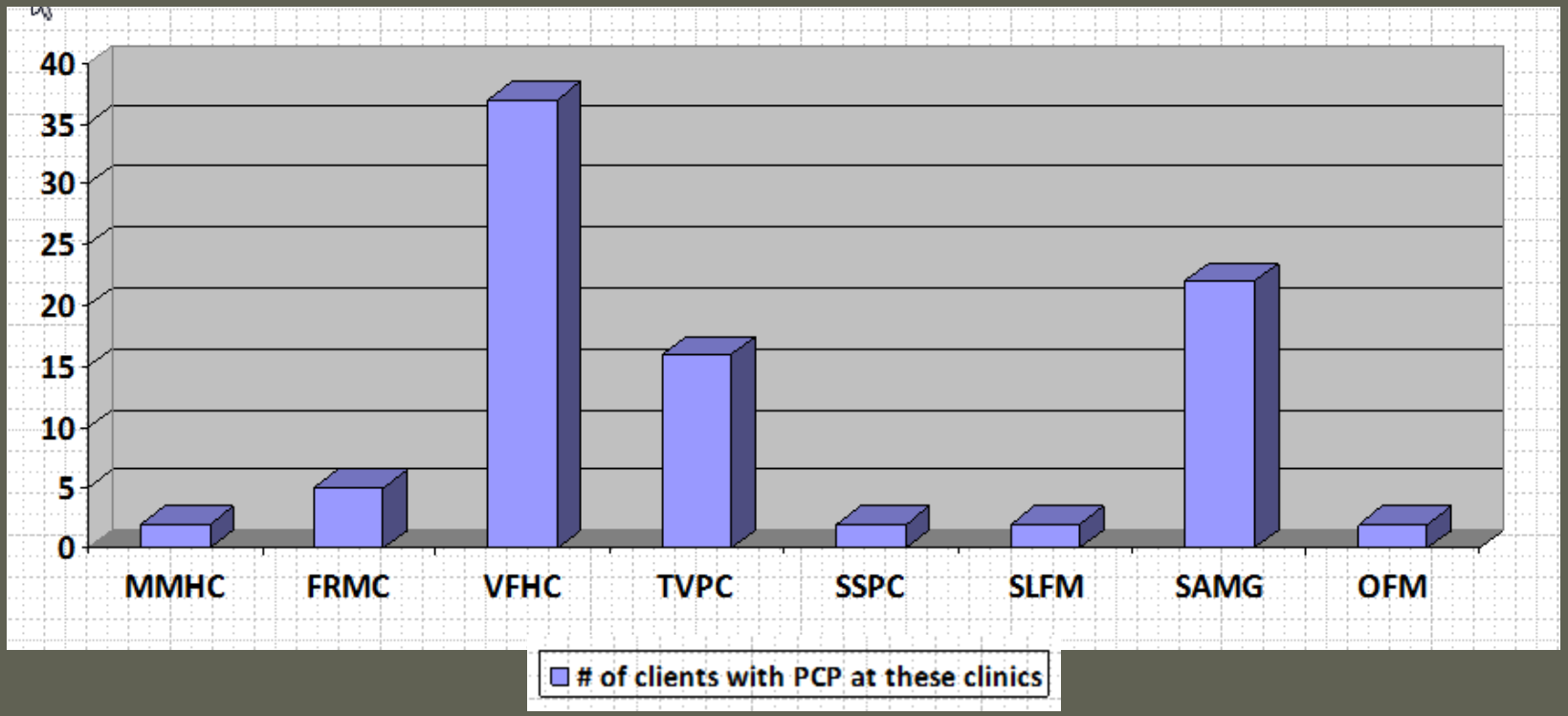


# 2. Identify Desired State

- Malheur LIFT Demonstration's Goals
  - Care coordination for clients in Tier 1 population
    - Medicaid eligible
    - Chronic Medical and Mental Health Diagnosis
    - Engaged in services
      - Enrolled in Community Support Services (CSS) program
      - Have assigned a Primary Care Physician
  - Active interface for physical health and mental health providers
    - Addressing concerns that are case specific
    - Building connections within the health care neighborhood

# Communicating Goals between Systems

- What motivates them to participate? Aside from improved outcomes, what do our health partners want?
- Acute Care Facility
  - Reduced readmission rates
  - Reduced ER wait time due to misuse
- Independent Practitioner, Provider Group
  - Skills that a PCMH status would value
  - Behavioral health intervention

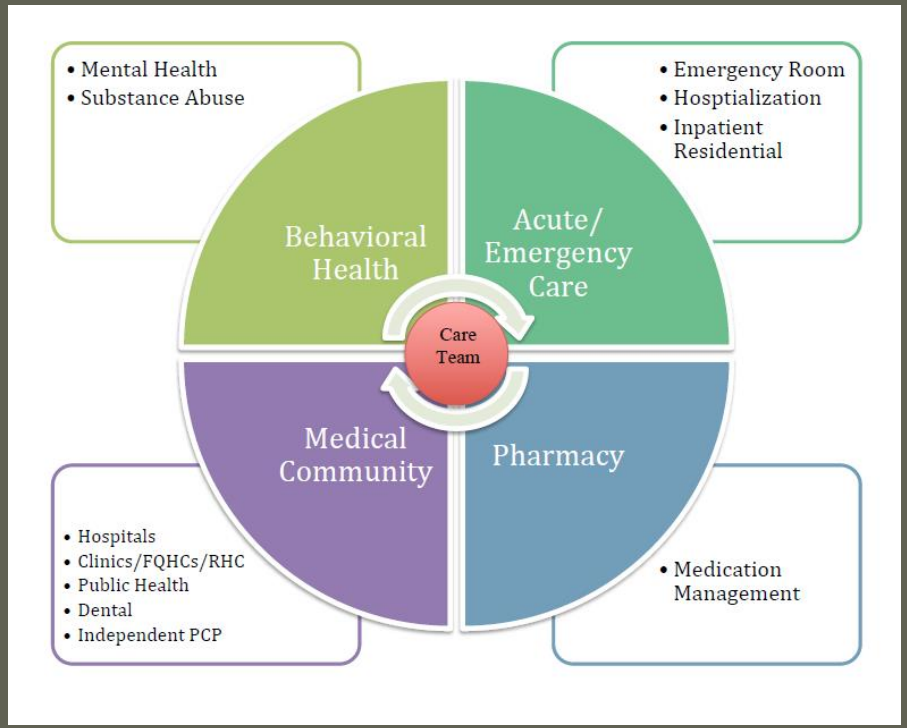
# 3. Define The Target—Our Healthcare Neighborhood

**Medical Community**
- St. Alphonsus Medical Group
- St. Luke's Clinic - Fruitland
- Valley Family Health Services
- Debra Alexander, FNP
- Malheur County Health Department

**Behavioral Health**
- Lifeways A&D
- Lifeways Mental Health

**Acute/Emergency Care**
- St. Alphonsus Emergency
- St. Alphonsus Hospital

**Pharmacy**



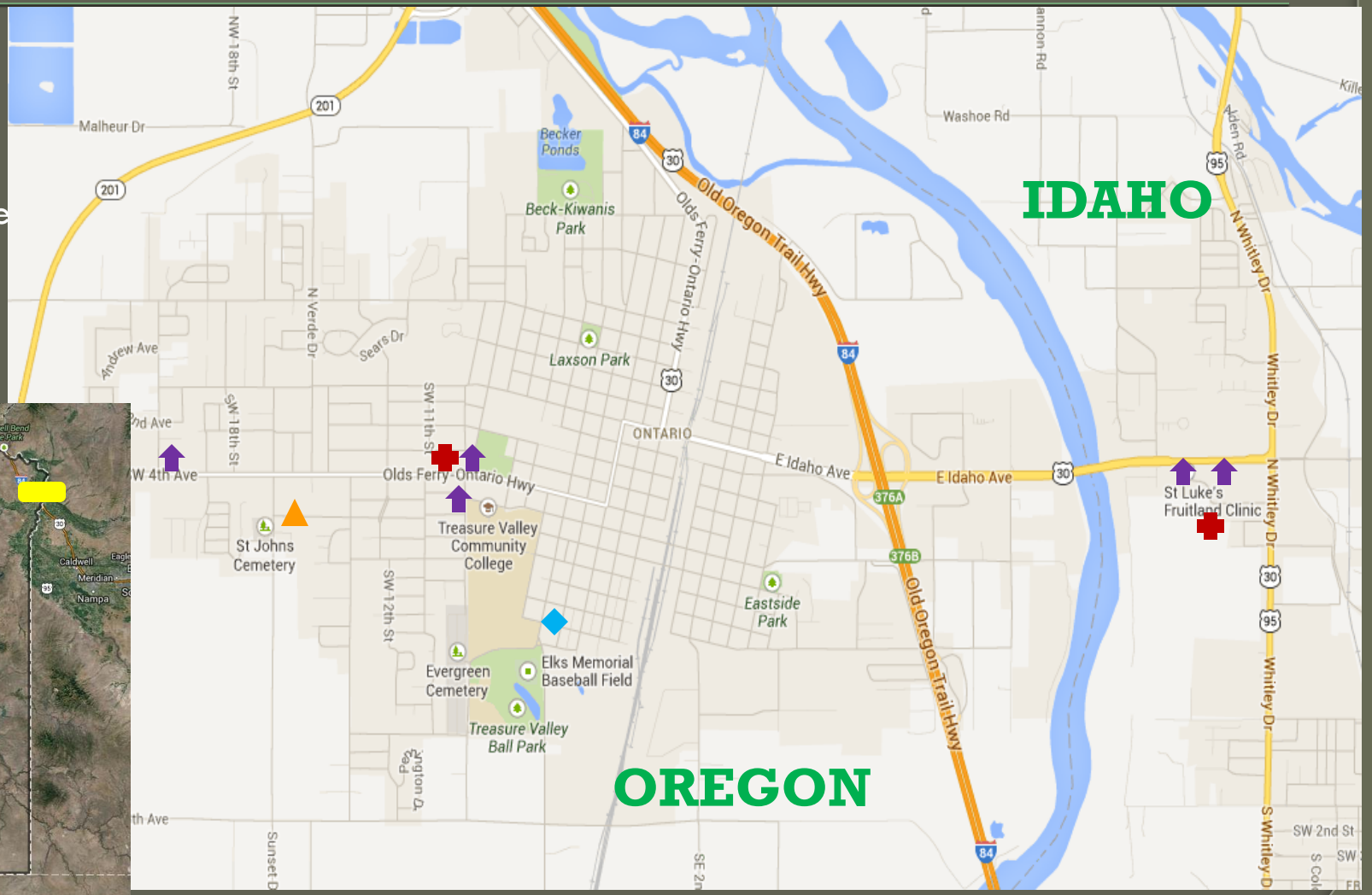
# Health Care Neighborhood

PH Clinic

BH Clinic

Acute Care

Health Dept

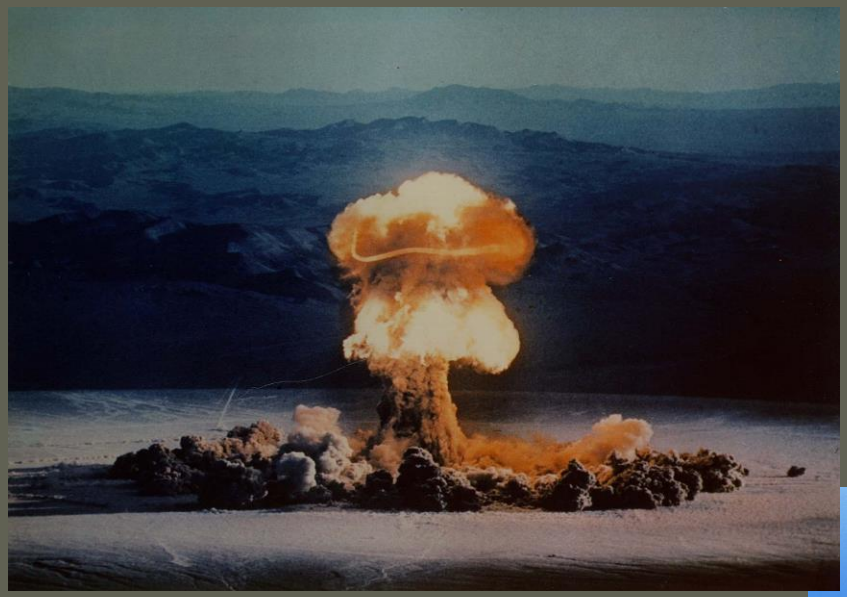
# 4. Select Interventions

- Community Organizing approach
  - Identify champions among partners
  - Clarify expectations on a system level of each partner's services and supports
  - Define roles and responsibilities, acknowledge limitations and strengths
  - Develop a protocol of contact and primary contact person in each organization
  - Identify positive outcomes desired and resources available

- Care Coordination services
  - Use of an existing model of team based care if possible (PCMH, FDM, Pathways, Wraparound, etc.)
  - Tailor documentation to suit adult client needs and include behavioral, physical, and other client goals
  - Structure and streamline referral and intake process to demonstration program

- Education and cross-training
  - Learning and discovering roles and responsibilities for staff and agencies involved (administrative and clinical)
  - Illuminate provider cultural barriers to co-management
    - Silo mentality
    - Mind-body split
    - Assumptions about other agencies
  - Provide facilitation training
  - Foster networking of staff familiar with client care continuum from outreach, engagement, and treatment modalities

# So, What Have We Accomplished?



# Results Thus Far

- Hotspotting efforts by all partners are shared
- Convening monthly care teams for 5 individuals
- Education and cross-training
  - Provider collaborative meetings monthly since Dec 2012
  - Two facilitation trainings to physical health and behavioral health staff
- Point of primary contacts for care coordination and systems change are defined in participating providers
- Moving from competition to collaboration
  - Involvement in others' initiatives (health fair, enrollment drives)
  - Supporting the development of our CAC

# Next Steps

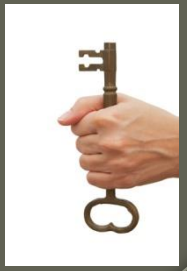
- Network Care Coordinating intake and referral process (parallel with Health Department Model)
- Pursuing innovation funding for Community Health Workers to be out stationed at provider offices and connected to LIFT Collaborative
- Defining outcomes and data collection methods
- Meaningful use of EHR

# Local Community Advisory Council

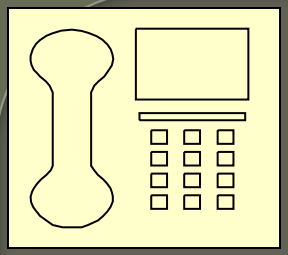
- Monthly meetings since Feb 2013
- Comprehensive membership
  - Healthcare (PCPs, Dental, Chiro, MH)
  - Social Services (CW, Community Chest, Ed, Public Safety)
  - Consumers (PWS, Ethnic Minorities)
- Working towards our CHA/CHIP
- Rural, frontier approach to getting things done
  - "Pull ourselves up by our bootstraps"
  - Pooling resources

# Keys to LIFT Network Growth

- Acknowledge your responsibility as a BH provider to allocate resources and leadership for systemic change in your healthcare neighborhood
  - Your clients are cost drivers in the system
  - Your experience with managed care and capitation is valuable
  - Your skills in community organization & intervention are critical in low resource areas
- Accept inertia from silo care, utilize momentum and partnership from transformation edicts
- Refocus on prevention, wellness and public health as the ultimate goals
  - The biopsychosocial model is at the heart of population-based health interventions and real outcomes.



# Questions & Comments



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