Integrating Behavioral & Physical Health:

Building Integrated Complex Care
Health Homes

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Sr. Director of Clinical Transformation & Integration
Inland Empire Health Plan
Finding “True North” in a Rapidly Changing Health Care Environment

- Achieving the “Triple Aim” for your Population.
- Making improvements that result in **Better Care**, to support **Better Health**, which results in **Better Cost**.
- With a long range focus on:
  - Helping healthy people stay healthy.
  - Helping prevent health conditions from becoming chronic health conditions.
  - Helping those with chronic health conditions, manage those conditions, lead better lives, and stay out of the emergency room and hospital.

Dale Jarvis, 2016
We are painfully aware...

• That healthcare finances have been wired so that we don’t have enough staff or time to do all of the above with the resources we have today.

• So We Look for Better Ways to Leverage What We Have.

Dale Jarvis, 2016
Why we need Population-Based Care for Complex Populations with Behavioral Health Conditions?

- Suffering
- Disability
- Expense
- Mortality
For Decades we have known: Chronic Disease + Depression = Higher Cost

<table>
<thead>
<tr>
<th>Chronic disease score</th>
<th>Annual Cost ($)</th>
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<tr>
<td>0 (n=859)</td>
<td>1000</td>
</tr>
<tr>
<td>1-2 (n=616)</td>
<td>2000</td>
</tr>
<tr>
<td>3-5 (n=659)</td>
<td>3000</td>
</tr>
<tr>
<td>6-16 (n=423)</td>
<td>6000</td>
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</tbody>
</table>


© University of Washington
Complex care patients are expensive.

Washington State Senate Ways and Means January 31, 2011

Co-occurring diagnosis among DL-U clients

DISEASE CONDITIONS
- Chronic Physical: 71%
- Mental Illness: 66%
- Substance Abuse: 38%

72 percent had substance abuse or mental illness identified
15 percent had a chronic physical condition only

SOURCES: MMIS claims, TARGET service encounters, and WSP arrest records, FY 2006-07. Chronic physical and mental illness diagnosis groups derived from CDPS grouper. Mental illness also indicated by receipt of mental health medications.
The Cost of Health Care
How much are we spending?

$2.5 Trillion
spent in the U.S. on health care in 2009

30% Waste

WASTE:
$765 Billion
30% of 2009 total health care spending

Unnecessary Services
$210 Billion

Excessive Administrative Costs
$190 Billion

Prices That Are Too High
$105 Billion

Fraud
$75 Billion

Inefficiently Delivered Services
$130 Billion

Missed Prevention Opportunities
$55 Billion

Lowering Costs and Improving Outcomes

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
“Our nation is at a crossroad. The care we have simply cannot be sustained. It will not work for health care to chew even more deeply into our common purse.”

“If it does, our schools will fail, our roads will fail, our competitiveness will fail. Wages will continue to lag, and, paradoxically, so will our health. The choice is stark: chop or improve.” (Don Berwick, former CMS Administrator)
What’s the Catch?

• Medi-Cal 2020 Waiver
  – California has convinced CMS that over 5 years, the programs will succeed to the point where they are saving as much Medi-Cal money as its spending on the initiatives.

• Section 2703 Health Home Program
  – California is promising that by the end of two years, the program will learn how to save enough money to be self-sustaining.

Translation: In the words of Don Berwick...

“The choice is stark: chop or improve.”

Dale Jarvis, 4, 2016
3 Health Reform Trajectories

- No Change, No Improvement
  - The Status Quo seems to be working
  - Or we can’t get our act together
  - Get ready to be disrupted or chopped

- Change Without Improvement
  - The Wrong Initiatives
  - Or the Right Initiatives Not Executed
  - Get ready to be disrupted or chopped

- Patient, Step By Step Improvement
  - The Right People
  - The Right Initiatives
  - The Right Number of Initiatives
  - The Right Execution
  - The Path to Sustainability

Dale Jarvis, 4, 2016
Michael Porter

• “In health care, the days of business as usual are over.”
• “It’s time for a fundamental new strategy.”
• “We must...
  – Shift the focus from volume to patient outcomes achieved
  – Replace today’s fragmented system with system in which services are concentrated in health-delivery organizations”

Dale Jarvis, 4, 2016
Do You Know About Atlanta?

• Fulton County Georgia’s Objective: create *health neighborhoods* with *one-stop centers* where people receive a holistic set of services under one roof that are customized to the needs of the neighborhood.

• Neighborhood Union Primary Care Partnership was the first of four one-stops.

Dale Jarvis, 4,2016
What’s in the Health Neighborhood?

• The Neighborhood Union Primary Care Partnership’s One Stop Shopping:
  – Well patient care
  – Sick-patient care
  – OB/GYN services
  – Travel immunization services
  – Communicable disease intervention
  – WIC/nutrition education
  – Oral health services
  – Behavioral health services
  – Employment assistance
  – Disability and vocation rehabilitation services
  – Foreclosure prevention services
  – Housing assistance

Dale Jarvis, 4, 2016
What’s in the Health Neighborhood?

• The second one-stop, The North Fulton Government Service Center has all of the above plus:
  – A day center for the children of parents receiving services
  – A branch of the public library
  – A reading room/information center that offers ESL classes
  – An office where you can pay your parking tickets and taxes
  – A farmer’s market
  – A community garden
  – A walking trail

Dale Jarvis, 4, 2016
The Crystal Ball is Starting to Clear

• The future is neither in plastics nor patient-centered medical homes.
• It’s in One-Stop Health and Wellness Centers providing Integrated Whole-Health Care.
• Combined with specialty care (medical and behavioral health; inpatient and ambulatory) provided at Centers of Excellence.
• Combined with Community Services & Supports that address the social determinants of health.
• Supported by Payment Reforms.
• Together this describes the Health Neighborhood of the near future.

Dale Jarvis, 4,2016
Which Brings Us to California’s PRIME-WPC-2703-CCBHC
## Aligning 2703 Health Home Program With all the Other Initiatives

<table>
<thead>
<tr>
<th></th>
<th>Medi-Cal 2020 PRIME</th>
<th>Medi-Cal 2020 Whole Person Care</th>
<th>2703 Health Home Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What</strong></td>
<td>Initiative to transform Public Hospitals into entities that take responsibility for the quality and cost of their patients inside the hospitals and in the community. Begins NOW.</td>
<td>County-Based, Lead-Entity Led Pilots to coordinate health, behavioral health and social services for vulnerable Medi-Cal beneficiaries who are high users of multiple systems. Begins late spring 2016.</td>
<td>Community-Based Care Management Entities that wrap care around the highest risk Medi-Cal enrollees to improve outcomes and health. Begins July 2017.</td>
</tr>
<tr>
<td><strong>Who</strong></td>
<td>Designated Public Hospitals, District Municipal Public Hospitals</td>
<td>County Agencies, Designated Public Hospitals, District Municipal Public Hospitals</td>
<td>Primary Care Clinics &amp; Other Provider Organizations that serve a high volume of HHP-eligible members.</td>
</tr>
<tr>
<td><strong>Goals</strong></td>
<td>Improve Care Coordination, Increase Integration Across Systems, Increase Team-Based Care, Integrate Physical and Behavioral Health, Improve Population Health, Improve Data Collection and Sharing, Improve Health Outcomes, Improve Cost, Increase Access to Social Services and Supports, focusing on the MOST COMPLEX, MOST EXPENSIVE MEMBERS!</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Plus the 4th Puzzle Piece: CCBHCs

- CCBHC = A Federal Definition
- CCBHC = The BH Sibling to FQHCs
- CCBHC = A Comprehensive Community Behavioral Health Provider Organizations with:
  - Common Scope of Services
  - Common Quality Metrics
  - Paid with a Prospective Payment System (PPS)
Looking at the IE for “Opportunities for Improvement”: Life Expectancy by Neighborhood/County

**LIFE EXPECTANCY**
- **82.4–88.1 years**
- **80.8–82.3 years**
- **79.7–80.7 years**
- **78.0–79.6 years**
- **72.8–77.9 years**

**TOP**
Orange: Newport Beach to Laguna Hills (88.1 years)

**BOTTOM**
Los Angeles: Watts (72.8 years)
Statewide vs Riverside and San Bernardino Counties (MedGov 2014 data):

<table>
<thead>
<tr>
<th>County</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Riverside</td>
<td>18.4%</td>
</tr>
<tr>
<td>San Bernardino</td>
<td>21.1%</td>
</tr>
<tr>
<td>California</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

These 2 counties consistently show the greatest room for improvement in the state.
Nine Required Services

Crisis Services (if needed)
- Screening, assessment, diagnosis
- Pt. Centered treatment planning

Outpatient MH/SA
- Psychiatric Rehab
- Peer support

Targeted case management

Primary Health Screening & Monitoring

Armed Forces and Veteran’s Services
CARE COORDINATION MAKES TEN
CCBHC Care Coordination

• Key Idea: CCBHCs are often where the client-service provider Alliance is the strongest for many with BH disorders.

• CCBHCs are tasked with coordinating care “across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral health needs.”

- FQHCs/RHCs
- Inpatient Psych
- Detox
- Residential Treatment
- Schools
- Child Welfare Agencies
- Juvenile & Criminal Justice Agencies
- Indian Health Service
- Child Placing Agencies
- Other Social and Human Services
- Department of Veterans Affairs Centers
- Inpatient Acute Care Hospitals and Hospital Outpatient Clinics
Develop an array of Health Homes that are tailored to support practice transformation and:

“Integrated care”

Integrated care “results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.” (Safety Net Medical Home Initiative, 2014)
What is Population Based Care? –

Definition 1:
Ensuring **outcomes** for all patients in a group with a targeted condition

Definition 2:
Not allowing our patients to fall between the cracks.

1. Tufts Managed Care Institute Newsletter, November 2000 [http://www.tmci.org/downloads/topic11_00.PDF](http://www.tmci.org/downloads/topic11_00.PDF)
2. Jurgen Unutzer, AIMS Center, University of Washington
Where Does Population-based Care “Fit In” With Holistic Integrated Care?
Behavioral Health Integration (BHI-I): Platform for Population Healthcare

- Build & Support Health Home Array with “BH Inside”
  - Supporting Provider Partners who are already integrating care to build out & refine what they have already begun
  - Linking best integration practices to achieve shared care plans that live and breathe and reflect the whole person

- Support New Trans Disciplinary Treatment Models for Complex Populations:
  - E.g. Combining Pain Management, Mental Health and Substance Abuse (SUD) to create a new Pain/Narcotic Misuse Treatment Center
IEHP invests $20,000,000 over 2 years to improve quality and access in 13 Safety Net Systems of Care (Hospitals/Clinics)

- **a)** $ for Staff, Exam Rooms, Tech Equip
- **b)** $ to Improve Chronic Care by building tailored health homes
- **c)** $ to Work collectively to improve the Inland Empire local health care system

### Support Practice Transformation with Coaching and Evaluation

**JCC Coaching Team Practice Improvement Areas**

- **a)** Population health
- **b)** Patient and Provider team experience
- **c)** Team-based care and treat-to-target
- **d)** Complex care management
- **e)** Self-Management

UCSD doing formal evaluation

### Support Culture Change from Volume to Value with QI Framework

**BHI-I Aim:**

Improve the whole health and wellness of all individuals in the Inland Empire by creating an array of population-based, integrated health homes
The safety net clinics span Riverside and San Bernardino and include:

- Hospital-based Clinics
- Primary Care Clinics (county and community FQHCs)
- Behavioral Health/Substance Abuse Treatment Sites (county and community clinics)
- Community Based Adult Services (CBAS) Center
- Assisted Living Location
- Pain Management Clinic
Leveraging “Hot Spotting” to Improve Whole Population Health Status

Great Interventions
Example: Care Management to help patients manage their BH disorders & chronic health conditions

“Free Up” Money
Reduce use of care for preventable conditions

Reduce Complex, High Cost Care
Example: Reduction in Emergency Room and Medical Inpatient

Hot Spotting
Identify and engage the 5%/50% population
Initially Focusing on the 5%/50% Target Population Then Spread Better Care “Upstream”

**Step 1 – Stratify Population**
- ACG Johns Hopkins Tool + Clinical Team Selection of additional Complex Patients
- 5%/50% + Clinician Identified Complex = Target Pop

**Step 2 – Implement Integrated Complex Care Management**
- Coaching Team Based Complex Care
- Addressing the Whole Person: Behavioral and Chronic Physical Conditions

**Step 3 – Tune Care to Deliver Better “Whole Person” Outcomes**
- QI/PDSA Coaching to Achieve Clinical Transformation
- Health Home/Team Care reduces ED and Bed Days

**Step 4 – Invest Savings by Spreading Team Based Care “Upstream” to Broader Population**
- Prevention and Treat to Target
- Keeping healthy people healthy & Managing Conditions Effectively to Reduce Chronic Conditions
Applying Predictive Modeling to Health Plan Data to support “Hot Spotting”

ACG Measures:

- Disease Patterns
- Age
- Gender

Stratifies Members into one of six morbidity cohorts

Adjusted Clinical Groups

**Resource Utilization Bands (RUBs)**
- RUB 0 (No Resource Use)
- RUB 1 (Low Expected Costs)
- RUB 2 (Low/Intermediate Expected Costs)
- RUB 3 (Intermediate Expected Costs)
- RUB 4 (Intermediate/High Expected Costs)
- RUB 5+ (High Expected Costs)
How Health Homes use the Stratification IEHP provides?

Step 1: Assign IEHP Members to BHI-I Health Homes

Step 2: Run ACG Report for all Health Home patients

Step 3: Identify those with the Highest Scores

Step 4: Use ACG scores to help determine the “candidates” for the Integrated Complex Care interventions & add Patients identified by the Clinical Team to Refine Target Pop

<table>
<thead>
<tr>
<th>Patient ID</th>
<th>Patient Name</th>
<th>PCP Name</th>
<th>Age</th>
<th>RUB Score</th>
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<tbody>
<tr>
<td>101</td>
<td>Joe</td>
<td>Dr Smith</td>
<td>35</td>
<td>6.523</td>
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<tr>
<td>102</td>
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<tr>
<td>104</td>
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<td>105</td>
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<td>Dr Smith</td>
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<td>106</td>
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<td>110</td>
<td>Laurie</td>
<td>Dr Smith</td>
<td>43</td>
<td>5.693</td>
</tr>
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</table>
Determining Candidates for Integrated Complex Care interventions

The ACG Score is not the only consideration in determining the Health Home’s target population. Adding in “Hand Selected” Patients is especially important for Health Homes that specialize in behavioral health treatment.

ACG is used as a coaching tool – Clinical Teams choose their target population based on 3 criteria:

- IEHP Members
- Have one or more chronic medical condition
- Would benefit from Complex Care Interventions
Moving Beyond BHI to the Integrated Complex Care Initiative (ICCI)

1. Improve physical and behavioral health care integration
2. Increase patient-focused, data-driven, team-based care
3. Increase complex care management and population health management
4. Improve population health outcomes, patient experience, health care team experience, and as a result, reduce total health care costs
5. Lay the ground-work for value-based payment
6. Increase use of quality improvement methods
ICCI & PRIME/WPC/HH

ICCI STRUCTURE

Peter Currie, PhD
Inland Empire Health Plan
Jennifer Clancy, MSW
Jen Clancy Consulting
One Size Does NOT Fit All
for People with Chronic Health Conditions

- Many Studies (Intermountain Healthcare, University of Washington AIMS Center, Oregon Health & Science University, UCSF, etc.) tell us...

- Care Management needs vary for different populations.

Marc Avery, MD 4, 2016
CARE MANAGEMENT W/ MILD TO MODERATE POPULATION

Patient Care Manager

MEDICAL SYSTEMS
- Hospital
- Skilled Nursing
- ER
- Inpatient Psych

BH SYSTEMS
- PRIMARY CARE
- SPECIALTY MH
- SUD

COMMUNITY SUPPORTS
- Peers and Peer Supports
- Employment
- Supported Employment
- Subsidized Housing
- Supported Housing
- Residential
- Family and Friends
- Other Natural Supports
- CORRECTIONS

HIE

Patient

Telephone
Face to face

- Rapport building
- Develop trust
- Teamwork

- Self-Management Support
- Health Literacy
- Healthy Behaviors

Self-Management Support

- Self-Management Support
- Health Literacy
- Healthy Behaviors

- Rapport building
- Develop trust
- Teamwork

CARE MANAGEMENT W/ MILD TO MODERATE POPULATION

Inland Empire Health Plan

Inland Empire Health Plan

Inland Empire Health Plan

Inland Empire Health Plan
Integrated Complex Care Initiative (ICCI) Management Model Components

**Patient Engagement**
- Rapport & Trust Building
- Patient Engagement & Activation
- Care Mgr Empanelment
- Shared Care Planning
- Supporting Self Care & Self-Mgmt

**Team-Based Care**
- Screening & Assessment
- Shared Care Planning
- Comprehensive Care
- Use of Clinical Practice Guidelines
- Treating to Target – Measurement-Based Care
- Care Coordination, Facilitating Referrals & Care Transitions

**Population Health**
- Active Use of Health Analytics
- Monitor and Address Social Determinants & Health Disparities
- Health Literacy & Promotion
For more information, please visit: www.bhintegration.com