A TALE OF TWO INTEGRATED CARE PROJECTS

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Presentation Team

Alexandria Lueth
Chief Executive Officer
CentraCare
a.lueth@mycentracare.com

Laura Ferrara
Director of Operations and Business Development
CentraCare
l.ferrara@mycentracare.com
Session Objectives

• Discuss the mechanics of the partnership between the PACE program and community mental healthy authority as well as how successful mental health treatment has facilitated improved physical health outcomes for PACE participants.
• Review and discuss how a PACE like model of care was developed for individuals served through the community mental health authority creating access to physical health care.
• Explore two interdisciplinary team models used to develop and implement integrated care to both populations.
• Review and discuss contractual models for developing similar relationships.
What is Integrated Care?

• Integrated primary and behavioral health care is the best approach to care for people with complex health care needs.

• Integrated care results from a practice team of primary care and behavioral health clinicians working with individuals and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

• Focus is on the integration of services.
Two Models of Integrated Care

Behavioral Health in Primary Care Settings

Primary Care in Behavioral Health Settings
**Why Integrated Care?** Integration.samhsa.gov

- Mild to moderate behavioral health problems are common in primary care settings.
  - Anxiety, depression, substance abuse
- Individuals with mental illness report difficulties establishing relationships with primary care providers
- Individuals with chronic illnesses often have behavioral problems that interfere with treatment.
- Without care integration:
  - Mental illnesses go untreated or undertreated
  - Substance abuse issues go untreated
  - Chronic medical illness is more difficult to treat
Principles of Effective Integrated Behavioral Healthcare

• Person-Centered Team Care / Collaborative Care
  • Co-location is not collaboration. Team members learn to work differently.

• Population-Based Care
  • All patients tracked in a registry. No one “falls through the cracks.”

• Measurement-Based Treatment to Target
  • Treatments are actively changed until the clinical goals are achieved.

• Evidence-Based Care
  • Treatments used are evidence-based.

• Accountable Care
  • Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.
BEHAVIORAL HEALTH IN PACE SETTING
PACE Participants and Behavioral Health

• Number of PACE participants:
  • 272 between 2 centers

• Number of SPMI diagnoses
  • 17 diagnoses of schizophrenia
  • 50 diagnoses of major depressive disorder, bipolar disorder, or paranoid disorders

• Challenges
  • Challenging behaviors unsuccessfully managed
  • Mental illnesses understressed
  • Team was not confident enrolling participants with behavioral health challenges
Community Mental Health Contract

- CentraCare will pay KCMH $500 per member per month for the following services (paid for the month of admission, but not discharge):
  - Psychiatric consults
  - Assessments, reassessments, and care planning performed by a social worker.
  - Emergency Mental Health Services – coordination with our team, discharge planning as needed.
- CPT codes included:

<table>
<thead>
<tr>
<th>Description</th>
<th>CPT CODE</th>
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<td>Psychiatric Evaluation</td>
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<tr>
<td>Psychiatric Medication Review</td>
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<tr>
<td></td>
<td>99202</td>
</tr>
<tr>
<td>(99201 - 99205 are NEW patient)</td>
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Community Mental Health Contract

- CentraCare will have access to KCMHSAS provider network.
  - KCMH will amend their contracts for individualized rates relating to the care needed for a CentraCare participant. These rates will include an administrative fee for contract and billing costs.
- KCMHSAS will provide CentraCare access to electronic health record.
Psychiatric Consultant Contract

• $143/hour – approximately 4 hours per month spent in team and as-needed consults.
  • Geriatric psychiatrist
    • History working at the interface of medicine and psychiatry for the past 20 years in the care of chronically ill individuals.
    • Associate professor of psychiatry in the Western School of Medicine
  • Team education regarding mental illness management and geriatric integrated care principles
    • Geriatric philosophy and focus, including a central role for the primary care physician
• Access to EMR
  • Documented recommendations
  • Ability to review current med list and problem list
Participant Case Study #1

- 77 year old male enrolled into PACE 2/1/2016
  - Eligible due to functional cognitive impairment d/t dementia
- Diagnoses
  - Dementia
  - Alcohol abuse
  - Anti-social personality disorder
  - Hx of CVA with left sided weakness
  - CHF
  - Chronic kidney disease
  - Seizure disorder
  - Restrictive lung disease
  - Etc.
- Recent hospitalizations d/t seizure disorder and aggressive behavior prior to enrollment
- Multiple incarcerations for physical assault
- Recently paroled and living in a halfway house, 15 months remaining on parole at the time of enrollment
Participant Case Study #1

• No DPOA on enrollment
• Expressed wish for functional goals of care and full code
• March 2016 evicted from half way house for continued substance use and aggressive behaviors toward other residents.
• At risk for re-incarceration for positive drug screen
• KCMH behavioral health staff and parole officer joined PACE IDT to evaluate psychiatric treatment and substance abuse treatment needs, integrated care plan developed.
• Within 2 weeks, AFC placement with experience caring for those with substance abuse and incarceration history found through KCMH provider network.
• Abstinence from alcohol and drug use
• Attends day center 5 days/week.
• Sister, previously estranged, now DPOA.
Participant Case Study #2

- 85 year old female enrolled 8/1/2015
- Diagnoses
  - Essential tremor
  - Hypothyroid
  - Depression with anxiety – medicated with Abilify and Zoloft
  - Cardiac arrhythmia has pacemaker
  - s/p right hip surgery s/p fall
  - Bilateral cataract surgery with implants
  - Mild cognitive impairment
  - Urinary incontinence
  - Recurrent UTI's
- Married to husband 64 years
Participant Case Study #2

- Weaned off Abilify shortly after enrollment due to complications with tremors.
- November 2015 expressed suicidal ideations due to her husband’s declining health and admission to a local nursing home and her son suffering a stroke (no plan or intent).
- November 2015 psychiatric consult – learned of previous behavioral health treatment through local CMH with psychiatric medication management, individual therapy, and senior behavioral health services.
  - History of depression for 13 years and inpatient psychiatric admission in 2006.
- January 2016 expressed suicidal ideations due to husband’s and son’s health challenges (no plan or intent).
- May 2016 participant’s husband passed away.
Participant Case Study #2

• August 2016 participant called reporting suicidal ideation and requesting staff assistance to help her die. MSW and RN staff went to participant home for well being check. 911 called due to no response.

  • Contract psychiatrist facilitated direct admit into psychiatric unit – 7 day hospital psychiatric hospital stay for severe depression related to grief. Medications titrated and changed to more effectively manage depression and grief.

  • Contract psychiatrist managed inpatient care and created a “warm handoff” with PACE PCPs at the time of discharge.
Intended and Unintended Results

• True integrated care physical and behavioral health care for the PACE participants with behavioral health needs.
• Identified opportunities for staff education related to participant behavioral health needs.
• Continue to identify how to better integrate behavioral health care team into PACE IDT.
  • A few bumps in the road as the behavioral health team members adapted to the PACE IDT model.
• Referrals from KCMH – behavioral health team identifying individuals for PACE enrollment with integrated behavioral health and PACE team.
PACE IN BEHAVIORAL HEALTH SETTING
Whole Health Initiative Project

- Primary Behavioral Health Care Integration Grant through Substance Abuse and Mental Health Services Administration
  - 4 year grant beginning October 2015
  - Intended to develop coordinated and integrated primary/behavioral health services through the co-location of primary care services at psychiatric clinic site.
  - Serving individuals with serious mental illness and co-occurring physical health care conditions (KCMH clients).
  - Requires the establishment of an integrated treatment team (similar to IDT).
  - Goal to improve the physical and behavioral health status and health care experience for individuals served.
Target Population

- Kalamazoo Community Mental Health and Substance Abuse Services
  - Promotes mental health, development disability and substance abuse resources that empower clients to succeed.
- Adults with serious mental illness (SPMI diagnoses).
  - Served at the KCMH psychiatric clinic.
  - Includes those with co-occurring substance abuse disorders.
  - Prioritize people who have not accessed PCP services in 12 months.
- Address the following disparities
  - Lack of access to PCP services
  - High rates of ED/hospital utilization.
  - Focus on improving BMI, smoking cessation, hypertension, and other key risks of early morbidity.
Project Goals

• Enhance health care for adults with serious mental illness
  • Use of evidence based practices addressing smoking cessation, individual nutrition/exercise plans, and heart disease management.
• Improve mental and physical health of adults with serious mental illness
  • Positive change in metrics of blood pressure, smoking and BMI
  • Adoption of healthy behaviors
  • Improvement in domains of mental health recovery
• Increase quality of care and care coordination
  • Trauma informed care
  • On-site primary care services
  • Reduce unnecessary hospital inpatient and ED use
Primary Care Services

- Onsite PCP coverage starting twice per week.
- Available on-site 5 days a week by year 2
- Partnership with CentraCare to provide PCP and nurse coverage
- Integrated Treatment Team – weekly team huddles
  - PCP – CentraCare ($145/hr)
  - Medical Assistant – CentraCare ($22/hr)
  - Psychiatrist/Nurse Practitioner – KCMH
  - Nurse Care Coordinator – CentraCare ($45/hr)
  - Integrated Care Manager – KCMH
  - Peer Wellness Coach – another organizational partnership
  - Substance Use Disorder Counselor – KCMH
Operational Considerations

- CentraCare staff provided access to KCMH electronic health record to review patient information and document patient treatment and contacts.
- CentraCare required to develop process to bill Medicare and Medicaid for PCP services.
- KCMH staff enrolled patients and scheduled visits with PCP.
Financial Challenges

- Unable to provide proper care (time) due to reimbursement schedules from Medicare/Medicaid
- Summary of cost vs. reimbursement

<table>
<thead>
<tr>
<th>Number of Patients</th>
<th>Annual Time spent (hours)</th>
<th>Cost (salary, wages, and admin)</th>
<th>Grant Reimbursement (admin time)</th>
<th>Medicaid Reimbursement</th>
<th>Medicare Reimbursement</th>
<th>Gain (Loss) Medicaid</th>
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Other Challenges

• Lack of fidelity to the interdisciplinary team model
  • PACE IDT member development includes 16 weeks of training and development
    • PACE philosophy,
    • Managed care principles,
    • Team dynamics
    • Individual autonomy and goals of care
    • Daily 45 minute meetings
  • WHI integrated team training and development
    • A four hour meeting to discuss team dynamics and team huddle agenda
    • A weekly 1 hour meeting
Other Challenges

• Model of care based on fee for service (15 minute) visits
  • Patients have many chronic co-morbid health conditions that have not been addressed for more than a year
  • PCP struggles to identify and sufficiently review the priority health concern and then schedule follow up to continue review other health concerns
  • On call coverage was left to the CentraCare PCP
  • Lack of coordination throughout the week in between team huddles
Intended and Unintended Outcomes

• CentraCare has had to stop PCP coverage due to PCP turnover.
• CentraCare nurse has learned the significance and opportunities for integration of behavioral and physical health care – positive impact on team.
• Collaboration of community partners to create a PCP coverage model that will financially work.
• Referrals to CentraCare for individuals who were considered potential WHI patients but identified to be more appropriate for PACE participants.
DEVELOPING AN EFFECTIVE MODEL OF INTEGRATED CARE
Characteristics of an Ideal Integrated Model

- Longitudinal care management, spanning time, setting, and discipline
- Intensive, interdisciplinary team care
- Organized provider and clinical arrangements to achieve horizontal and vertical alignment
- Appropriate targeting – serving the right population and keeping the size of the patient panel within manageable limits
- Mechanisms to pool funding streams to assure administrative and clinical flexibility
- Geriatric philosophy and focus, including a central role for the primary care physician
Principles of Geriatrics Essential to Effective Integrated Care

• Medical conditions are often multiple and multifactorial
• Functional ability and quality of life are critical outcomes
• Social history, social support, and patient preferences are essential aspects of managing the patient
• Best Care is multidisciplinary
• Iatrogenic illnesses (polypharmacy) are common and often preventable
• Ethical issues and end-of-life care are critical aspects of the practice
QUESTIONS?