Innovative Community-Based Care Models For Consumers With Complex Conditions

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Annie Medina, MBA, ACNP-BC, Senior Associate, OPEN MINDS
I. Community-Based Care Models: An Overview

II. Expert Insights
   • Banner University Health Plans
   • Merakey

III. Questions & Discussion
Community-Based Care Models
An Overview
Home- & Community-Based Services

- Home- and community-based services (HCBS) include person-centered care delivered to address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing.

- HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.

- HCBS include services such as case management, personal care services, skilled nursing care, and hospice care.
What Exactly Is “A Community-Based Workforce”?

- Not hospital- or clinic-based
  - a. This is a “we come to you” experience

- Some definitions, adapted from The Bureau of Labor Statistics
  - a. Services for the elderly and persons with disabilities, which provides for the social welfare of the elderly, people with intellectual and developmental disabilities, and people with disabilities, both in daycare settings and in the home
  - b. Home health care services, which provides skilled nursing services and a wide range of personal care and medical care services in the home
  - c. Community care facilities, which provides residential care, personal care services, and, in some instances, skilled nursing care
Community-Based Models: Key Features

- Collaborative, interdisciplinary team approach
  - Can be in coordination with a primary care provider
  - Can also include a community health partner
- Consumer-centric & personalized service
- Flexible service definition and service location
- Services support integration & inclusion
- Acknowledge & support diversity
- Vision-driven, with effective administration of services
- Open communication & feedback loops
Why Use Community-Based Care Models For Complex Consumers?

- Reduce restrictive and institutional settings
- Encourage integration into community settings
- Assist in care transitions
  - From one setting to another
  - From inpatient back home
- Prevent admissions and rehospitalizations
  - Allows for targeting of key drivers of admissions and readmissions
- Align multiple aspects of care (psychological, social)
- Improve consumer, family, and provider satisfaction
Two Sides To Community-Based Care

Challenges

- Perceived safety
- Staying connected
- Education & training
- A different way of working

Benefits

- Meet people where they are
- A new understanding of Social Determinants of Health
- Can allow for engagement of more of the family
- Allows for flexible service delivery
Innovative Community-Based Care Models
For Consumers With Complex Conditions

Healthy Together Care Partnership: a Joint Health Plan/Provider Venture

Nancy Wexler  DBH, MPH
Director, Innovation and Collaborative Care
Learning Objectives

• Identify key components of an interdisciplinary collaborative care model for high-need, co-morbid adults

• Describe population-based strategies to patient identification and engagement

• Discuss the business case for value-based payer/provider/team-based partnership
About Banner University Health Plans

• Not-for Profit, Medicaid and Medicare Health Plan

Tucson, Arizona

• In Central and Southern Arizona regions
• University Family Care –Medicaid
• University Care Advantage-Medicare Special Needs –Dual Eligible
• Cenpatico Integrated Care (SMI/Medicare)
• Merged with Banner Health (March 2015)
• Arizona Long Term Care (October 2017)
• Will offer Complete Care (Integrated GMH/SA) October 2018
Banner University Medical Group

• Resides in an academic medical center (University of Arizona)
• Multi-site primary care clinics
• No after hours or extended day clinics
• Not a comprehensive ‘medical home’
Healthy Together Care Partnership

- Home-based Collaborative Care program since 2014
- Interdisciplinary team
  - Nurse Practitioner, Clinical Pharmacist, Behavioral Health Consultant, RN Case Manager, Community Health Partner
- Funded by Banner University Health Plans
Healthy Together Collaborative Model

Partnering with patients, providers, and community to facilitate collaborative care that is high value and integrates all aspects of health and wellness.
Program Features & Goals

• Co-management with primary care
• Home and community-based
• Short term, self sufficiency
• Healthy University (Healthy U)

• Aims to
  ✓ Improve appropriate utilization
  ✓ Bend cost curve
  ✓ Improve quality of life
  ✓ Improve provider and patient satisfaction
Program Focus

- Align clinical care across disciplines

- Support of the psychosocial aspects of care
  - Trauma
  - Poor support
  - Few resources
  - Confusing medication protocols
  - Poor health behaviors
  - Anxiety
  - Language and cultural barriers
The Tale Of The ‘Garage Band’
Meet The Band

https://www.youtube.com/watch?v=OCrSfNFCzso
Program Population

HTCP is a clinical effort of Banner University Health Plans and Banner University Medical Group Primary Care Providers serving Medicaid and Dual Eligible Medicare adults

- 20% of HTCP population (600) accounts for more than 85% of all costs (needs assessments conducted)

- HTCP aims to enroll 70% of the top utilizers

- 2 or more chronic conditions
- 2 or more hospitalizations or ED
- Comorbid BH
- Polypharmacy
Healthy U Core Components

- Supports **sustainable health behavior change** through integrated, patient-centered approaches

- Utilizes **evidence-based integrated health** and community support practices

- Reinforces **positive health behaviors** and **intrinsic rewards**

- Establishes a **patient empowerment ‘curriculum’** focused on the psychosocial and environmental barriers to care

  ✓ manage medical conditions
  ✓ manage medications
  ✓ health management goal
  ✓ designated PCP
  ✓ preventive health measures
  ✓ support systems
“Now I know why my patient is having a hypertensive crisis”!

- HTCP Nurse Practitioner at a home visit
Meeting Tanya’s Needs With HTCP

Meet Tanya…

42 year old woman with hospital admission for bowel obstruction. She has multiple conditions including hypertension, anxiety, depression, morbid obesity, chronic pain, and history of falls.

With the help of her Healthy Together care partners she:

• Established care with a trusted PCP
• Made medication changes to prevent loss of balance
• Managed her hypertension with weekly monitoring
• Lost significant weight with daily exercise, and dietary changes
• Enrolled in COPE for behavioral health services
• Developed advanced care directives
• Obtained service dogs
Additional Benefits

• **Team satisfaction**
  Team members work at full capacity

• **Provider satisfaction/retention**
  Supported by a team

• **Patient satisfaction/retention**
  Patients are more involved in their own care
Patient Perception Of Care & Health Status

**Satisfaction**
- 94% - Very Satisfied
- 94% - Likely to Recommend

**Health Management**
- 87% - Improved understanding of condition
- 94% - Better able to manage health

**Health Status**
- 87% - Health improved
How Do We Pay For This?

• Many hospital-based services are preventable

• These services average $5,000 per hospital admission and $400 per emergency visit

• The top high-cost group’s costs are two-three times higher

• A reduction of 10%-15% in utilization of the total population can cover the cost of the program

• Potential for increased revenue from coding accuracy – improved documentation of diagnoses
Findings

Primary Care at home Model (2013)
• $61.00 PMPM savings in medical expense

Co-management model (2014) – total target population
• 10% decline in total medical expense
• 16% decline in ED visits
• 26% decline in admissions
Metrics – Admissions (2014)

HTCP - Admissions per 1,000
21yo+
Rolling 12 month

Admissions per 1,000

Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15

Original Cohort
Target (10% Reduction)
Stretch Target (15% Reduction)
Metrics – ED Visits (2014)

HTCP - ED Visits per 1,000
21yo+
Rolling 12 month

ED Visits per 1,000

Jan-14 Feb-14 Mar-14 Apr-14 May-14 Jun-14 Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15

Original Cohort Target (10% Reduction) Stretch Target (15% Reduction)
Healthy Together Care Partnership – Intervention Population 2016

<table>
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<tr>
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<th>Pre-HTCP</th>
<th>Post-HTCP</th>
<th>Difference</th>
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<tr>
<td>ED Visits</td>
<td>1.50</td>
<td>1.36</td>
<td>0.14↓</td>
</tr>
<tr>
<td>IP Admissions</td>
<td>0.55</td>
<td>0.44</td>
<td>0.11↓</td>
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ED Visits had a 10% reduction
Inpatient Utilization had a 20% reduction

Additional Analysis – Patterns are particularly significant for patients with DX:

- **Behavioral Health**: 17% ↓ reduction in IP Admissions
- **Chronic Kidney Problems**: 32% ↓ reduction in IP Admissions
- **Diabetes**: 29% ↓ reduction in IP Admissions
- **Hypertension**: 10% ↓ reduction in ED Visits & 15% ↓ in IP Admissions
Alternative Payment Model

• Fee for Service for clinical care rendered
• $90.00 PMPM care management fee for total target population (approx. 600)
• Quality incentive bonus for achieving performance targets in key areas:
  ✓ Readmission rate
  ✓ Hypertension control
  ✓ Diabetes control
  ✓ Medication Adherence
  ✓ Comprehensive Health Assessments
  ✓ Annual Wellness Visits
Key Lessons Learned

• Recruit an entrepreneurial team
• Identify a specific target group
• Integrate into the medical record
• Engage the medical providers and spend time in their clinics and meetings
• Clarify roles and functions of the team members
• Partner with one payer and one clinical group
• Develop a tracking database!
• Ensure populations of need can be identified
• Develop a solid evaluation plan and resources
“Tuck ‘em in!”

“What we as primary care providers in the current model cannot do is reach into the lives of the ones we are responsible for when they need it most to offer appropriate and timely care solutions. Our Healthy Together Care Partnership colleagues exist to do this”

–BUMG PCP

“Since I started my new insulin I have stopped having high highs and low lows. My sugars are level. I feel better with my diabetes. Thank you for all of the support. I feel better just knowing people are looking out for me.”

–HTCP Patient Partner
Questions? Ideas?
Contact Me:

Nancy Wexler, DBH, MPH
Program Manager, Healthcare Innovation
Banner University Health Plans
2701 E Elvira Tucson, Arizona 85756
nancy.wexler@bannerhealth.com
(520) 874-2428
Dual Diagnosis
Treatment Team
DDTT
1. Review the basic structure of the DDTT based on Merakey’s model for service delivery.

2. Review a case study that depicts how the model works for an individual who participated in the program.

3. Review questions regarding the service, model or case study.
DDTT Is Characterized By:

- A team approach
- Services in natural environment
- A small caseload
  - *14-30 individuals (full team)
  - *6-8 individuals (modified team)
- Time-limited services (12-18 months)

- A shared caseload
- Flexible service delivery
- Fixed point of responsibility
- Crisis management available 24 hours a day, 7 days a week
• Psychiatrist
• Registered Nurse
• Pharmacology Consultant
• Director
• Behavior Specialist
• Recovery Coordinators
• Administrative Assistant
Admission Criteria

• 18 years of age or older
  * Unless there is an exception from OMHSAS (16/17 year olds)
  * Adolescent pilot in N23 West
• Diagnosed w/ a major psychiatric disorder
• Presents with an Intellectual/Developmental Disability (IDD)
• Has experienced frequent interactions with crisis services and/or hospitalizations
• At risk of losing current community housing and/or supports
• Requires step-down, transitional services back to the community from a higher level of care
Short Term Service

Services will be provided an average of three times per week, for each individual, over a 12-18 month period in various phases.

- Assessment (initial phase and ongoing)
- Treatment (evidence based and data driven)
- Transition (individualized fade plans)

Discharge planning begins at Day 1.

*If an individual who is discharged needs a “booster”, a “Brief Service Period” of DDTT is available.
DDTT Care Coordination & Skill Transfer

- Activities of daily living
- Housing
- Family life
- Employment/education
- Benefits
- Behavioral supports

- Health care
- Medications
- Co-occurring disorders integrated treatment (IDD/MH)
- Counseling/therapy
- Diversion from inpatient hospitalizations for BH support
DDTT Coverage

- DDTT currently supports 43 counties in the state of Pennsylvania.
- 9 DDTT teams support these 43 counties.
DDTT PA Coverage Area

DDTT Coverage Map: PA

DDTT Director: Rachele Emmert
DDTT Director: Samantha Adams
DDTT Director: Deonna Walker
DDTT Director: Nancy Hamilton
DDTT Director: TBA

DDTT Director: Heather Schreiner
DDTT Director: Allison Berger
DDTT Director: Jessica Hahn
DDTT Director: Elizabeth Moore
Case Study

“Bob”

• 42 year old male
• Tenure in jails and institutions
• Banned from CLA support (waiver) in the county due to aggression, stalking and threatening staff/supports.

DDTT found supports and transitioned skills for:
• Transportation
• Community engagement
• Medication management (transition)
• Housing supports that worked for the individual
• Gainful employment

*Bob’s chief goal upon admission.
• DDTT is a time-limited, community-based service that supports individuals with co-occurring mental health and intellectual/developmental disabilities.

• The teams work to support an individual on their own path through recovery in a person-centered manner by creating integrated recovery treatment plans that focus on each individual’s hopes, needs, desires and goals.
DDTT Contact Information

Tinnesia Snyder, MBA: Vice President of Managed Long Term Support Services
Tsnyster@merakey.org

Kevin Kumpf PhD, NCC, ACS, LPC: DDTT Clinical Director
Kevin.kumpf@merakey.org

Kristin Cline M.S., LPC, CAADC: Clinical Lead Specialist
Kristin.cline@merakey.org
Questions & Discussion
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Addiction Treatment  ▪  Social Services  ▪  Intellectual & Developmental Disability Supports
Child & Family Services  ▪  Juvenile Justice  ▪  Adult Corrections Health Care