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San Diego Convention Center

San Diego, CA

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Commit. Transform. Succeed.

Care Transformation Collaborative-RI
Associates in Primary Care

"A Successful Blueprint for Integrating Behavioral Health into Primary Care"

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Care Transformation Collaborative of RI

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Associates in Primary Care Medicine

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Integrated Behavioral Health Specialist

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Faculty Disclosure

- **Susanne Campbell, RN MS PCMH CCE** has no financial relationships to disclose relating to the subject matter of this presentation.
- **Martin Kerzer, D.O** has no financial relationships to disclose relating to the subject matter of this presentation.
- **Kristin David, Psy.D** has no financial relationships to disclose relating to the subject matter of this presentation.

Disclosure

- The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational use(s) of drugs, products, and/or devices (any use not approved by the U.S. Food and Drug Administration).
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  - This activity has been independently reviewed for balance.

Learning Objectives

Utilize a population health/performance improvement framework and team approach to successfully identify patients with behavioral health needs and integrate strategies that will improve financial outcomes;

Apply lessons learned based on experiences from a practice team that focused on patients with a) high emergency department usage b) diabetes who scored high on diabetes distress screens;

Successfully measure outcomes that support sustainability of the IBH model of care.

Care Transformation Collaborative

Lead the transformation of primary care in Rhode Island in the context of an integrated health care system.

Care Transformation Collaborative’ s Impact Across the State

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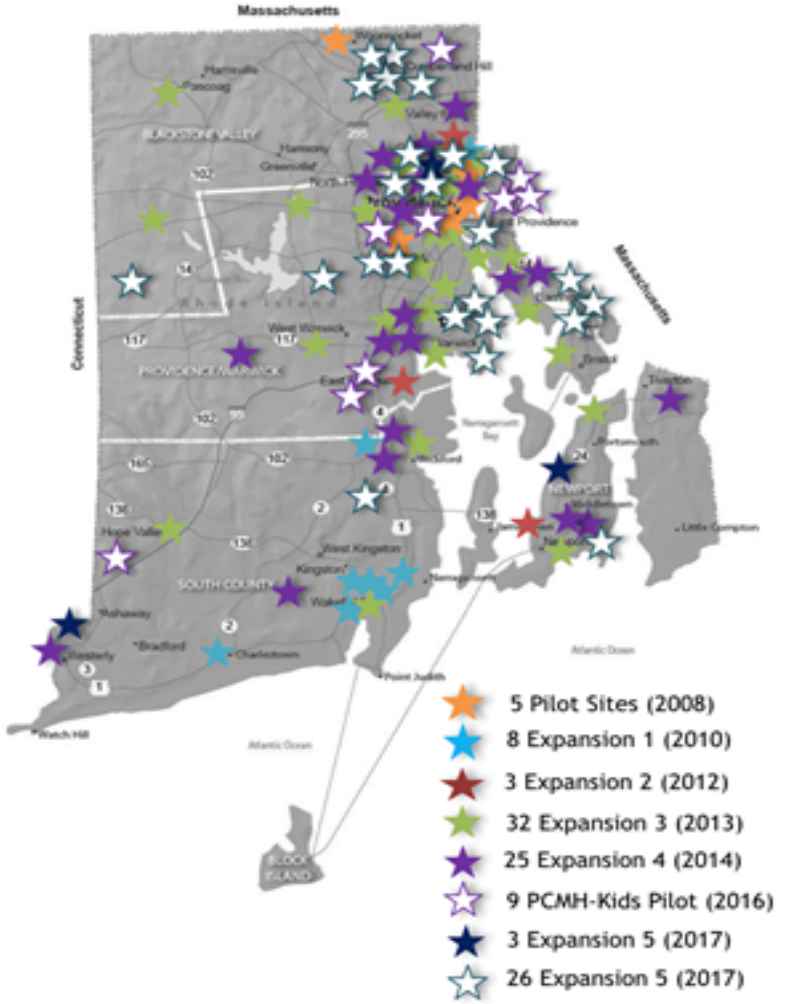
Care Transformation Collaborative of RI

The Care Transformation Collaborative of Rhode Island has a growing impact across the state, and includes:

- **106 primary practices**, including internal medicine, family medicine, and pediatric practices.
- Approximately **550,000 Rhode Islanders** receive their care from one of our practices.
- **659 providers** across our adult and pediatric practices.
- Investment from **every health insurance plan** in Rhode Island, including private and public plans.
- **All Federally Qualified Health Centers** in Rhode Island participate in our Collaborative.
- Saving more than $217 million in total cost of care dollars in 2016 (compared to non-patient centered medical homes in Rhode Island), according to data from the state's All Payer Claims Database.



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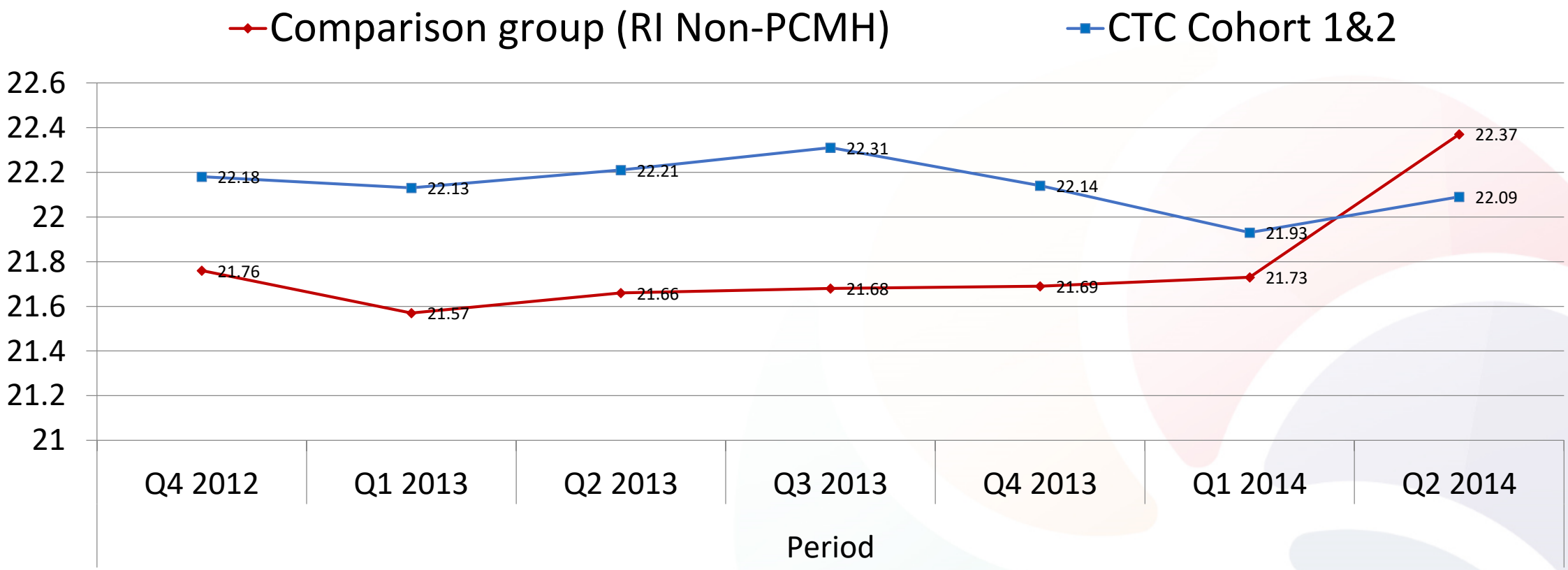
Impetus: All Cause ED – CTC-RI and Comparison Group

Year Ending Q4 2012 - Q2 2014



Source: CTC-RI internal documentation

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Funding Partners

RHODE ISLAND FOUNDATION

TUFTS Health Plan

Health & Human Services

State of Rhode Island

Application for Implementation and Evaluation of an IBH Model in Primary Care

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Practice Payment: $35,000 over 2 Years

Infrastructure Payment	1st payment: month 1	2nd payment: month 5
$15,000 prorated per 5000 attributed lives	$10,000	$5,000
Incentive Payment	Year 1: month 12	Year 2: month 24
$10,000 each year for meeting screening targets	Depression: 70% Anxiety: 50% Substance use disorder: 50%	Depression: 90% Anxiety: 70% Substance use disorder: 70%

12 Practicing Sites

Cohort 1 (blue) January 2016-December 31 2017
Cohort 2 (yellow) November 2016- October 2018

Associates in Primary Care	East Bay Community Action Program (Newport and E. Providence)*	Providence Community Health Centers (Chaffee)*
Women's Medicine Collaborative	Tri-Town Community Action Program*	Affinity Family Medicine at Women's Care*
Coastal Hillside Family Medicine*	Providence Community Health Centers (Prairie)*	Providence Community Health Centers (Capitol Hill)*
University Medicine	Memorial Family Practice*	Wood River Health Center

*** Practices 50% more Medicaid CTC COLLABORATIVE AGREEMENT SCOPE OF SERVICE/WORK**

IBH Framework in Primary Care Model

- 12 PCMHs to implement depression, anxiety and substance use screening for all patients over the age of eighteen in primary care across 2 years
  - Rescreened within 6 months if positive screening
  - Onsite IBH providers offer evidence-based treatment
  - Warm hand-off's , coordination with care team for huddles and review data
- Three PDSAs
  - Increase screening/rescreening rate
  - High ED utilization with behavioral health
  - Chronic care condition and behavioral health

IBH Milestone Summary

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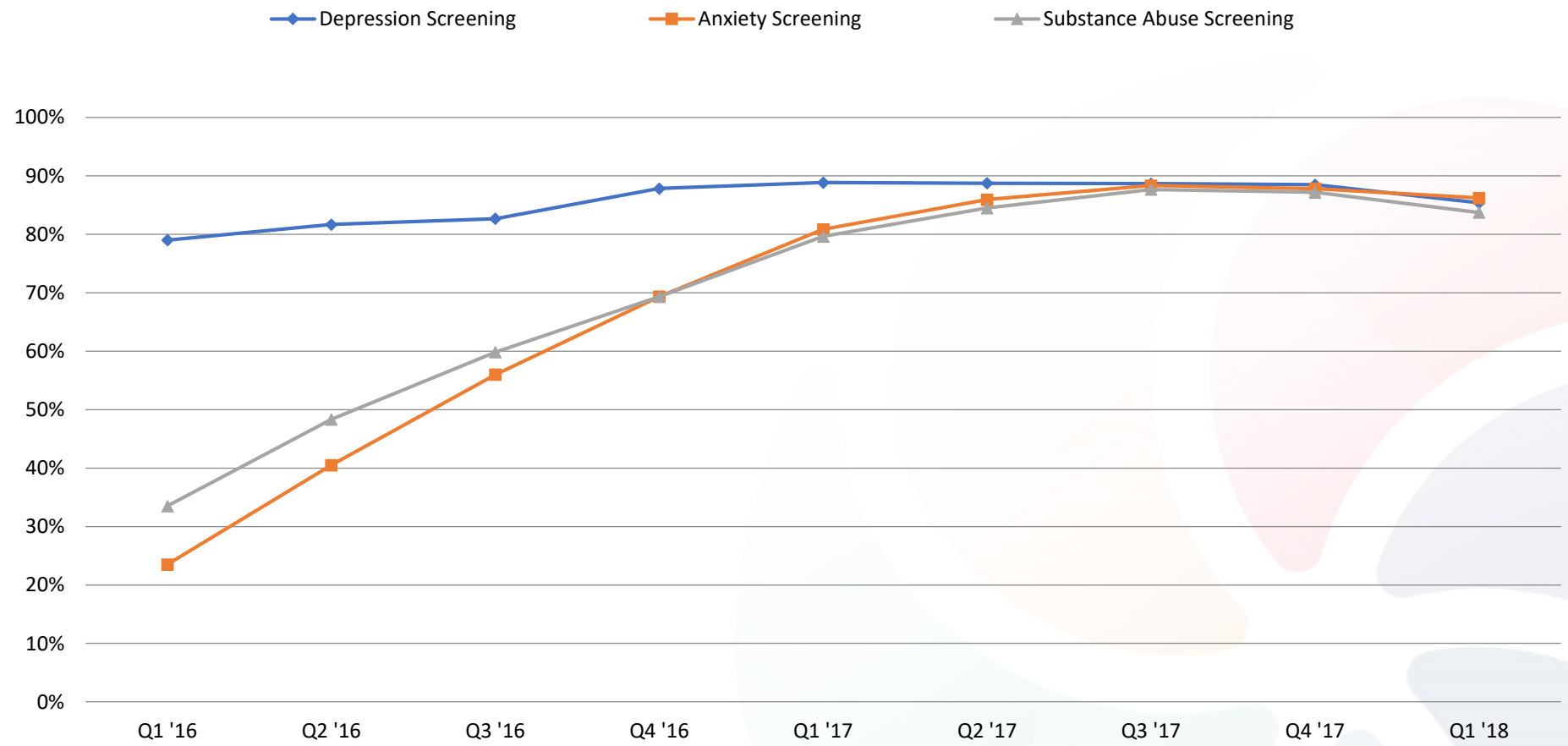
Practice Facilitation Deliverables

- Monthly one hour practice facilitation meetings with each practice implementation team and Dr. Burdette
- Deliverables:
  - Hire and train Licensed IBH Provider (0.5-1.0 FTE) to bill for and/or provide sustainable IBH services
  - Compact with Community Mental Health Center
  - Baseline assessment of IBH at beginning and end of pilot
  - Quarterly reporting of universal screening targets , PDSA's
  - Quarterly learning network meetings
  - 3 PDSAs cycles

Integrated Behavioral Health Pilot Program (Cohort 1) Screening Rate Q1 2016 – Q1 2018



[IBH Pilot Program Measure Specifications for Initial Screening]

Integrated Behavioral Health Pilot Program (Cohort 1)

"I'm surprised especially with the anxiety screener that there's more out there than I knew about. I was talking to somebody yesterday. You think this wouldn't be useful information. I know the patient pretty well, and the patients, if they had an issue, I'm sure they would tell me. But it comes up on this, on the screener." *(Medical Provider)*

Unnecessary ER visit reduction: IBH Plan

Team approach to support patients use of the PCMH to address non-emergent matters.

Utilizing the PCMH team to reduce ER visits
Outreach and Post ER Follow up

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ER SURVEYS

- Every patient who utilizes an ER is called the next day for follow up
- Alerts are entered into the EMR for patients using the ER inappropriately
- Alerts are addressed by the providers at the time of the visit
- Patients who utilize the ER for non-urgent matters, are given a survey at their follow up visit
- We are trying to identify why patients go to the ER rather than coming to the office for a same day sick visit
- TV's in exam rooms with a slide: Call First before going to the ER
- All staff wears Call First buttons

ER SURVEYS

ER SURVEY

Please take a moment to fill out this survey to help us understand why our patients go to a walk in on an Emergency Room. Your cooperation is appreciated in our continued efforts to improve health care for our patients.

1. It was closer to my home/job.
2. I was not aware your office offers 24 hour/7 days a week coverage to speak with a provider.
3. I was not aware the office offered same day sick appointments.
4. I was not offered a convenient time to be seen at the office.
5. I thought it would be faster.
6. They have an x-ray, Cat Scan, MRI machine there.
7. I did not have a copay/they will bill me for costs.
8. I thought it was an emergency.
9. Other:

   _____

   _____

ER SURVEYS

It was closer to my home/job. **7 responses**

I was not aware your office offered 24 hour/7 days a week coverage to speak with a provider. **6 responses**

I was not aware the office offered same day sick appointments. **2 responses**

I thought I would be seen faster. **3 responses**

They have an x-ray, Cat Scan, MRI machine. **3 responses**

I thought it was an emergency. **11 responses**

Other: It was a Sunday or late in the evening. **4 responses**


NOT FEELING WELL?
CALL OUR OFFICE BEFORE
GOING TO THE EMERGENCY ROOM
Ask me about
Call First
Integra

High Utilizer Plan for Unnecessary ER Visits(HU/ER)

- Identified patients from January 2016-November 2016
  - ≥3 unnecessary ER visits
- Determine Eligibility
  - Are presenting problems affected by behavioral health.
- Outreach to these patients
  - Phone calls
  - Schedule patients for initial HU/ER Care plan development
- Track and monitor
  - Designed and “worked” a patient registry

IBH to Reduce Emergency Room Utilization: High Utilizer Emergency Room (HU/ER) Protocol

- 22 Patients met criteria and were scheduled with an IBH provider
  - Nurse Care Manager and Psychologist are considered IBH
- Individual IBH intervention
  - IBH and patient create a Care Plan to reduce unnecessary ER visits
  - IBH “flags” the patient’s EHR with instructions on HU/ER
- ER visit initiates contact from the PCMH
  - Medical Assistant alerts care team and schedules patient with a practice provider.
- Bimonthly meetings are held to discuss the HU/ER registry

Unnecessary ER visit reduction: IBH Plan

Team approach to support patients use of the PCMH to address non-emergent matters.

High ER Utilizer Case Example

HU/ER Case Example: Mr. Smith 43 y/o Male

Active Problems:

- benign essential hypertension
- intermittent explosive disorder
- periodic limb movement disorder
- posttraumatic stress disorder
- sinus bradycardia
- developmental reading disorder/illiteracy
- panic disorder without agoraphobia
- allergic rhinitis
- displacement of cervical intervertebral disc without myelopathy
- paresthesia.
- Illiteracy, childhood positive for emotional, physical, and sexual trauma. Doesn't trust "anyone"

Cont.

- chronic back pain
- constipation
- body mass index 30+ - obesity
- generalized anxiety disorder
- gastroesophageal reflux disease
- osteoarthritis of knee
- mixed hyperlipidemia
- shoulder strain
- genital herpes simplex
- hypertrophy of breast
- chronic pain syndrome

HU/ER Case Example: Mr. Smith 43 y/o Male

From January 2016 through October 2017 Mr. Smith presented seven times to the local emergency room:

01/18/2016 Trouble Breathing
02/13/2016 Headache
03/20/2016 Anxiety
06/30/2016 Dizziness
09/14/2016 Pelvic Pain
09/18/2016 Motor Vehicle Accident
10/24/2016 Leg Pain

HU/ER Integrated Behavioral Health Interventions

11/02/16 Welcoming:
- **NCM initiated outreach with Mr. Smith.**

Care Coordination:
- **Contact with Mr. Smith's existing psychiatrist and counselor.**
- **Emergency Room contacted and initiated into their special needs Care plan**

11/10/16 Sick Visit:
- **Psychogenic Pruritius**
- **Pt is advised around triggers.**
- **Integrated Medication Review completed by Pharm D and Primary care Physician.**

11/17/16 Sick Visit:
- **Psychogenic Dyspnea**
- **Pt advised around coping strategies**

11/18/16 Care Coordination:
- **White Cross Pharmacy engaged to help with medication compliance**
- **NCM Visit Reviewed Care Plan around HU/ER protocol**

HU/ER Integrated Behavioral Health Interventions

11/22/16 **ER Visit: Psychogenic Dyspnea.**

- **HU/ER Protocol**
  - **M/A administers an ER follow-up survey**
  - **Nurse Care Manager initiates a review of the HU/ER Care Plan**

12/02/16 **Sick Visit: Psychogenic Dyspnea.**

- **HU/ER Protocol**
  - **PCP reviews Care Plan**

08/17/17 **ER Visit: Chronic Pain**

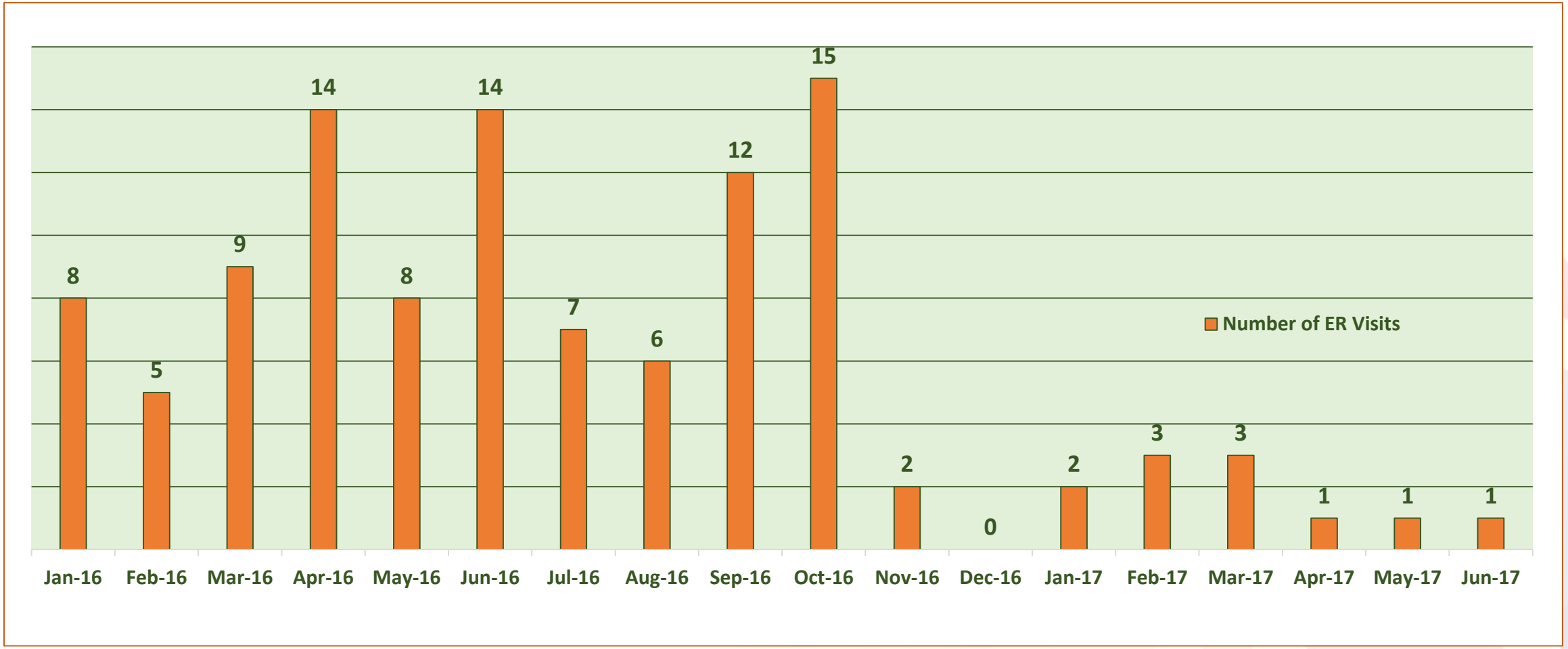
- **HU/ER Protocol**
  - **•M/A administers an ER follow-up survey**
  - **Nurse Care Manager initiates a review of the HU/ER Care Plan**

Mr. Smith's ER Use Ten Month Post IBH Intervention

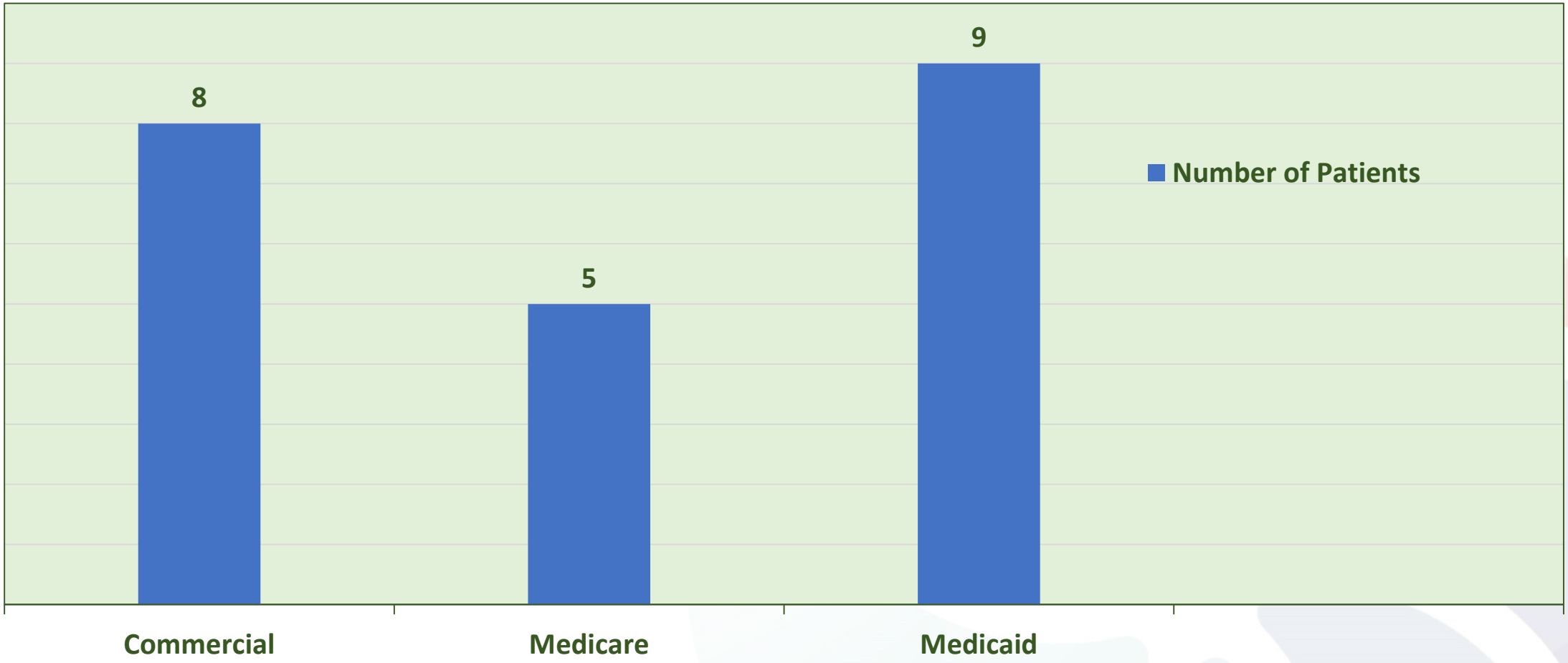
From November 2016 through August, 2017, ten months since Mr. Smith was engaged in the HU/IBH intervention, he presented to the ER twice.

11/22/2016 Anxiety
08/17/2017 Chronic Pain

Number of Unnecessary ER Visits: Pre/Post Intervention



Insurance Categories



Improved Quality of Care and Reduced Cost

- *The average cost of an ER visit:
  - Medicaid: $368
  - Medicare: $667
  - Commercial: $1154
- In the 8 month course of our interventions, we have prevented 63 ER visits

*RI DOH

Improved Quality of Care and Reduced Cost

- “One of the things we identified was somebody was going [to the emergency department] almost every other day, and it was due to anxiety. So he was given tools to kind of control that, and it actually empowered him. He felt like he had taken control of this issue. And his ER visits dropped right off. He was being seen here [at the primary care practice] more frequently, but that's okay. We'd rather he come here than go to the ER.” *(Practice Coordinator)*

Chronic Health Condition IBH Plan

Using the Diabetes Distress Scale to identify and shape treatment of Diabetes

Lowering A1C Through Group Visits

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Planned Intervention

PLAN: Identify patients with distress regarding their chronic disease, diabetes.

ACTION: Outreach and invite identified patients to attend a interdisciplinary Group Visit.

FOLLOW UP: Collect pre/post measures on all identified patients regardless of their participation in a Group Visit using a measure of A1C and the DDS.

Chronic Health Condition IBH Plan

Using the Diabetes Distress Scale to identify and shape treatment of Diabetes

Diabetes Distress Scale: Screening and Informing Treatment

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Diabetes Distress Scale

What is the DDS:

- "The DDS is a 17-item scale that captures critical dimensions of distress. First published in 2005, it has been used widely around the world as a clinical instrument for opening conversation with one's patients as well as a critical outcome measures in numerous studies."*

4 Subcategories of the DDS

- Emotional Burden
- Physician Distress
- Regimen Distress
- Interpersonal Distress

1. Polonsky, W.H., Fisher, L., Esarles, J., Dudl, R.J., Lees, J., Mullan, J.T., Jackson, R. (2005). Assessing psychosocial distress in diabetes: Development of the Diabetes Distress Scale. Diabetes Care, 28, 626-631.

2. Fisher, L., Hessler, D.M., Polonsky, W.H., Mullan, J. (2012). When is diabetes distress clinically meaningful? Establishing cut-points for the Diabetes Distress Scale. Diabetes Care, 35, 259-264.

Four Subcategories

Emotional Burden

- Feeling that diabetes is taking up too much of my mental and physical energy every day.
- Feeling angry, scared and/or depressed when I think about living with diabetes.
- Feeling that I will end up with serious long-term complications, no matter what I do.
- Feeling that diabetes controls my life.
- Feeling overwhelmed by the demands of living with diabetes.

Physician Distress

- Feeling that my doctor doesn't know enough about diabetes and diabetes care.
- Feeling that my doctor doesn't give me clear enough directions on how to manage my diabetes.
- Feeling that my doctor doesn't take my concerns seriously enough.
- Feeling that I don't have a doctor who I can see regularly enough about my diabetes.

Four Subcategories cont.

Regimen Distress:

- Not feeling confident in my day-to-day ability to manage diabetes.
- Feeling that I am not testing my blood sugars frequently enough.
- Feeling that I am often failing with my diabetes routine.
- Feeling that I am not sticking closely enough to a good meal plan.
- Not feeling motivated to keep up my diabetes self management.

Interpersonal Distress:

- Feeling that friends or family are not supportive enough of self-care efforts (e.g. planning
- activities that conflict with my schedule, encouraging me to eat the "wrong" foods).
- Feeling that friends or family don't appreciate how difficult living with diabetes can be.
- Feeling that friends or family don't give me the emotional support that I would like.

Chronic Health Condition IBH Plan

Using the Diabetes Distress Scale to identify and shape treatment of Diabetes

Diabetes Distress Scale: Screening and Informing Treatment

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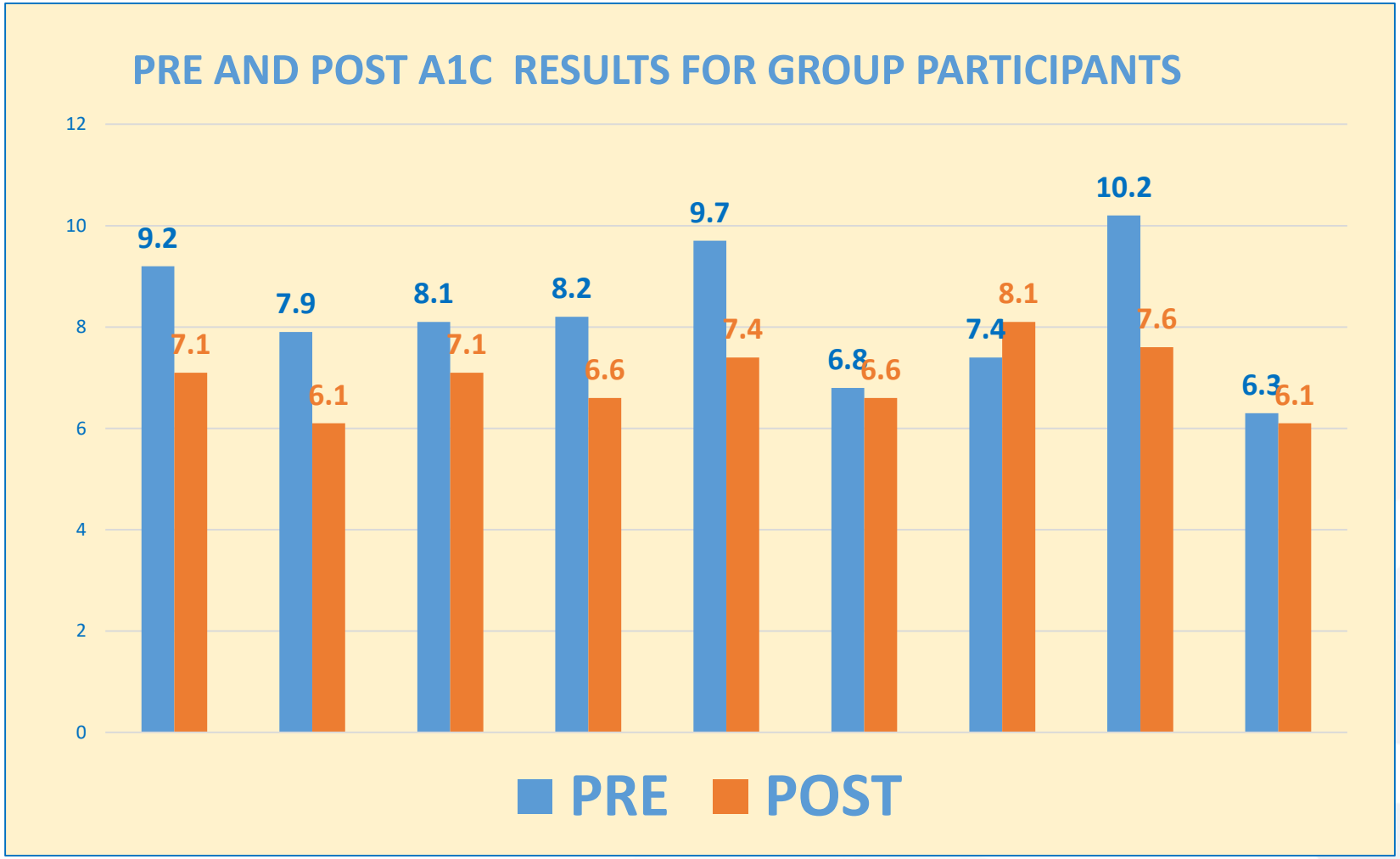
Results

- 15 patients identified Diabetes Distress, as evidenced by their DDS, at a significant level and qualified for the Group Visit.
- 9 of the 15 patients identified attended the Group Visit
- 8 of the 9 patients who attended the group lowered their A1C
- 9 of the 9 Patients who attended the group lowered their Diabetes Distress, as evidenced by their DDS scores.

Pre/Post A1C RESULTS FOR PATIENTS WHO ATTENDED

PRE-GROUP A1C	POST-GROUP A1C
9.2	7.1
7.9	6.1
8.1	7.1
8.2	6.6
9.7	7.4
6.8	6.6
7.4	8.1
10.2	7.6
6.3	6.1


PRE AND POST A1C RESULTS FOR GROUP PARTICIPANTS
12
10
8
6
4
2
0
9.2
7.1
7.9
6.1
8.1
7.1
8.2
6.6
9.7
7.4
6.8
6.6
7.4
8.1
10.2
7.6
6.3
6.1
PRE
POST

Patients Who Declined

- OF THE 6 PATIENTS WHO DIDN'T ATTEND THE GROUP
  - 3 PATIENTS HAD AN INCREASE IN THEIR A1C
  - 2 PATIENTS HAD NO CHANGE IN A1C
  - 1 PATIENT DECREASED THEIR A1C
  - 1 PATIENT DIDN'T HAVE REPEAT A1C DONE

  - WE DO NOT HAVE DDS RE-SCREEN RESULTS FOR THESE 6 PATIENTS

Overcoming Stigma With A Name Change

- Our diabetic group visits were originally entitled Diabetes Distress Group Visits. After the positive reception to a group entitled “The Power Of Positive Thinking,” we reevaluated our group visit title strategy and came to call these “Diabetes Empowerment Visits” to invoke a more positive, supportive connotation.

Moving Forward

- WE WILL CONTINUE TO SCREEN DIABETIC PATIENTS USING THE DDS17, PARTICULARY FOR NEW DIABETICS OR DIABETICS WITH AN A1C ABOVE 8.0
- DIABETES DISTRESS GROUPS ARE SCHEDULED EVERY OTHER MONTH THROUGHOUT THE YEAR
- SIGNAGE AND INFORMATION IS AVAILABLE IN OUR OFFICE AND ON OUR WEBSITE

Feedback

"I ENJOY THE GROUP VISITS AND I ALWAYS LEARN SOMETHING."

"ATTENDING THE GROUP VISITS GIVES ME THE ABILITY TO TAKE CONTROL OF MY BLOOD SUGARS."

https://www.ctc-ri.org Care Transformation Collaborative - Rhode Island

Behavioral health integration helps patients and lowers ER visits at Associates in Primary Care Medicine

Associates in Primary Care Medicine (APCM), a small Warwick-based practice participating in CTC's Integrated Behavioral Health initiative, wanted to determine if an intervention with the in-house psychologist or working with the Nurse Care Manager could decrease the number of these visits, and decided to launch a concentrated effort.

Over an 11-month period, APCM identified patients with behavioral health and medical needs who had three or more emergency room (ER) visits. Based on review of the patient data, 22 patients were identified for more intensive on-site team intervention. Patients were asked how the practice could better meet their needs and team strategies to improve outreach, communication and care coordination were initiated. Alerts were also entered into the patient's electronic medical records to assist practice team members with recognizing patients who may need additional support when calling for appointments and being seen by providers, psychologist or the Nurse Care Manager. Bi-monthly meetings were held between the provider, nurse care manager, and practice manager to further discuss ways to improve care and engage the identified patients.

"About a couple of months into the quality improvement cycle, we felt we had made a breakthrough with one patient in particular," said Jamie Handy, Practice Manager at APCM. "We noticed in our follow-up work that this patient had not returned to the ER since being provided with an action plan by the Nurse Care Manager. Most of his ER visits were due to anxiety symptoms. This was a great success, since prior to this effort, he was seen on a weekly basis at the ER. We believe that the patient now felt some empowerment about his healthcare, as he now knows what to do should he have anxiety symptoms."

As a result of these efforts to engage and educate patients, two patients saw the psychologist, two patients were counseled by their provider, and eight patients developed an 'ER action plan' with the Nurse Care Manager. Through the eight-month course of APCM's intervention work, 63 ER visits were prevented. APCM's preliminary evaluation in March 2017 demonstrated that 17 of the 22 patients had not been back to the ER.

Now at APCM, as the practice looks to expand on this impactful work, patients who utilize the ER for non-urgent matters are given a survey at their follow-up primary care visit. The practice is working to better understand why patients may go to the ER rather than the office for a same-day sick visit.

"The biggest take away so far has been the idea that small changes can make big differences," said Handy. "We understand that this process will always be a challenging effort, but one we feel is worthwhile. Many factors can be involved in the overuse of the ER by patients, including transportation, mental health issues, and financial difficulties to name a few."

APCM will continue to monitor its identified patients, and is implementing this protocol practice-wide to support others that may be over-utilizing the ER. With an established team to work with and support its identified patients (including its receptionists, medical assistants, providers, practice manager, nurse care manager, and psychologist) the APCM team is now meeting monthly to monitor their patients' progress, and believes more questionnaire data and time will help identify continued strategies for improvement and progress.

"If we are able to reduce the unnecessary ER visits, we are cutting costs, providing better care, and ultimately empowering patients to be a more active participant in their healthcare," said Handy.

Care Transformation Collaborative

Lead the transformation of primary care in Rhode Island in the context of an integrated health care system.

Integrated Behavioral Health: Measuring Success

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Our Successes

- Participating in 5 value-based contracts (3 risk) managing 120,000 member lives
- In aggregate, we saved the healthcare system **14 million** over our last measurement period.
- Most importantly, we scored in the 95th percentile in quality!

integra
Community Care Network

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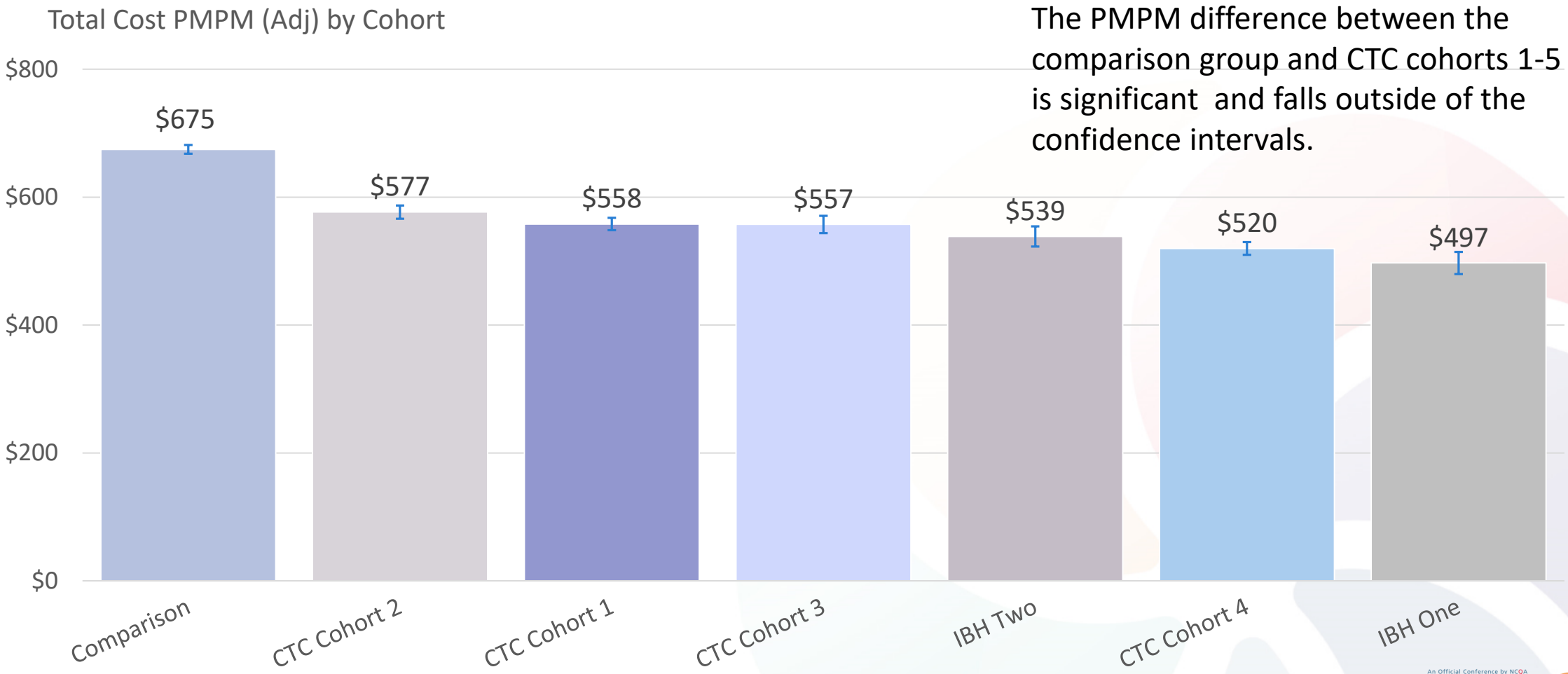
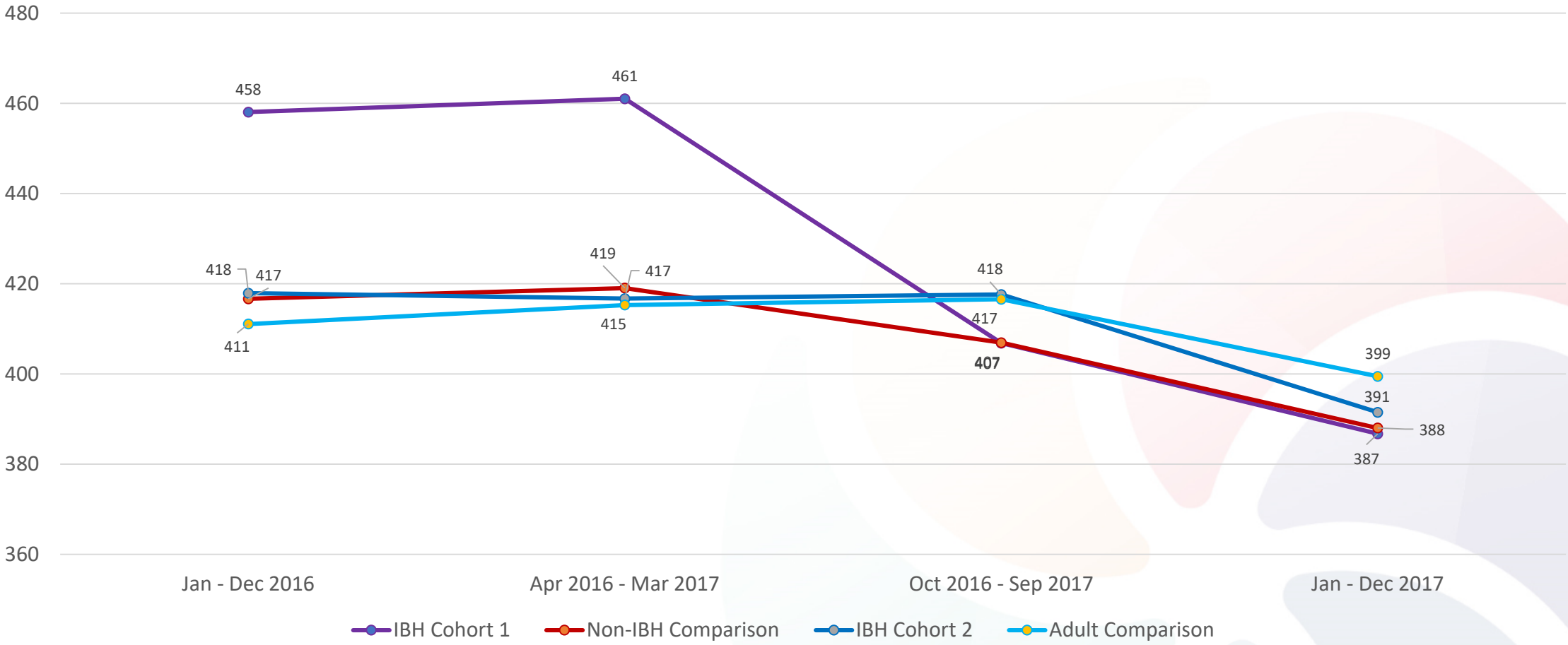
Total Cost Results All Payer Claims
1/1/16 - 12/31/16



The PMPM difference between the comparison group and CTC cohorts 1-5 is significant and falls outside of the confidence intervals.

Emergency Department Visits

Risk Adjusted (Visits per 1,000 Member-Years Count)



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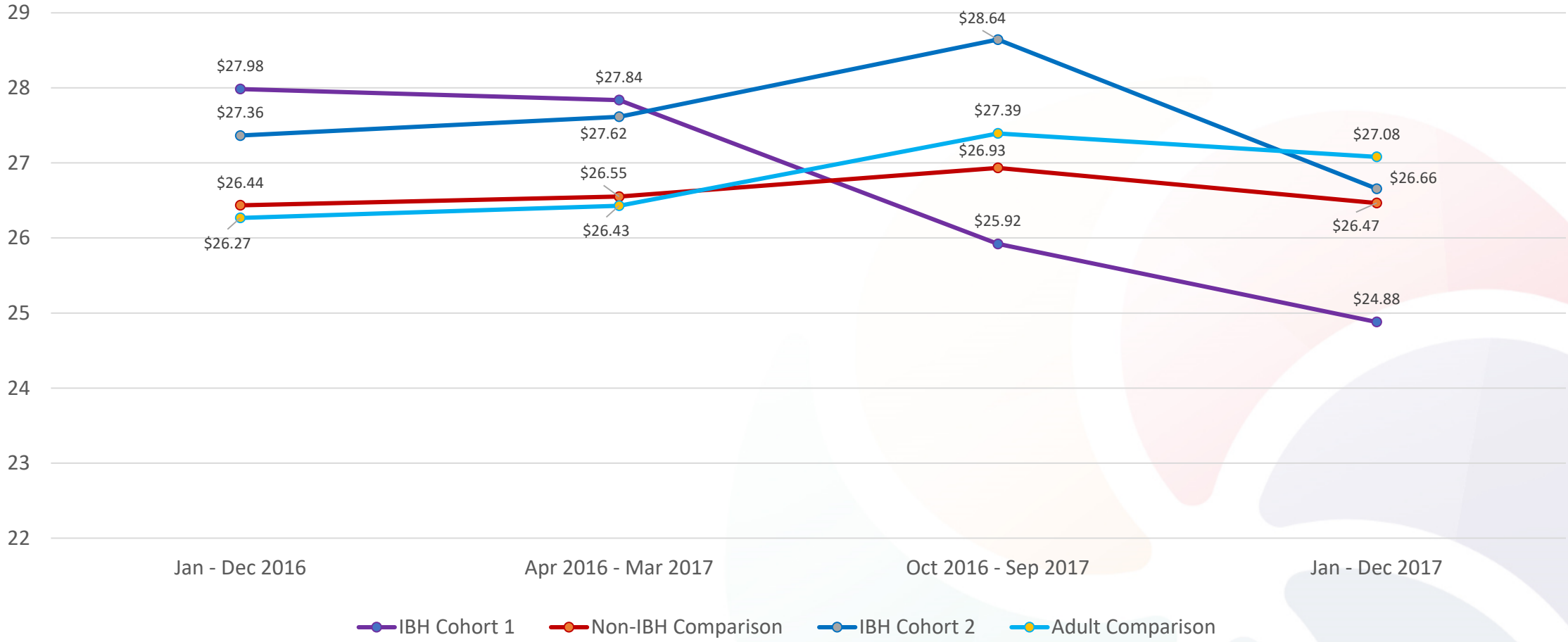
Emergency Department Costs
Risk Adjusted (Cost per Member-Month)



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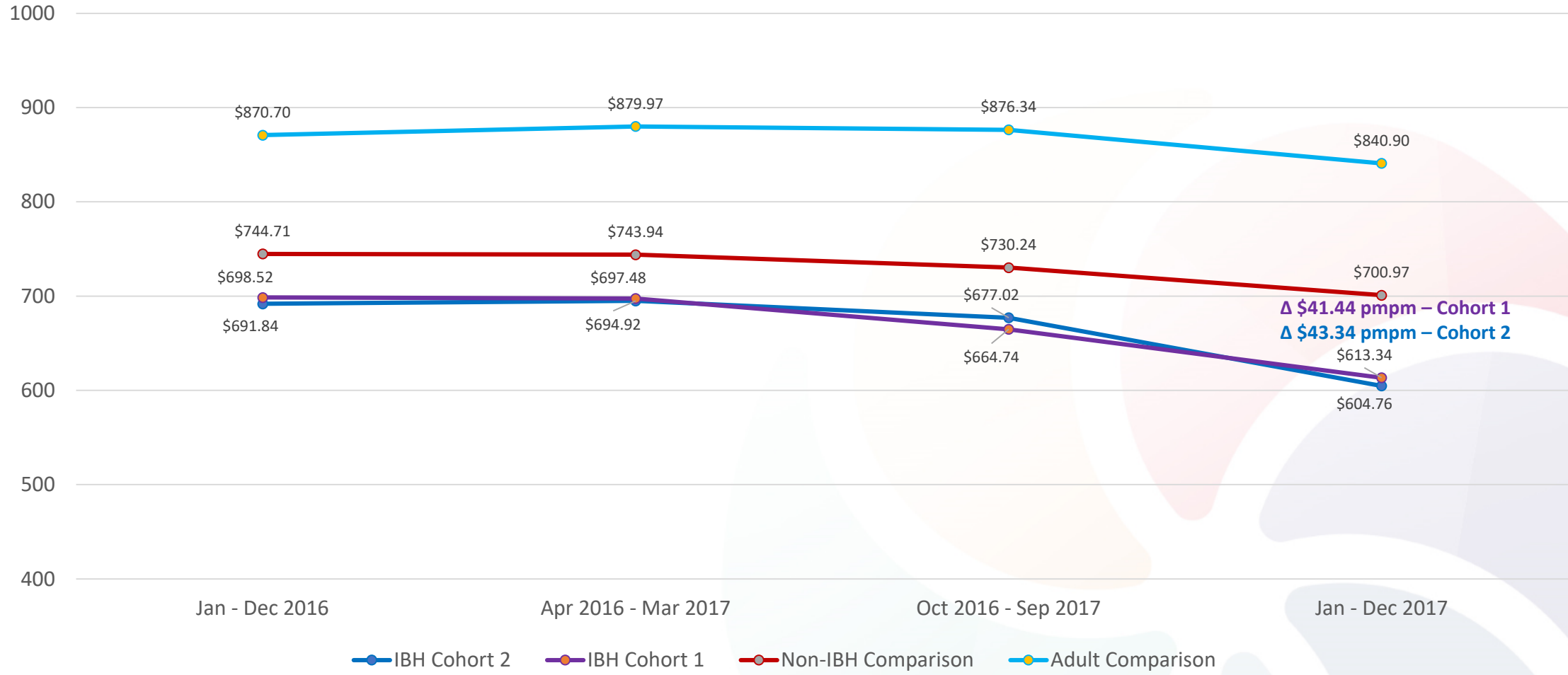
Total Medical & Pharmacy Costs (with Exclusions)

Risk Adjusted (Cost per Member-Month)



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Sustainability

- Evaluation results: qualitative analysis and APCD data results done which indicate positive impact; matched comparison quantitative analysis is in process
- IBH Alternative Payment model: Rhode Island, through the Office of the Health Insurance Commissioner (OHIC), is developing plans to pilot an IBH alternative payment model
- Policy efforts: IBH co-pays at primary care rate; health plan credentialing for behavioral health required to be done within 60 days; OHIC conducting a mental health parity analysis
- Work force development: IBH practice facilitator training program, HRSA IBH training program with Rhode Island College

Sustainability

"I mean, when I say how much I love having integrated behavioral health, is that I can't imagine primary care without it. It just makes so much sense to me to have those resources all in the same place because it's so important. So I love it. I can't speak highly enough of it." *(Medical Provider)*