Stronger Together

Session 3

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Agenda

1. Quick Review of Integration
2. Introduction to Value-Based Care
3. Data and Quality Measures
4. Paradigm Shift

Integrated Care Lens

- Improve overall health and wellness of patients
  - Chronic Illness is often able to be managed through behavioral interventions and changes
  - So ANYONE with ANY chronic illness is appropriate for a BH intervention
- Improve health outcomes for all patients
  - Utilize the ENTIRE team to wrap around the patient
- Reduce hospitalizations
- Reduce the cost of healthcare
- Reduce bias for receiving behavioral health and substance use treatment
- Enhance motivation and empower patients to live with vitality!

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Context

- Forty-six of the 56 counties in Montana have 6 or fewer people per square mile.
  - They are designated as "frontier".
- In 2019, there were 2 cows to every 1 person in Montana
- EVERYONE on the team plays an important role in providing patient care.
- When we are building services and workflows, we need to remember our context of Primary Care and Frontier Montana.

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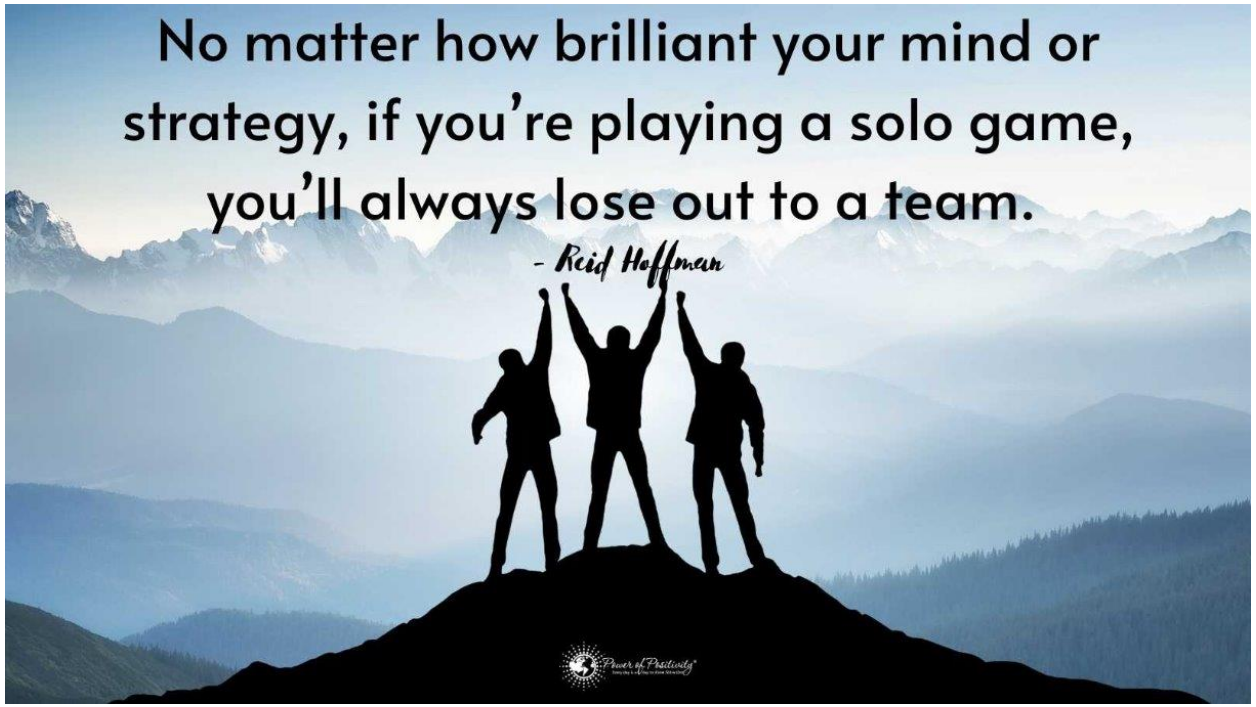
Building Strong Teams

- Everyone on the team matters – From Patient Access to Billing to HR to Direct Care Providers
- Each team-mate needs to understand the mission and vision and their role



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Integration 101

- Integration is not only the responsibility of the BH Team
- Integration is the ENTIRE team understanding:
  - Motivational Interviewing,
  - De-Escalation Techniques,
  - The Culture of Poverty,
  - HIPAA, Mission and Vision,
  - Their Role in Workflow,
  - Maslow's Hierarchy of Needs,
  - ACCESS!!!!!
  - If the ENTIRE team is not practicing these values – your clinic is not practicing Integration
  - (See Goals of Integration)

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Integrated Team Goals

- Improve overall health and wellness of patients
- Improve health outcomes for all patients
- Reduce hospitalizations
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Value-Based Care

What is Value-Based Care?

A health care delivery model under which providers are paid based on the health outcomes of their patients and the quality of services rendered.

- Health care spending in the US increased from about 5% of the total economy in 1960 to nearly 18% in 2016.
  - Currently totaling upwards of $3.5 trillion annually.
  - We spend 2-3 times more than most developed countries annually…and achieve worse results.
  - All of us shoulder that burden.

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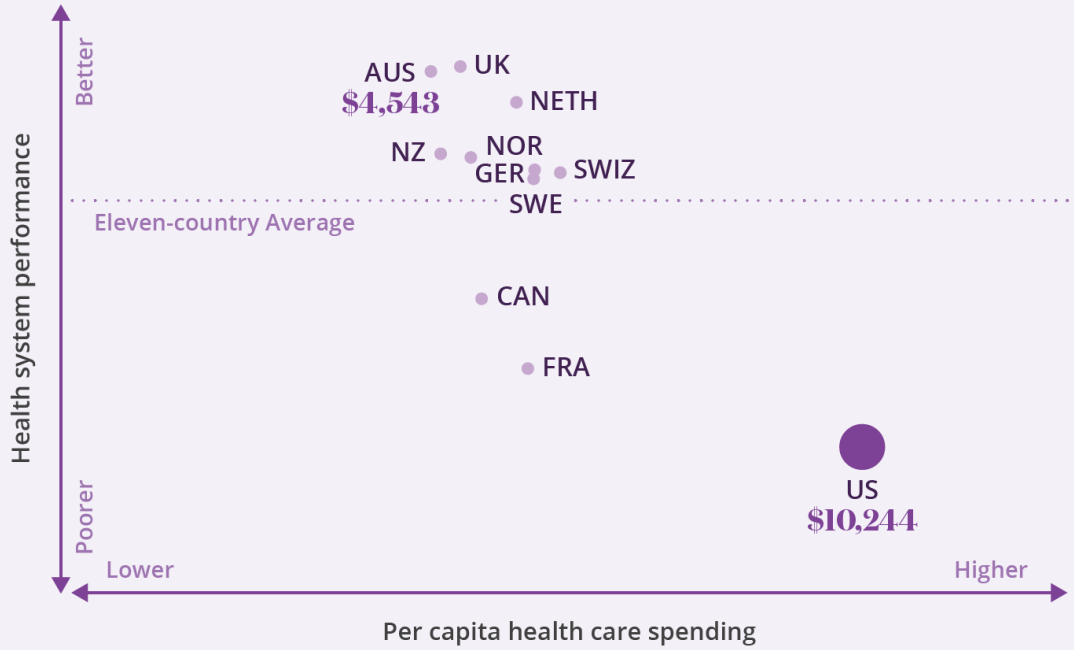
More Stats – From Aetna

- The disease burden in the U.S. is the highest among developed countries.
- 6 in 10 Americans have at least one chronic condition — high blood pressure, diabetes, mental illness — and 4 in 10 are managing more than one.
- 90 percent of health care dollars spent each year is for people with chronic health conditions.

We spend too much, and we get too little.

The U.S. spends the most on health care, but has the worst outcomes and highest disease burden among developed nations.[3][4]



Social Drivers of Health

- Who screens in your clinic?
- How do you meet these needs once you have screened for social drivers?
- Providing population care.
  - UDS if you are in FQHC
  - Performance Improvement Goals
  - Collaborative Meetings and Huddles
  - Shared Care Plans with the Patient at the Center of the Care

Your ZIP code matters

250%

People living in poverty are 250% more likely to be diagnosed with type 2 diabetes than those with greater income stability.[10][11][12]

Why? Poor communities have less access to...

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What is Value-Based Care, How it Works & Benefits I Aetna

Sounds Familiar…

"Value-based care puts greater emphasis on **integrated care**, meaning health care providers work together to address a person's **physical, mental, behavioral and social needs**.

In this way, providers treat an individual as a **whole person**, rather than focusing on a specific health issue or disease."

- CMS – Value Based Care

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The Gist

Insurances want us to provide high-quality, cost-effective care to their customers by providing whole person care.

Good News!

WE DO THAT!

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Care Coordination

- SDH Screening and referrals
- Must be followed up with
- How do we track that we are following up with a patient?
- These patients are often referred to BH with frustration that they are not improving…and they don't have basic needs met.
- Housing is healthcare!

Maslow's hierarchy of needs

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Screening for SDH

- An ongoing conversation using Motivational Interviewing or Empathic Interviewing skills.
- Patients in Integrated Care have a relationship with their Care Team that allows for open communication about all needs that impact healthcare.
- This isn't just checking a box once a year – or handing a patient a piece of paper.
- Care Coordinator/Manager etc follows up with patients and is known as the central communicator for the team.

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Reframing our Thinking

- We already do many of these practices with Integrated Care.
- How do we document this well?
- And improve our Care Coordination to ensure health equity?
- And assess if there are patients slipping through the gaps in care that we can outreach?

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Patient Registries

- AZARA DRVS
- Can be used to run gap reports from your EMR of patient needs and gaps in care.
- Then delegated to appropriate members of the team for patient outreach.
- Contact Toni Wood for more training/info
  - twood@mtpca.org

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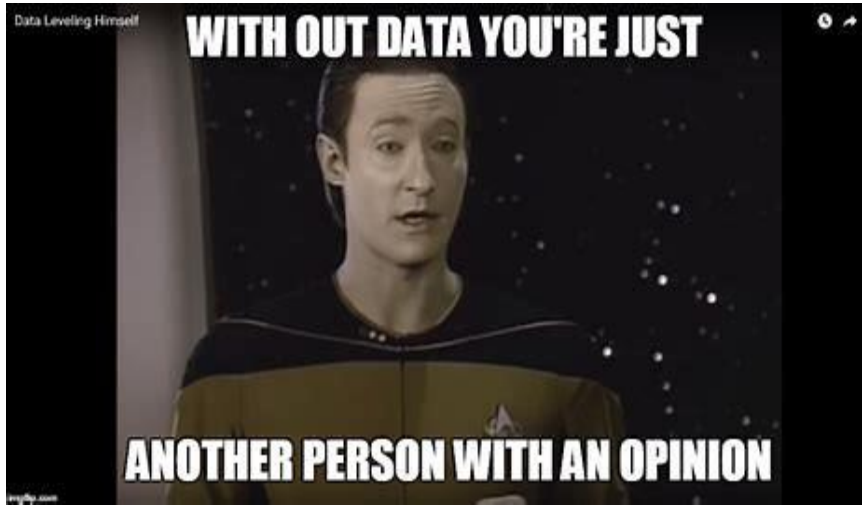
Data Driven Care

- Unique Patients
  - Unique lives touched by the provider
  - When we engage the entire team, we have more time to touch many lives and work at the top of our license.
- Compared to number of appointments
  - Fee for service – we want to reduce overall cost of care
  - Work as efficiently as possible



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Single Session Mindset

- How do we show that patients are improving?
  - Screeners, surveys, hospital visits, etc
- If our data shows that they are NOT improving, what are we doing to adjust treatment?
  - Do patients understand our role and are they engaged in their care plans?
  - Are we meeting the patient where they are in their context? With their goal? (not ours)

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Reframe!

- Chronic illness management – Is our patient functioning, even with their chronic illness?
  - DUKE Functional Assessment, PSEQ
  - BH should/could be engaged for EVERY patient in primary care.

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The Quadruple Aim

- **Team documentation** in the EHR.
- **Pre-visit planning** to reduce time wasted on follow-up results review.
- **Expand roles** to allow nurses, MA's and other team-mates to support the PCP in chronic illness management.
- **Co-locate teams** so PCP's work in the same space as their team members.
- **Train and support** staff who assume new responsibilities.

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Easier Said Than Done…

- When the pressure for metrics lies on one professional, that is overwhelming and unreasonable.
- With Value-Based Care (and integration), we are wrapping our entire group of professionals around the patient in the context of what the patient is willing and able to engage in.
  - When we do this, we hope that the metrics follow – and if they don't, we expect the function will.
  - And if it doesn't, we keep working with the patient to experiment in trying something different.

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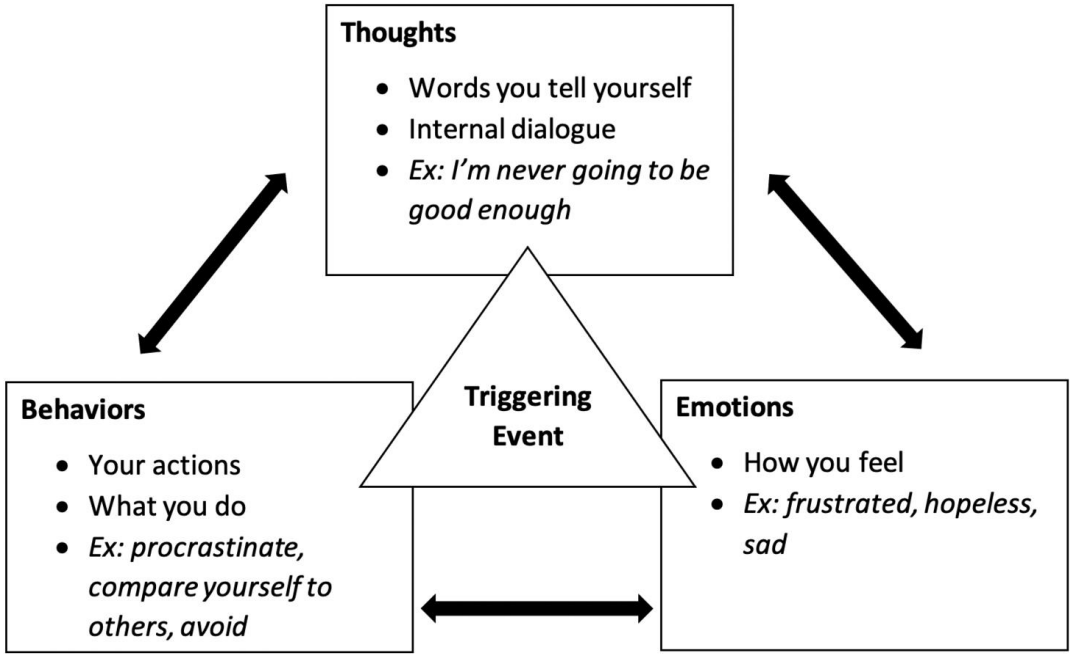
Personal Belief



- Patients came to our clinic for assistance. They want to feel better!
- If our medical team is struggling with a chronic medical issue with a patient, it could be time to engage your BH Team.
- The BH Team will assess the context of the situation.
- What the patient can engage in. What success would look like for them. What a small step could be.
- SDH that could be impacting the patient's ability.
- And continue experimenting with the patient to improve their health and wellness.

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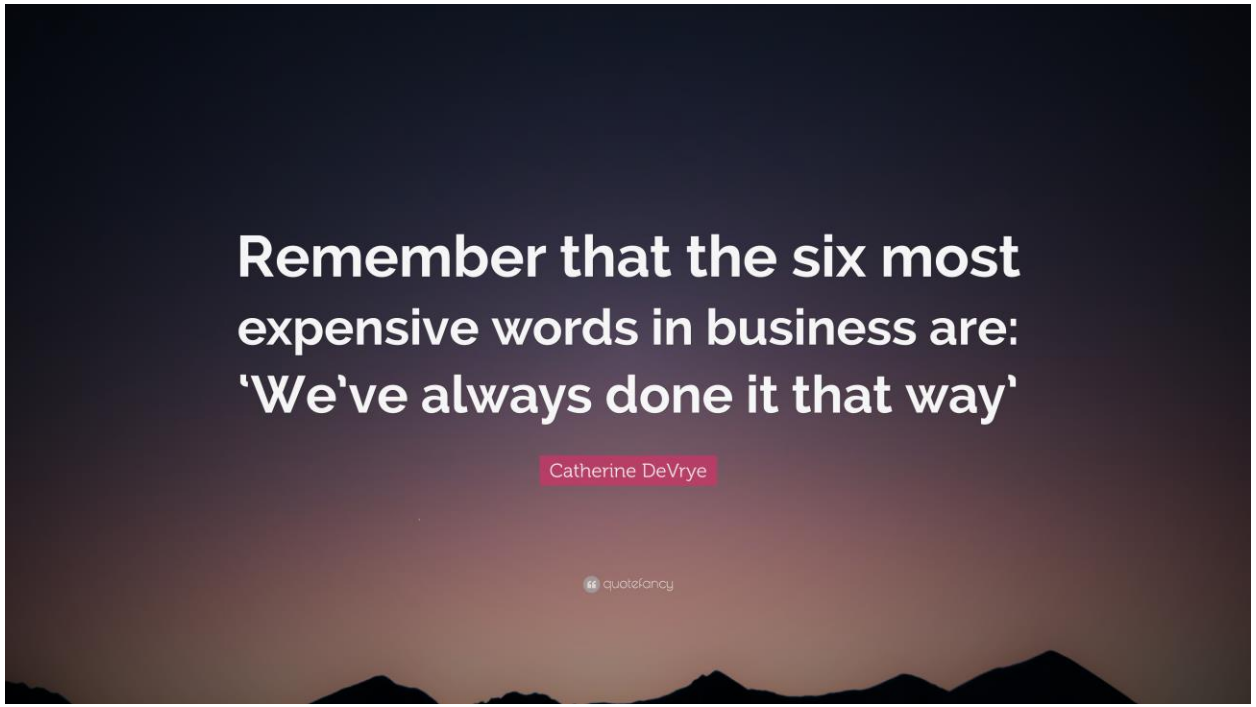
Training – A Paradigm Shift

- Colleges are not training social workers in Integrated Care – yet.
- Therapists do not generally learn how to use data to drive their interventions.
- BH Providers often do not learn about Substance Use.
- PCP's often don't learn to lead an Integrated Team or engage in QI.
- But to have a successful Integrated Team – we have to break out of these silos!
  - For example….



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What's the Difference?

PRIMARY CARE BEHAVIORAL HEALTH

- Targeted Treatment from the 1st Session
- Treat as though patient may only be seen once
- Accessible – often same day – No wait list
- Do not "fire" from treatment
- Do not "discharge" – see patient for lifetime
- Chart in the medical record with a Shared Care Plan with the PC Team

TRADITIONAL MENTAL HEALTH

- Wait List – Then scheduled appointment
- Initial Assessment – Information Gathering, Not Treatment
- TP's that last months-years
- Terminated from care if miss appointments
- Discharge when treatment is complete
- Communication to the PC Team is limited

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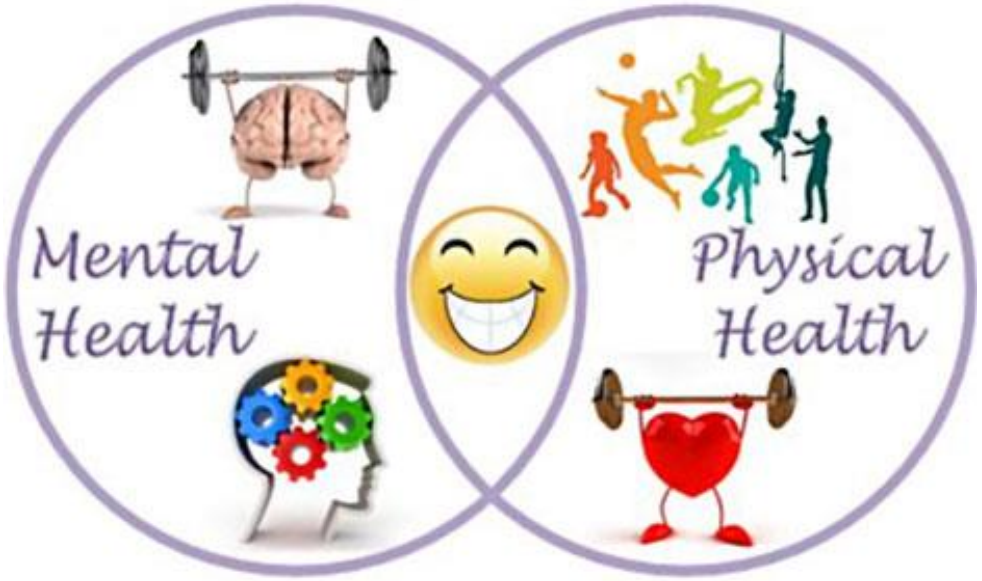
Onboarding vs. Orientation

Why Integration to Primary Care?

- It's care over a person's lifetime.
- It's preventative.
- It's destigmatizing.
- It's mission-driven in creating access and addressing barriers.
- It's LOGICAL.
- It's Value-Based Care



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Resources

What is Value-Based Care, How it Works & Benefits I Aetna

Value-Based Care | CMS

From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider - PMC (nih.gov)

By Mission And Definition, Community Health Centers Already Perform Value-Based Care | Health Affairs

About HRSA | HRSA

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Upcoming Trainings

Stronger Together – Webinar May 16th at 9:00

Collaborative Documentation – Webinar May 30th 9:00

Events Calendar - Montana Primary Care Association (mtpca.org)