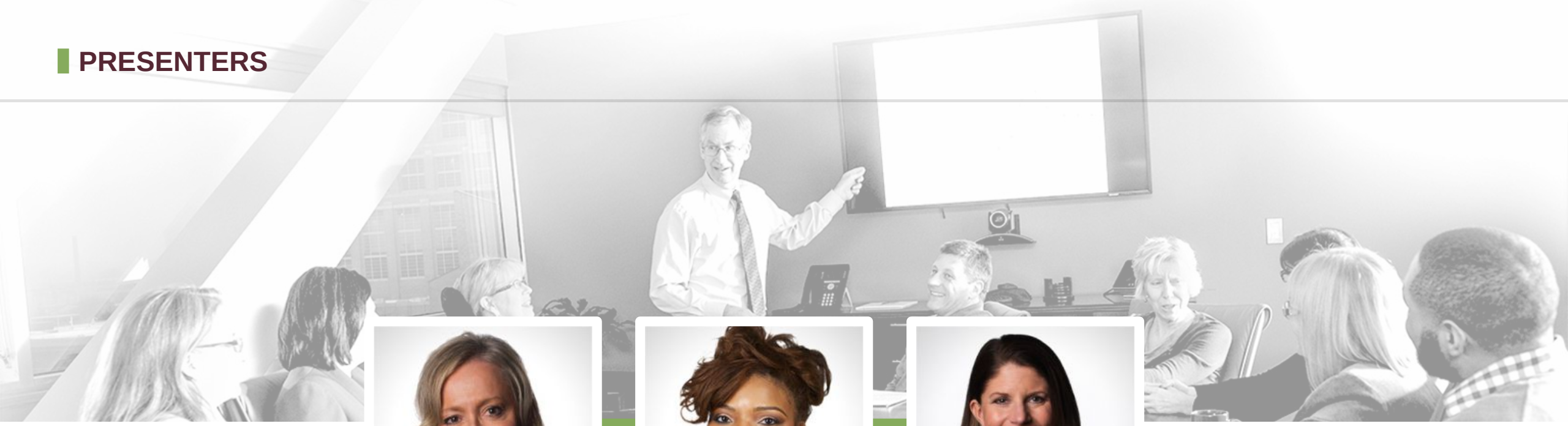
HEALTH MANAGEMENT ASSOCIATES

Building a Community Collaborative:

Bringing Together Healthcare Providers, Community-Based Organizations, Health Plans, and the Criminal Justice System for Effective Complex Care

4/12/17

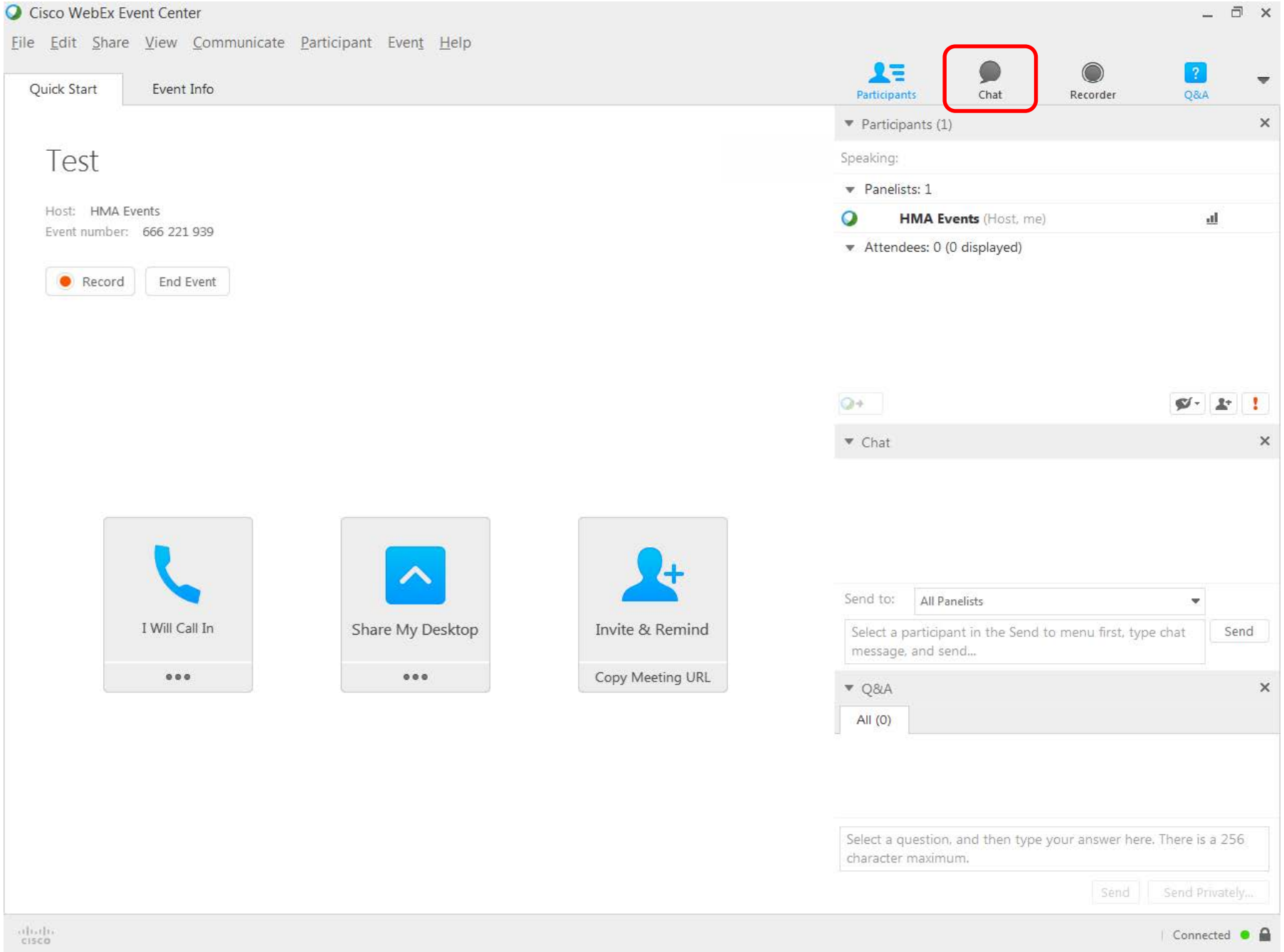
PRESENTERS

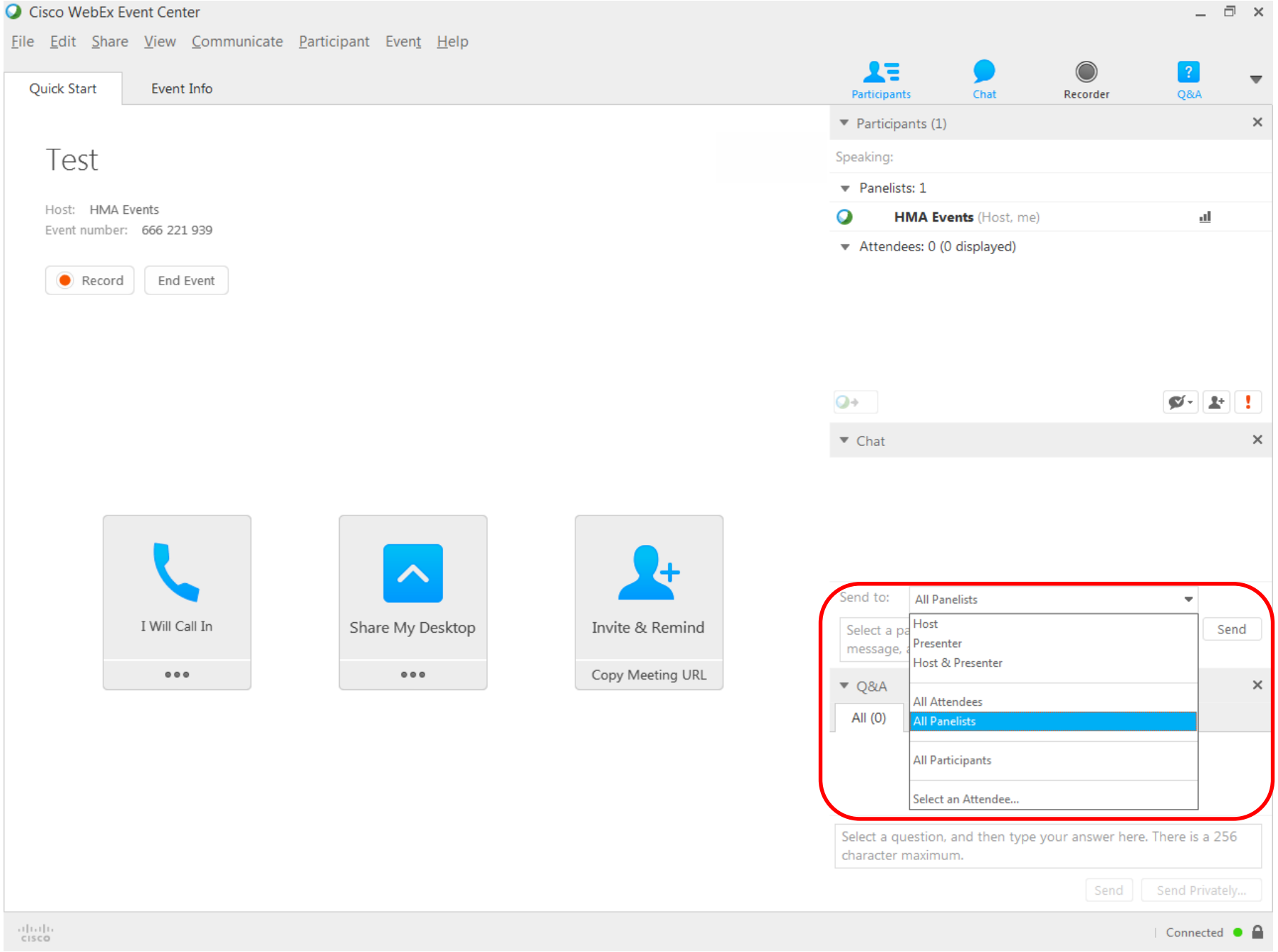


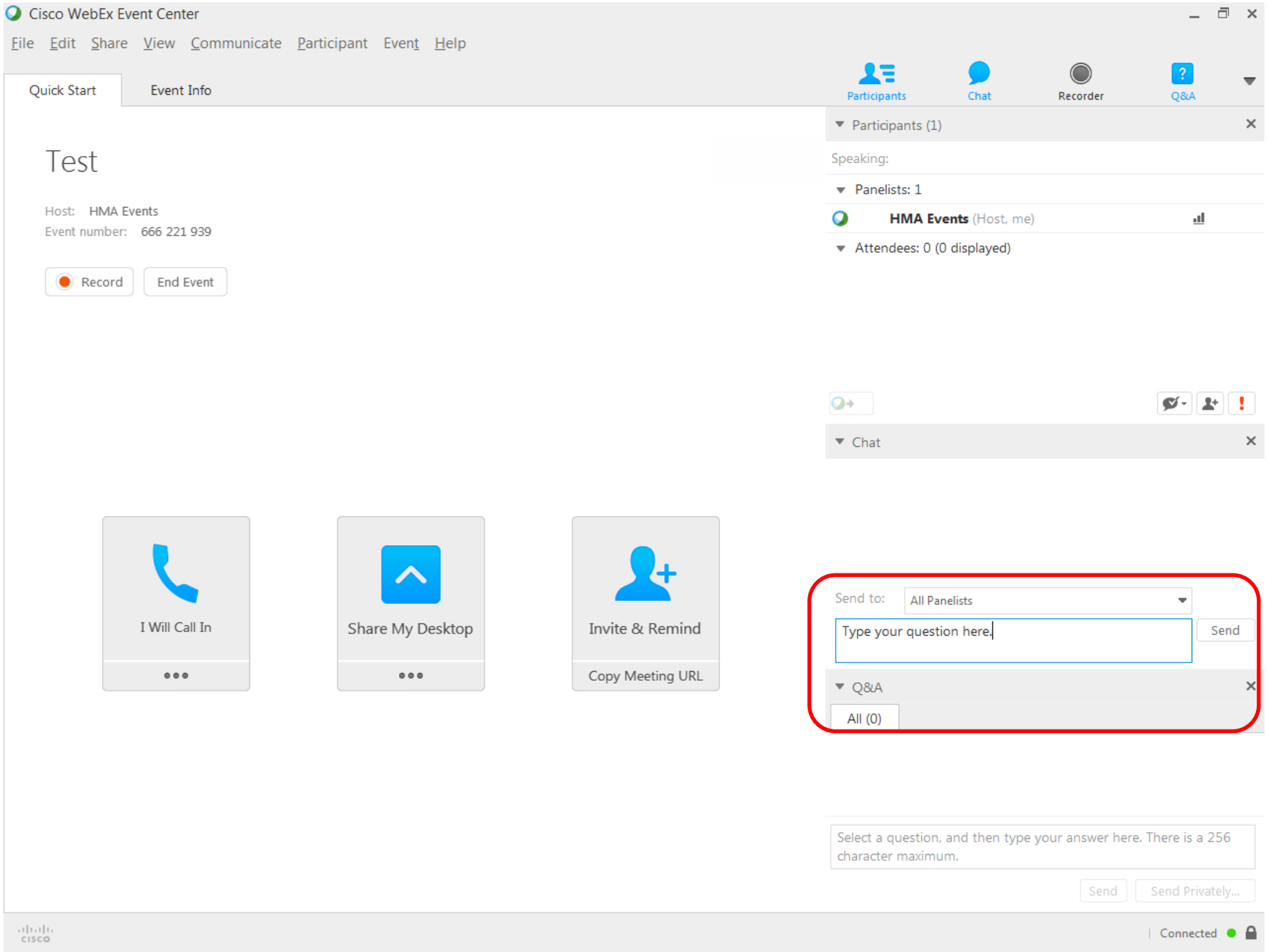
Bren Manaugh
Principal,
San Antonio

Laquisha Grant
Senior Consultant,
New York

Amanda Ternan
Senior Consultant,
San Antonio


Cisco WebEx Event Center
File Edit Share View Communicate Participant Event Help
Quick Start
Event Info
Participants
Chat
Recorder
Q&A
Test
Host: HMA Events
Event number: 666 221 939
Record
End Event
I Will Call In
Share My Desktop
Invite & Remind
Copy Meeting URL
Participants (1)
Speaking:
Panelists: 1
HMA Events (Host, me)
Attendees: 0 (0 displayed)
Chat
Send to: All Panelists
Select a participant in the Send to menu first, type chat message, and send...
Send
Q&A
All (0)
Select a question, and then type your answer here. There is a 256 character maximum.
Send
Send Privately...
Connected


Cisco WebEx Event Center
File Edit Share View Communicate Participant Event Help
Quick Start
Event Info
Participants
Chat
Recorder
Q&A
Test
Host: HMA Events
Event number: 666 221 939
Record
End Event
Participants (1)
Speaking:
Panelists: 1
HMA Events (Host, me)
Attendees: 0 (0 displayed)
Chat
I Will Call In
Share My Desktop
Invite & Remind
Copy Meeting URL
Send to:
All Panelists
Host
Presenter
Host & Presenter
All Attendees
All Panelists
All Participants
Select an Attendee...
Send
Q&A
All (0)
Select a question, and then type your answer here. There is a 256 character maximum.
Send
Send Privately...
Connected


Cisco WebEx Event Center
File Edit Share View Communicate Participant Event Help
Quick Start
Event Info
Participants
Chat
Recorder
Q&A
Test
Host: HMA Events
Event number: 666 221 939
Record
End Event
Participants (1)
Speaking:
Panelists: 1
HMA Events (Host, me)
Attendees: 0 (0 displayed)
Chat
I Will Call In
Share My Desktop
Invite & Remind
Copy Meeting URL
Send to: All Panelists
Type your question here.
Send
Q&A
All (0)
Select a question, and then type your answer here. There is a 256 character maximum.
Send
Send Privately...
Connected

COMMUNITY COLLABORATIVE MODEL FOR HIGH IMPACT: TWO FOCAL POINTS

- **Beneficiaries with Complex Needs/Super Utilizers of Emergency Departments and Inpatient Hospitalization with Complex Co-Occurring Behavioral Health, Chronic Medical Conditions and High Levels of Social Service Needs**
- **Community Members with Behavioral Health Conditions with Criminal Justice System Involvement**

OBJECTIVES FOR TODAY'S PRESENTATION

- ❑ Understand two primary focal points of a high impact "Community Collaborative Accountable System of Care (ASOC)" model
- ❑ Understand the clinical components of a complex care Community Collaborative
- ❑ Define roles and responsibilities of key partners
- ❑ Define data infrastructure

New York and Texas are very different in politics and policy.

What do they have in common?

A need to find a better way to respond to individuals who are frequent utilizers of ED and inpatient when they could be better served in less acute settings;
and helping people who would be better served by mental health treatment than jail.

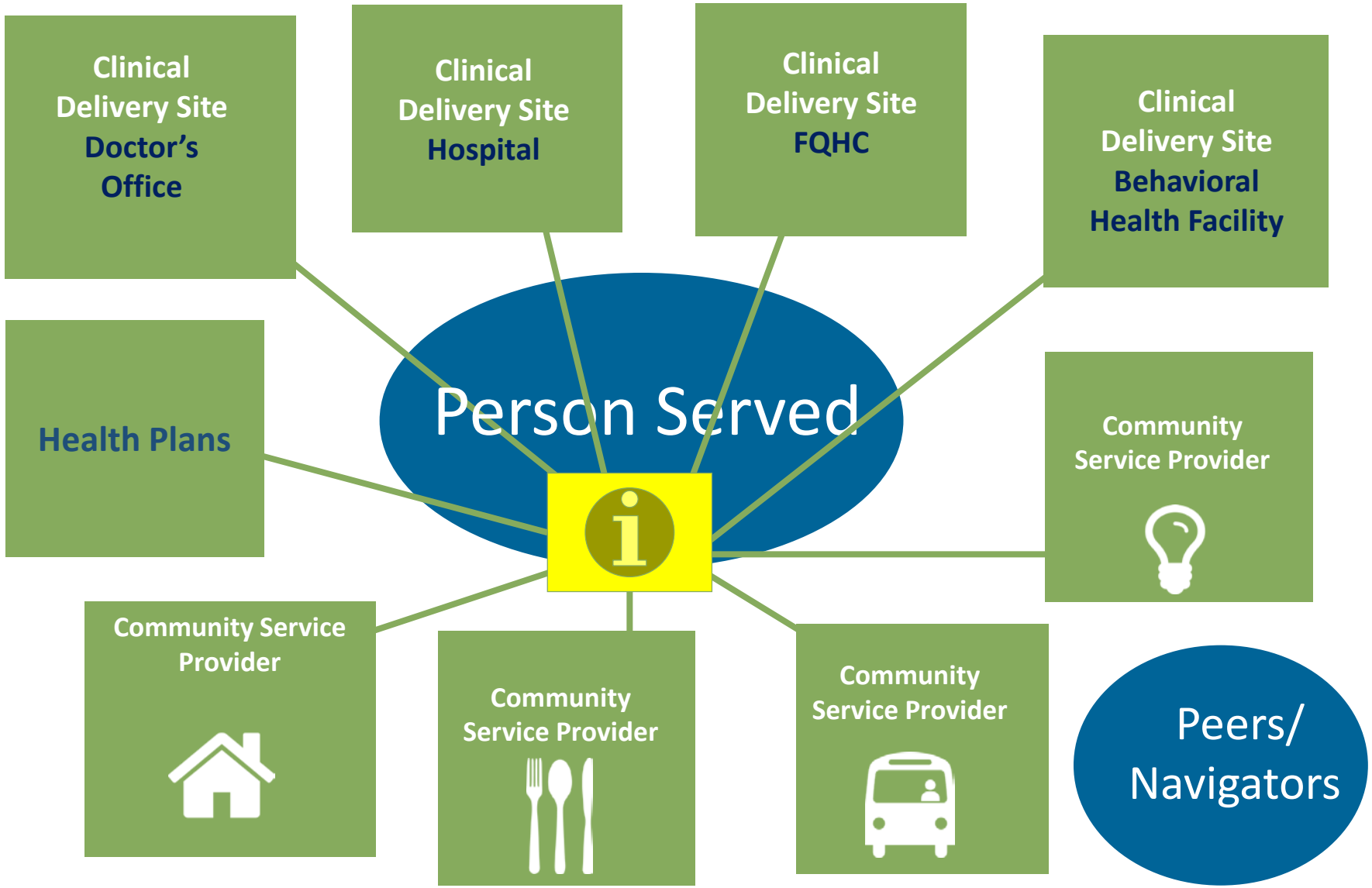
ASOC: A NEW PARADIGM

Community Collaborative "Accountable System of Care"

+ Not the Medical Model
+ Not a Social Services Model
+ Not co-location or integration

Person-centered system of care driven by value

ASOC: A NEW PARADIGM



OLD PARADIGM

Focus on Service Delivery/ Encounters

Encounters: Volume and Process Driven

System-Centered: Person served must fit the system

Lack of Empathy and Regard

NEW PARADIGM

Focus on Community Member in Need

Engagement: Empathy, Dignity and Respect

Understanding: Individualized, Person-Centered, Trauma-Informed

Trust: Healing relationships

ASOC: A NEW PARADIGM

Culture Change

Changing to a person-centered system of care requires:

+ Collaboration
+ Respect and Trust – toward persons served and among partners

NEW PARADIGM

Clinical Model: Universal Coordination of Care and all Interventions Incorporate:

- Person-Centered Model
- Strengths-Based and Recovery-Focused
- Trauma-Informed
- Social Determinants of Health – “Life”


SOCIAL DETERMINANTS
OF HEALTH

SOCIAL DETERMINANTS OF HEALTH

- Access to housing and food
- Access to transportation
- Safety; Trauma-Informed
- Access to health care resources
- Access to social services and supportive connections

Core Health-Related Social Needs

- **Housing** instability (e.g., homelessness, inability to pay mortgage/rent, housing quality);
- **Utility needs** (e.g., difficulty paying utility bills);
- **Food insecurity;**
- **Interpersonal** violence (e.g., intimate partner violence, elder abuse, child abuse, etc.); **and**
- **Transportation needs** (beyond medical transportation).

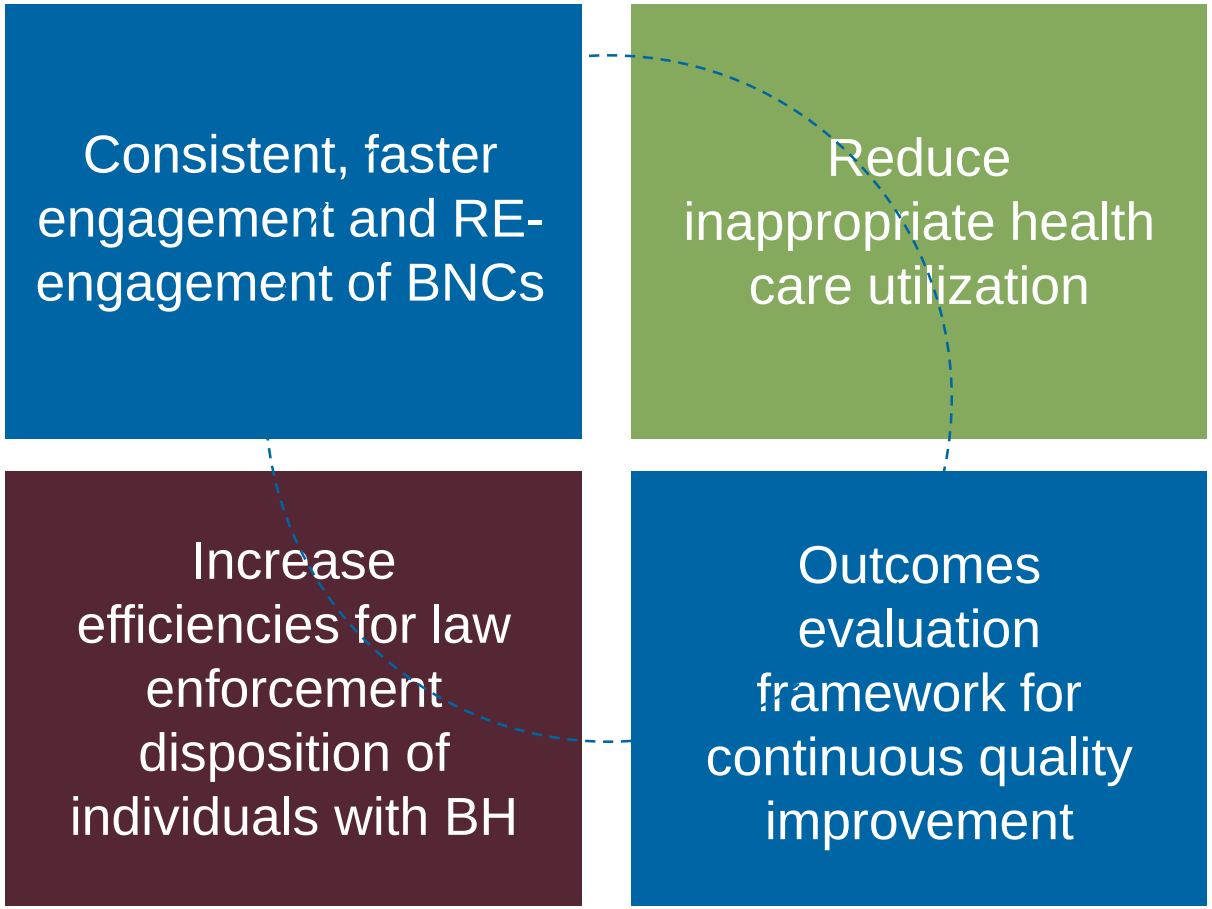
Universal Screening Tool

- Relevant Clinical Information
- Transportation Needs
- Housing Instability
- Utility Needs
- Food Insecurity
- Interpersonal Violence

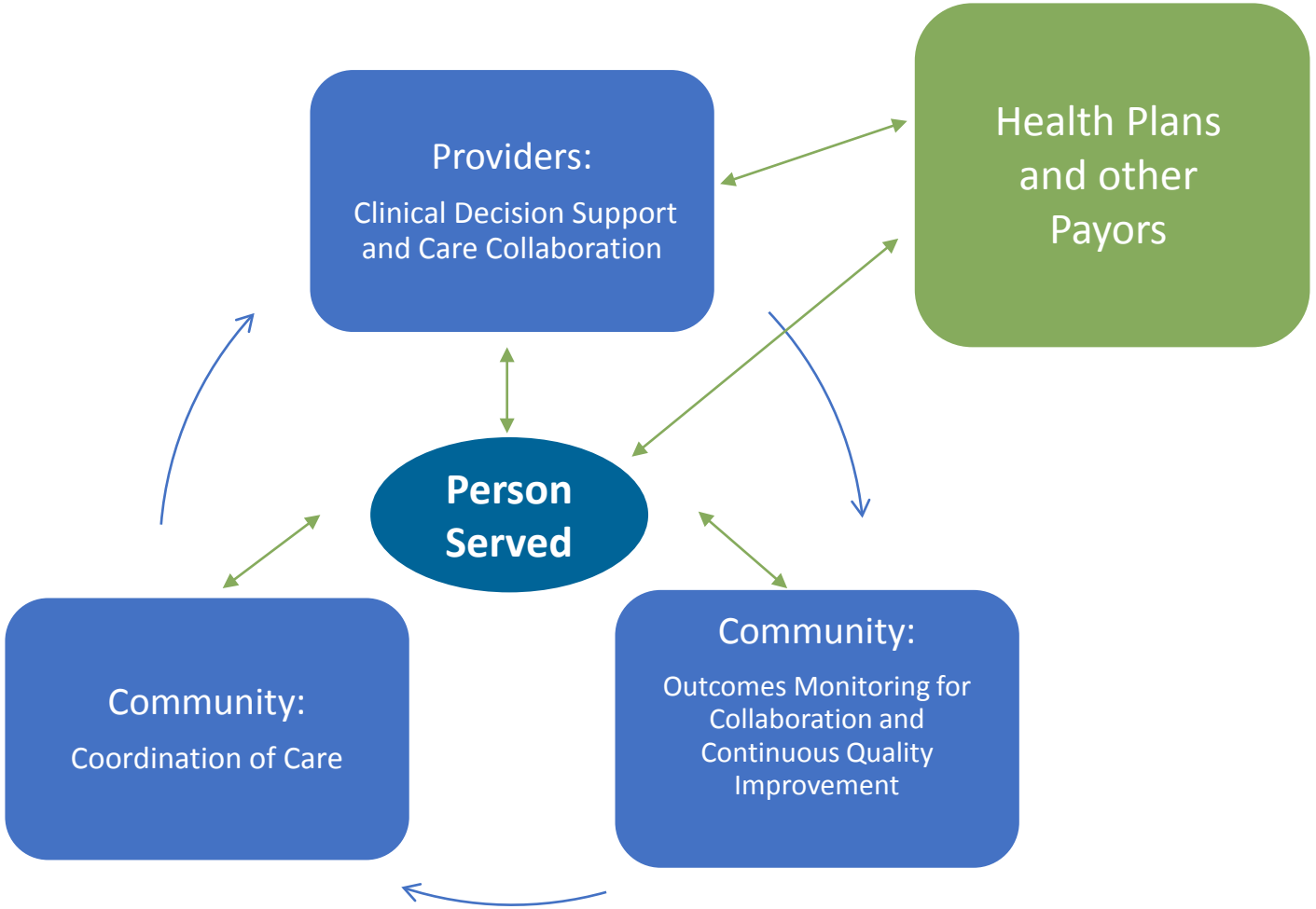
Data to Drive Effectiveness

TELL THE STORY:

- **THE PERSON SERVED AND**
- **THE COMMUNITY**



Information Sharing: Potential of the system to drive better care *depends on* data sharing and analysis capacity



DATA: UNIVERSAL SCREENING AND CARE COORDINATION

- Demographics including housing status
- Current medications
- Current and Recent History of Diagnosis(es); Presentation
- Case History Notes
- Treatment Plan Progress Updates
- Staff Involvement – All “touches”
- Common Services Used by Consumer
- On Call and Crisis Information

EFFECTIVE MODELS FOR COMPLEX CARE: COMMUNITY CONNECTION AND IMPACT

- Continuity of Care and Care Coordination
- Mobile, agile, no wrong door
- Community Re-Entry: Built for Success
- Universal Assessment and Care Plan; Alerts
- Pre-Discharge and Pre-Release Engagement

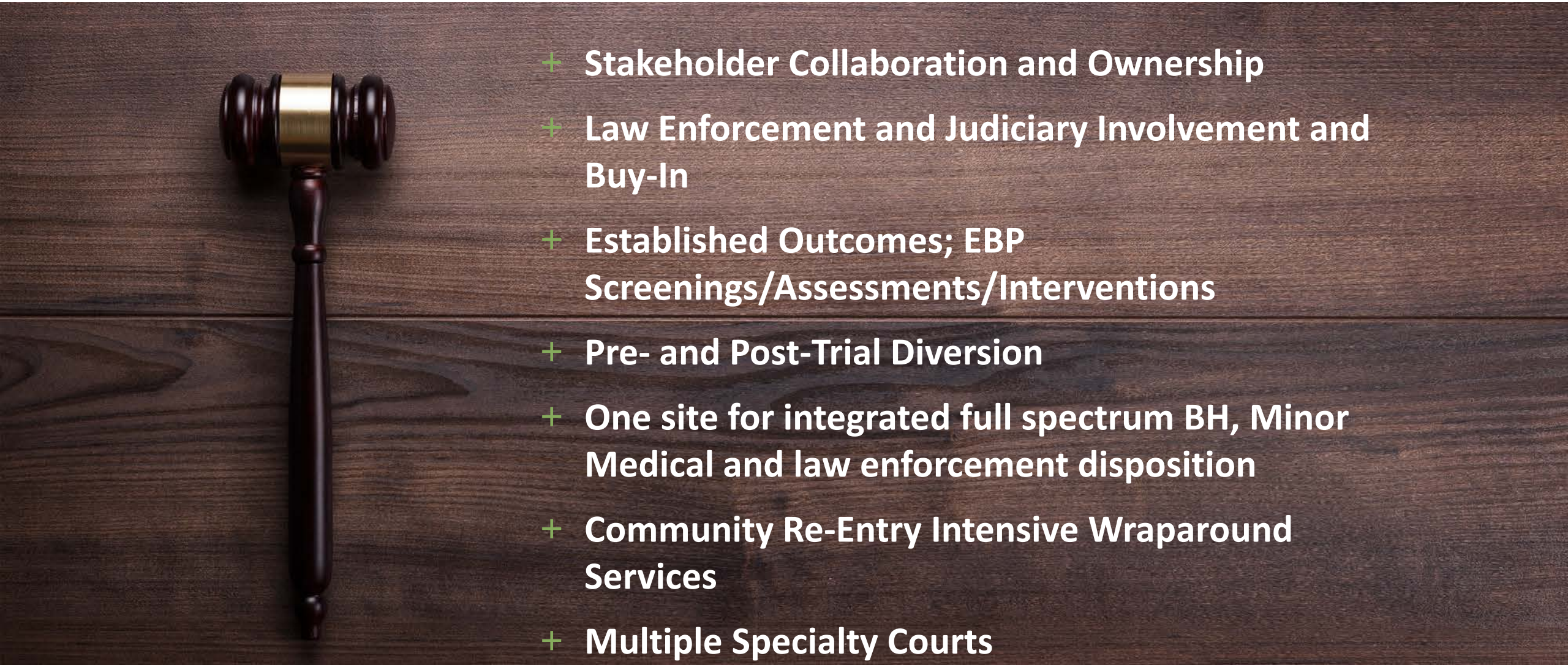
BEXAR COUNTY DIVERSION MODEL

DIVERSION BEFORE BOOKING: Magistrate or Judge receives recommendation for diversion to mental health treatment

DIVERSION AFTER BOOKING: Judge issues order for release to treatment from Jail. Public Recognizance bond valuable tool

COMMUNITY CONNECTION: Comprehensive coordinated services to support outcomes for Diversion and Re-Entry

BEXAR COUNTY BH JAIL DIVERSION: KEY MODEL COMPONENTS



- + Stakeholder Collaboration and Ownership
- + Law Enforcement and Judiciary Involvement and Buy-In
- + Established Outcomes; EBP Screenings/Assessments/Interventions
- + Pre- and Post-Trial Diversion
- + One site for integrated full spectrum BH, Minor Medical and law enforcement disposition
- + Community Re-Entry Intensive Wraparound Services
- + Multiple Specialty Courts

SUPER UTILIZERS in BEXAR COUNTY

2600 cases each year of “super utilizers”, most with co-morbid substance use disorders, living in poverty (200%FPL). Estimated costs reported for serving people with mental health disorders in the Bexar County Jail and local hospital emergency department – Totaling $82,637,141

SUCCESS: Model SU program served 320 of these individuals and was able to reduce ED and inpatient utilization by 60% after 90 days engaged in the program.

BEXAR COUNTY SUPER UTILIZER PROGRAM KEY MODEL COMPONENTS

- Person-Centered; Trauma-Informed
- Integrated Care Treatment Team – Clinic and Mobile/Field-Based
- Collaborative Care Model Implemented in a Fully Integrated Clinical Service Delivery System
- Community Connection: Communication and collaboration with hospitals, EMS, and law enforcement
- Strong data evaluation and sharing framework

BEXAR COUNTY DIVERSION and SUPER UTILIZER METRICS

- ED Utilization
- Behavioral Health-Related Hospitalizations
- Recidivism: Re-arrests; Re-Booking
- Jail Days
- Behavioral Health Crisis Encounters

Lessons Learned

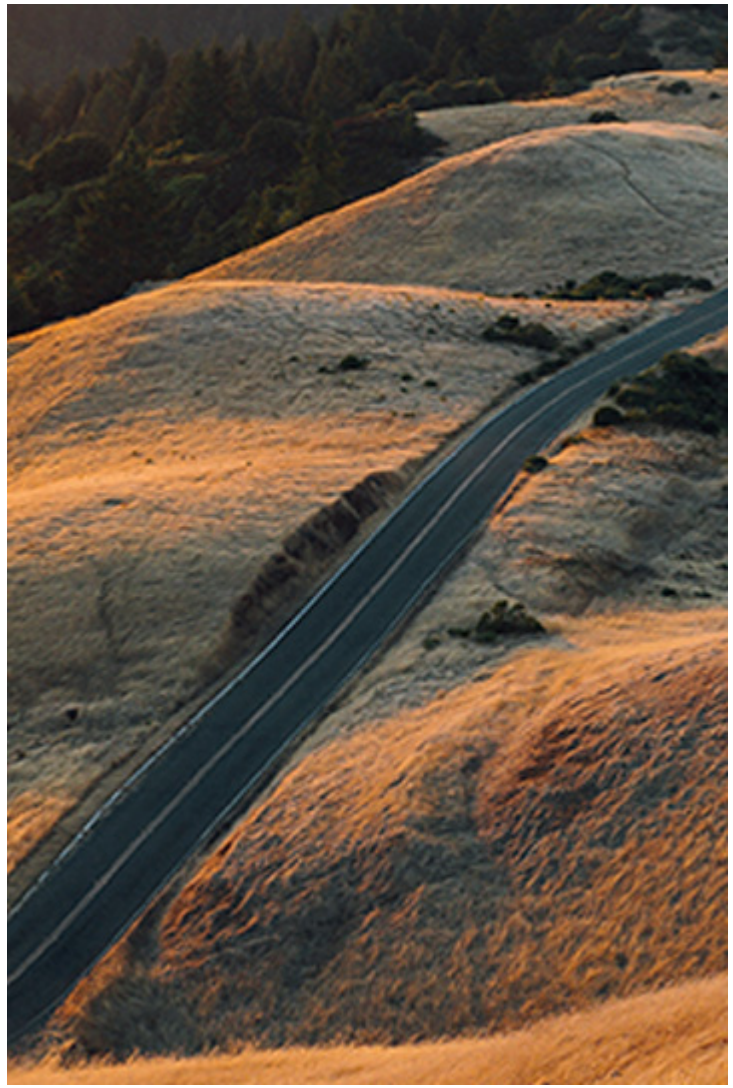
- Requires a champion and "front loaded" investment to launch and develop buy-in
- Solicit input through an established forum; report outcomes and monitor progress
- Establish strong data evaluation framework before initiating

- One Super Utilizer model worked with key community leaders of public and private providers of primary, tertiary, emergency and behavioral health care to identify points of intersection between physical and behavioral health
- Created a connected information system that assisted included sectors in the care of adults with severe mental illness and co-occurring substance abuse or physical health issues

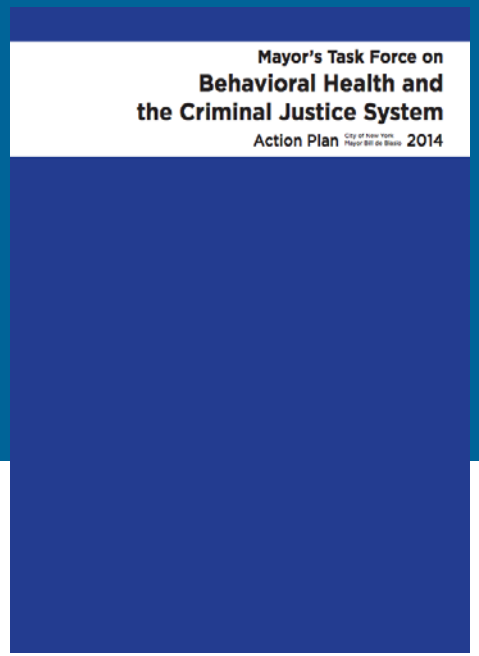
+ Created a Community Treatment Plan (CTP) including key universal data elements
+ The CTP was uploaded from the EHR into the HIE allowing EDs access to critical information on the Super Utilizer
+ HIE specific consents in addition to general consents were created in the EHR for the SU population, including an expiration timeframe to allow for evaluation purposes
+ HIE Community Participation and Partnerships
+ Using the HIE Alerts dashboard, case managers had near real-time information when their clients presented in the ED.

- HL7
- Mirth Connect
- Selenium IDE
- SQL Server Integration Services (SSIS)
- HIE Analytics & Alerts

- Looking Ahead
  - Partitioned Access for Law Enforcement and other groups that don't need full client information
  - Inform the community when needed without violating PHI regulations
  - Identify Partnerships
  - Continue to build on the established evaluation framework for participating consumers
    - Improvements at the individual level
    - Decrease in the use of EDs, Hospitalizations and Incarcerations
    - Increase in consumer engagement
    - Program costs and savings



2014: Decreasing jail population; increasing mental health population in jail



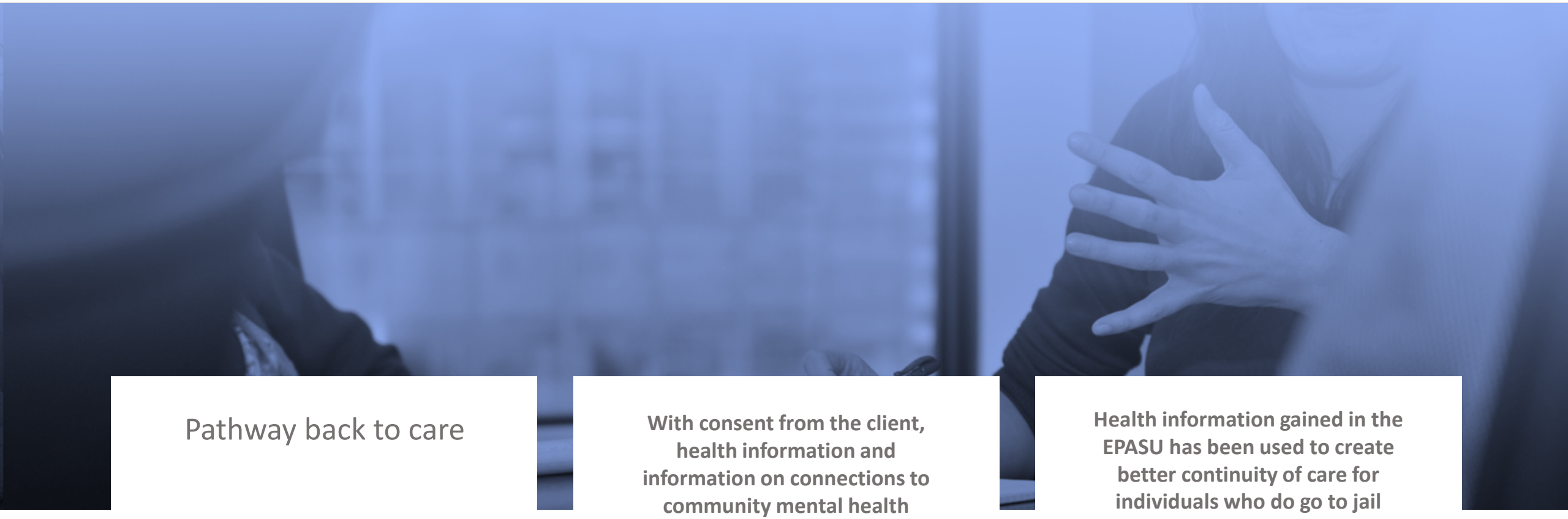
- "Action Plan" includes 24 recommendations along Sequential Intercept map for ensuring individuals with behavioral health needs
  - do not enter the criminal justice system in the first place;
  - if they do enter, that they are treated outside of a jail setting;
  - if they are in jail, that they receive treatment that is therapeutic rather than punitive in approach;
  - and that, upon release, they are connected to effective services.
- Best practice programs such as CIT, Public Health Diversion Centers, specialized treatment units in jail, and supportive housing

NYC: Enhanced Pre-Arraignment Screening and Diversion

New York City's Health + Hospitals --- the Correctional Health Services (CHS) entity in NYC--- implemented a behavioral health pilot program in called the Enhanced Pre-arraignment Screening Unit (EPASU).

- **Early identification of behavioral health need through comprehensive screening**
- **Electronic Health Records and Medicaid Claims systems show clinical needs and use of supportive services in community**
- **Mental Health staff ask about program involvement**
- **Immediate treatment of acute medical conditions saves trips to the hospital**

NYC: PRE-ARRAIGNMENT SCREENING AND DIVERSION



Pathway back to care

With consent from the client, health information and information on connections to community mental health programs has been used to advocate for release instead of jail

Health information gained in the EPASU has been used to create better continuity of care for individuals who do go to jail

Justice-Involved Supportive Housing (JISH)

High users of shelter and correction services

+ Department of Homeless Services and Department of Correction data
+ List of 200 individuals with at least 5 jail stays and 5 shelter stays over 4 years
+ High prevalence of mental illness and substance use disorder
+ 3 Non-profit organizations work with city agencies (health department, correctional health, department of homeless services, district attorneys office, etc.) to actively find eligible high-users

Based on the Frequent Users Service Enhancement (FUSE) model, which showed participants spent 146.7 fewer days in shelter and 19.2 fewer days incarcerated (40% reduction) than did a comparison group and to save $16,000 per individual in annual jail, shelter, and emergency room costs. 55% reduction in days in a psychiatric hospital over two years.

Process for finding a clients

- Daily match of JISH-eligible clients against jail and shelter rosters
- Client is matched with one of the JISH providers, screened, assessed and immediately receives case management (even before moving into an apartment)
- Client is given keys to an apartment and receives in-home visits from care managers

Lessons Learned

Best practices are not “one-size fits all”

Models should consist of a series of interconnected programs, not siloed by intercepts

HEALTH MANAGEMENT ASSOCIATES

Community Collaborative ASOCs

HEALTHCARE & SERVICE DELIVERY SYSTEM TRANSFORMATION:

APMs/VBP provides an opportunity to capture value – increased payment and reduced care costs with services that:

- **Help people stay out of the hospital**
- **Help people stay out of EDs**

- *Help people get jobs*
- *Help people get into and stay in school*
- *Help people get and stay housed*
- *Help people stay out of jails*

all of which also help people with the first two!

FOCUS ON VALUE

- Funding and payment models must shift from Fee for Service and Cost Reimbursement to value-based
- Healthcare providers, hospitals, health plans, EMS, law enforcement, government health officials, community based organizations can partner to mine value
  - Outcomes!!
    - Improved quality
    - Reduced costs

TAKEAWAYS

- **Volume → Value: Person-Centered System of Care**
- **Partnerships: Share risk and responsibility to share savings and improve outcomes**
- **Social determinants have a HUGE IMPACT on healthcare outcomes** (& must be taken into account when defining value and how to measure it)
- **Investment in infrastructure is not optional**
- **Opportunity awaits with careful planning**

Consultation and technical assistance for developing and implementing integration and complex care at all levels; provider, communities and states.

VBP Tool provides primary care and behavioral health providers with actionable information on their readiness to succeed under value-based payment and to identify critical gaps to address

+ Designed by **HMA** and **CohnReznick** in partnership with the **DC Primary Care Association**

QUESTIONS?

BREN MANAUGH
Principal, San Antonio
bmanaugh@healthmanagement.com

LAQUISHA GRANT
Senior Consultant, New York
lgrant@healthmanagement.com

AMANDA TERNAN
Senior Consultant, San Antonio
aternan@healthmanagement.com

HEALTH MANAGEMENT ASSOCIATES