Welcome to the New England QIN-QIO Webinar!

Thank you for joining. Our presentation will begin shortly.

If you haven’t already, please dial in to the audio line:

888-895-6448   Passcode: 122-8904

Slides may be downloaded at:
http://www.healthcarefornewengland.org/event/webinar-enhancing-transitions-through-a-collaborative-approach/
Enhancing Transitions Through a Collaborative Approach

Supporting Individuals with Behavioral Health Conditions Using Multidisciplinary Care Management within the Community

April 11, 2018 | 11:00am – 12:00pm

This material was prepared by the New England Quality Innovation Network-Quality Improvement Organization (NE QIN-QIO), the Medicare Quality Improvement Organization for New England, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. CMSMAC312018041389.
Speaker Disclosures

Today’s speakers have no conflicts of interest to disclose

In adherence to the regulation standards of the Connecticut Pharmacists Association, the Accreditation Council of Pharmacy Education, Northeast Multistate Division (NE-MSD) this notice confirms that the information contained in this presentation is free of commercial bias and the speakers have no related vested financial interest in any capacity, inclusion of shareholder, recipient of research grants, consulting or advisory committees.
Our speakers include program leaders from two Massachusetts Health Centers:

• Brookline Community Mental Health Center
• Lynn Community Health Center
HPC’s Health Care Innovation Investment Program

The Health Care Innovation Investment Program: $11.3M invested in innovative projects that further the HPC’s goal of **better health and better care at a lower cost.**

Health Care Innovation Investment Program
Round 1 – Three Pathways

- **Targeted Cost Challenge Investments (TCCI)**
- **Telemedicine Pilots**
- **Mother and Infant-Focused Neonatal Abstinence Syndrome (NAS) Interventions**

**Primary Goal:**
Lower Costs

- 8 diverse cost challenge areas:
  - SDH
  - BHI
  - VIC-Purchasers
  - VIC-Providers
  - Practice Pattern Variation
  - PAC
  - SAI & EOL
  - Site & Scope of Care

**Greater Access**

- Patients from the following categories with Behavioral Health needs:
  1. Children and Adolescents
  2. Older Adults Aging in Place
  3. Individuals with Substance Use Disorders (SUDs)

**Better Outcomes**

- Pregnant women with Opioid Use Disorder (OUD) and substance-exposed newborns

**100% of initiatives launched**

**100% of Initiatives launched**

**100% of Initiatives Launched**
Targeted Cost Challenge Investments (TCCI)

### Targeted Cost Challenge Investments Awardee Highlight: Brookline Community Mental Health Center

<table>
<thead>
<tr>
<th>Challenge Area</th>
<th>HPC Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Integration</td>
<td>$418,583</td>
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<table>
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<tr>
<th>Partners</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>- Beth Israel Deaconess Care Organization (BIDCO)</td>
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<tr>
<td>- Springwell ASAP</td>
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<table>
<thead>
<tr>
<th>Target Population</th>
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<tbody>
<tr>
<td>BIDCO patients over age 18 whose expenditures in the last year were ≥50% and who have a behavioral health condition with ≥1 of 7 chronic medical diagnoses:</td>
<td></td>
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<table>
<thead>
<tr>
<th>Primary Aim</th>
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<tbody>
<tr>
<td>Reduce total health care costs with a focus on chronic behavioral health issues.</td>
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</table>

<table>
<thead>
<tr>
<th>Service Model</th>
<th></th>
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<tbody>
<tr>
<td>Deploy a psychiatric case manager team that includes a social worker, primary care provider, and nurse.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Total Initiative Cost</th>
<th>Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$891,643</td>
<td>$6,630,724</td>
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</tbody>
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<table>
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<tr>
<th>Evidence Base</th>
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<tbody>
<tr>
<td>Healthy Lifestyles Program</td>
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Targeted Cost Challenge Investments Awardee Highlight: Lynn Community Health Center

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<th>Challenge Area</th>
<th>Site and Scope of Care</th>
<th>HPC Funding</th>
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<td>Provide intensive care coordination through community health workers who promote medication adherence and the consultation from clinical pharmacy services.</td>
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<th>Total Initiative Cost</th>
<th>Estimated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>$811,000</td>
<td>$1,400,000</td>
</tr>
</tbody>
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### Lynn Community Health Center

- Eisenhower Pathway to Health
- Test-driven program piloted in Lynn
- Multi-site implementation to include 15 additional sites and 1000 additional patients
Learning Objectives

- Describe the impact of behavioral health on healthcare utilization in New England,
- Explore approaches to addressing health-related social needs for patients with behavioral health conditions, and
- Identify required elements for a successful behavioral health integration/coordination model.
Chat in...

Introduce yourself...

please type in your name, organization and state....
Today’s Speakers

Hannah Scott, RN, BSN
Director of Care Integration
Brookline Community Mental Health Center

Henry White, MD
Clinical Director
Brookline Community Mental Health Center

Emily Johnson, LSW
Director of Community Outreach
Lynn Community Health Center
Setting the Context

Population rates of ED visits involving mental and substance use disorders, 2006-2013

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2006 and 2013
Why Behavioral Health Matters to the Public Health

• BH affects most Americans
• Increases risk for/co-exists with other diseases, yet is preventable

## New England Readmission Rates by Diagnosis using Quarter 3 2017 Claims Data

<table>
<thead>
<tr>
<th>Rank</th>
<th>Readmission Diagnosis Category</th>
<th>Number of Readmissions for Diagnoses</th>
<th>Total Readmissions</th>
<th>Percent of Total Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Septicemia (except in labor)</td>
<td>2179</td>
<td>24496</td>
<td>8.90%</td>
</tr>
<tr>
<td>2</td>
<td>Congestive heart failure</td>
<td>2062</td>
<td>24496</td>
<td>8.42%</td>
</tr>
<tr>
<td>3</td>
<td>Complications of surgical procedures or medical care</td>
<td>970</td>
<td>24496</td>
<td>3.96%</td>
</tr>
<tr>
<td>4</td>
<td>Mood disorders</td>
<td>931</td>
<td>24496</td>
<td>3.80%</td>
</tr>
<tr>
<td>5</td>
<td>Complication of device; implant or graft</td>
<td>901</td>
<td>24496</td>
<td>3.68%</td>
</tr>
<tr>
<td>6</td>
<td>Chronic obstructive pulmonary disease and bronchiectasis</td>
<td>839</td>
<td>24496</td>
<td>3.43%</td>
</tr>
<tr>
<td>7</td>
<td>Acute and unspecified renal failure</td>
<td>801</td>
<td>24496</td>
<td>3.27%</td>
</tr>
<tr>
<td>8</td>
<td>Cardiac dysrhythmias</td>
<td>711</td>
<td>24496</td>
<td>2.90%</td>
</tr>
<tr>
<td>9</td>
<td>Respiratory failure; insufficiency; arrest (adult)</td>
<td>625</td>
<td>24496</td>
<td>2.55%</td>
</tr>
<tr>
<td>10</td>
<td>Alcohol-related disorders</td>
<td>583</td>
<td>24496</td>
<td>2.38%</td>
</tr>
<tr>
<td>11</td>
<td>Schizophrenia and other psychotic disorders</td>
<td>573</td>
<td>24496</td>
<td>2.34%</td>
</tr>
</tbody>
</table>
### US Medicaid Readmissions

<table>
<thead>
<tr>
<th>Principal diagnosis for index hospital stay*</th>
<th>Number of all-cause, 30-day readmissions</th>
<th>Readmissions as a percentage of total Medicaid readmissions</th>
<th>Total cost of all-cause, 30-day readmissions (in millions), $</th>
<th>Readmission total cost as a percentage of total cost of Medicaid readmissions</th>
<th>Readmission rate (per 100 admissions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mood disorders</td>
<td>41,500</td>
<td>6.2</td>
<td>286</td>
<td>3.8</td>
<td>19.8</td>
</tr>
<tr>
<td>Schizophrenia and other psychotic disorders</td>
<td>35,000</td>
<td>5.3</td>
<td>302</td>
<td>4.0</td>
<td>24.9</td>
</tr>
<tr>
<td>Diabetes mellitus with complications</td>
<td>23,000</td>
<td>3.2</td>
<td>251</td>
<td>3.3</td>
<td>26.6</td>
</tr>
<tr>
<td>Other complications of pregnancy</td>
<td>21,500</td>
<td>3.2</td>
<td>223</td>
<td>1.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Alcohol-related disorders</td>
<td>20,000</td>
<td>3.1</td>
<td>187</td>
<td>1.9</td>
<td>26.1</td>
</tr>
<tr>
<td>Early or threatened labor</td>
<td>19,000</td>
<td>2.9</td>
<td>178</td>
<td>1.1</td>
<td>21.2</td>
</tr>
<tr>
<td>Congestive heart failure; nonhypertensive</td>
<td>18,000</td>
<td>2.8</td>
<td>273</td>
<td>3.6</td>
<td>30.4</td>
</tr>
<tr>
<td>Septicemia (except in labor)</td>
<td>17,600</td>
<td>2.6</td>
<td>319</td>
<td>4.2</td>
<td>23.8</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease and bronchiectasis</td>
<td>16,400</td>
<td>2.4</td>
<td>178</td>
<td>2.3</td>
<td>25.2</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>15,200</td>
<td>2.2</td>
<td>103</td>
<td>1.4</td>
<td>18.5</td>
</tr>
<tr>
<td>Total</td>
<td>230,200</td>
<td>34.1</td>
<td>2,061</td>
<td>27.1</td>
<td>20.0</td>
</tr>
</tbody>
</table>

*Hines et al. HCUP Statistical Brief #172. April 2014. Agency for Healthcare Research and Quality, Rockville, MD*
Medicare Beneficiaries Age 65+ With SMI and SUD Spending

Relative Per Capita Medicare Parts A and B Spending For Medicare Beneficiaries Aged 65+, By Number of Chronic Conditions and Severe Mental Illness Status, 2010

Dotted line represents average Medicare spending for all beneficiaries age 65 and over

Note: Spending is expressed as a multiple of the average Medicare spending for all beneficiaries aged 65+ with and without severe mental illness (SMI). Medicare Part A and B spending includes inpatient and outpatient hospital services, physician visits, home health, skilled nursing facility, durable medical equipment, hospice, and misc. services.

N = 22,166,860 Medicare beneficiaries age 65 and over without SMI, 1,356,980 with SMI, and 12,100 with both SMI and substance use disorder.
Chat in...

We’d like to hear from you...

How are you addressing your patients’ behavioral healthcare needs?
HEALTHY LIVES: Community-Based Care Coordination for Complex Patients

**Targeted Cost Challenge Investments Awardee Highlight:**
*Brookline Community Mental Health Center*

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**Target Population**
BIDCO patients over age 18 whose claims-based expenditures in the last year were at least $50,000, and who have a behavioral health condition and at least 1 of 7 chronic medical conditions.

**Primary Aim**
Reduce total health care expenditures for adults with a serious chronic medical condition and a behavioral health comorbidity by 15%.

**Partners**
- Beth Israel Deaconess Care Organization (BIDCO)
- Springwell ASAP

**Total Initiative Cost**
$598,445

**Estimated Savings**
$4,630,224

**Service Model**
Deploy a mobile multidisciplinary care management team including an RN care manager, a social worker, and CHWs to integrate behavioral health, primary care, and community services.

**Evidence Base**
Healthy Lives Program

Supported by a Health Care Innovation Investment grant from the Massachusetts Health Policy Commission.
HEALTHY LIVES: Community-Based Care Coordination for Complex Patients

Henry White, MD
Hannah Scott, RN, BSN
The patient population lies at the intersection of those with high medical needs, complicated behavioral health needs, and multiple needs related to the social determinants of health.
Most care for complex patients is delivered in segregated systems. Providers in each system work in isolated settings without inter-disciplinary communication or integrated care planning.
The TEAM

• Managed by a Nurse Care Manager or LICSW
• Consists of Bachelor’s Level Community Health Workers
• Share proficiency in medical, mental health, and social service expertise
The APPROACH

- Begin with patients in their home environments
- Goal: build a comprehensive understanding of the patient’s environment including family, friends, agencies, and providers
The INTERVENTION

- Form a team around the patient for long-term support
- Address all domains of health
- Connect providers and supports
- Create an integrated, shared understanding of the patient for all team members
The EXPERIENCE

“SUSAN”

- Low fixed income
- In danger of eviction
- Isolated/No social supports

- Diabetes
- Obesity
- Congestive Heart Failure
- Heavy Smoker

- Bipolar 1 Disorder
- Distrustful
- Poor executive functioning
The EXPERIENCE

INTERVENTIONS
- Consolidate debts
- Collaborate with housing
- Connect to service providers
- Meal Planning & Delivery
- Daily Weights
- Appointment Attendance
- Smoking Cessation
- Integration of Care Team
- Focus on Relationship Building
- Concrete Assistance w/Tasks
**Inpatient Utilization**  
(per patient/6 months)  
1.5 before  
1.2 after

**ED Utilization**  
(per patient/6 months)  
2.4 before  
1.6 after

**Hypertension**  
86% of patients improved  
Avg. Systolic Change = 35.4

**Diabetes**  
71% of patients improved  
Avg. A1c Change = 2.8%

**DNK’d Appointments**  
80% of patients decreased DNKs  
Avg. # of appt/year = 43  
Avg. Change = decreased by 27%

**(Net) Cost Savings**  
$21,768 per patient per year
A hierarchy of care coordination/care management services has been developed by healthcare systems.
In CONCLUSION

By creating a shared, integrated understanding of the patient and assembling a long-term care team for a patient’s comprehensive needs, health care costs are significantly decreased and patient health outcomes are improved.
contact us

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Hannah Scott, RN, BSN
Director of Care Integration
hannahscott@brooklinecenter.org
Targeted Cost Challenge Investments Awardee Highlight:
Lynn Community Health Center

**Lynn Community Health Center**

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**Target Population**
Primary care patients with a serious mental illness

**Primary Aim**
Reduce unnecessary health care utilization by 15%

**Partners**
- Eaton Apothecary
- Partners Connected Health
- Massachusetts Behavioral Health Partnership

**Service Model**
Provide intensive care coordination through community health workers who remotely monitor medication adherence with the consultation from clinical pharmacy services

**Total Initiative Cost**
$881,843

**Estimated Savings**
$1,400,000

**Evidence Base**
- Hints for You program piloted by NHP
- Meta-analyses of 16 cost-saving CHW demonstrations
- NAMI digital tech use amongst SMI population

Emily Johnson, LSW
Director of Community Outreach

*Supported by a Health Care Innovation Investment grant from the Massachusetts Health Policy Commission.*
Our Mission

Comprehensive health care of the highest quality to everyone in our community, regardless of ability to pay.
History

Lynn Community Health Center was established as a small storefront mental health clinic in 1971 in response to an almost complete lack of mental health services in our community. Since then, as the needs of our community have grown and changed, we have evolved to meet them.

Today we have more than 650 staff and 150 clinicians who provide primary medical care, dental care, behavioral health, eye care, pharmacy services, and social services to more than 40,000 patients at 20 locations in the City of Lynn.
Serving the Lynn Community
Addressing the needs of individuals with Serious Mental Illness (SMI)

Goal and Approach

REDUCE
Total Medical Expenditure (TME)

Leverage partners to reduce healthcare utilization
Our Interventions

- Comprehensive assessment
- Person-centered care plan
- Care coordination
- Medication reconciliation
- Simplified medication regimen
- Remote monitoring
- Supported medication adherence
Meet Mrs. X

• 54 yr old female
• Suffers from...
  – Schizophrenia
  – Post-Traumatic Stress Disorder
  – Type 2 Diabetes
  – Heart Murmur
  – Tobacco Abuse
Outcomes

- INCREASED engagement/participation in preventative medical and behavioral health care
- INCREASED awareness/opportunity to address social determinants
- INCREASED achievement of patient goals
- INCREASED detox utilization & increased length of sobriety
- REDUCED emergency department visits
- REDUCE hospital admissions

The most important lesson learned is to meet the patient where they are. Be sure to maintain a person centered approach
Contact Information:

Emily Johnson, LSW
Director of Community Outreach
Lynn Community Health Center
269 Union Street
Lynn, MA 01902

Phone: (781) 691-7169
Email: ejohnson@lchcnet.org
Enhancing Transitions Through a Collaborative Approach

Connecting Individuals with Mental and/or Behavioral Health Needs with Appropriate Care

~ Discussion & Questions~

Moderated by Stephanie Baker and Marghie Giuliano

Lynn Community Health Center
Emily Johnson, LSW

Brookline Community Mental Health Center
Hannah Scott, RN, BSN
Henry White, MD
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Continue The Conversation – Connect with the New England QIN-QIO on Social Media!