From Fragmentation to Integration: The North Carolina Center of Excellence for Integrated Care

Rowland-Hite Health Planning Seminar
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A legacy of separate and parallel systems

A forced choice between:
- Two kinds of problems
- Two kinds of clinicians
- Two kinds of clinics
- Two kinds of treatments
- Two kinds of insurance
Common clinical presentations don’t stay neatly in those medical or MH boxes.

Today, MH care is part of medical care.

- 70% of all PC patients present with psychosocial issues.
- 50% of all behavioral health care is provided by PCP’s.
- 67% of all psychoactive drugs are prescribed by PCP’s.

CJ Peek, PhD
Of patients presenting to primary care, 40% complained of:

- Headache
- Back pain
- Fatigue
- Abdominal pain
- Insomnia
- Edema
- Dizziness
- Shortness of breath
- Chest pain
- Numbness
Chronic Medical Conditions

• 125 of 276 million Americans suffer from one of four chronic diseases:
  – Diabetes
  – Heart Disease
  – Asthma
  – Major Depression

• 44% have more than one of these conditions.
Common Chronic Diseases and Depression

- **Diabetes**: 11-15%
- **Heart Disease**: 15-20%
- **Multi-Condition Seniors**: 23%
- **Stroke**: 30-50%
Untreated Depression = Higher Utilization and Health Care Costs

- Depressed patients:
  - Use 3 times more health care services
  - Have 7 times more ED visits
  - Have longer hospital stays
## Annual Medical Costs for Adults

<table>
<thead>
<tr>
<th>Condition</th>
<th>Without MH</th>
<th>With MH</th>
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<tbody>
<tr>
<td>All Adults</td>
<td>$1,913</td>
<td>$3,545</td>
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<tr>
<td>Heart Condition</td>
<td>$4,697</td>
<td>$6,919</td>
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<tr>
<td>HTN</td>
<td>$3,481</td>
<td>$5,492</td>
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<tr>
<td>Asthma</td>
<td>$2,908</td>
<td>$4,028</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$4,172</td>
<td>$5,559</td>
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ED Utilization

• NC: ED visits for patients with a BH/DD/SA diagnosis rose 11.3% in FY2007/8 and 12.4% in FY2008/9.

• Of more than 4M total ED visits, more than 500,000 were patients with BH issues.

• US: Up to 60% of US trauma patients tested positive for 1 or more intoxicants (2005).

• Of these, 1 in 4 had a second drug or alcohol-related injury in the same year.

NC Division of MH/DD/SAS ED Utilization Report; Maier, 2009
Behavioral health issues directly affect patient outcomes.

- Patients with serious behavioral health conditions die 25 years earlier than the general US population.
- Many patients with behavioral health conditions do not have a medical home.
- Behavioral health providers unevenly distributed: 20% of NC counties designated behavioral health shortage area.
- Coordination of care is impeded by state and federal law.
Reasons for separate and parallel systems are no longer relevant.

- Biological basis of many behavioral health and substance abuse conditions makes coordination essential.
- Patients with multiple chronic and behavioral health conditions require integrated management.
Integrated Care Works!

Randomized clinical control trials demonstrate:

- More effective medication management
- Reduced severity of depression
- Improved health status
- Decreased disability
- Better occupational function
- Improved patient satisfaction
- Cost-effectiveness

Katzelnick, et al, 2000
Examples of Cost Effectiveness

- 91 studies (1967-97) showed a medical cost offset averaging 20% when behavioral health was provided with medical treatment. (Chiles, et al., 1999)

- Behavioral health management of diabetic patients with psychological symptoms dropped care costs by $980 per patient during a 2-year period. (Annals of Family Medicine, 2005)

- SBIRT model for treating patients with risky drinking saved $4.30 for every $1 spent on treatment in EDs. (Massachusetts PH, 2009)
Patient Centered Care includes:

**INTERNAL COLLABORATION**

**CLINICAL**
- quality care
- patient driven

**OPERATIONAL**
- systems
- organization
- process improvement

**FINANCIAL**
- coding
- billing
- reimbursement
Patient Centered Care includes:

**ON-SITE Integrated Care Team**

- Physician
- NPs  PAs
- Receptionists
- Nurses and Medical Assistants
- Psychiatrists
- Behavioral Health Therapists
- Medical Records

All supported by:
- Common Chart
- Documentation Standards
- Billing Procedures
- Clinic Management System
Patient Centered Care includes: INTEGRATED CARE PROGRAM

Nurse screens patients at established visits and annual appointments.

Physician sees patient and validates screening.

Physician introduces patient and therapist.

Physician and therapist provide team approach for coordinated care.

Behavioral Health Services integrated with Primary Health Care:

- Screening
- Assessment
- Brief supportive counseling
- Therapy
- Case management
- Medication monitoring
- Coordinated team care
North Carolina’s Approach to Integrated Care

- In 2006, a large group of statewide organizations led by the NC Foundation for Advanced Health Programs created ICARE: Integrated, Collaborative, Accessible, Respectful, Evidence-Based.

Develop/adopt practice standards, protocols, algorithms, patient tools; develop & deliver training and TA; and pilot integrated care in primary care practices.
ICARE Funding Partners

- The Duke Endowment
- Kate B. Reynolds Charitable Trust
- AstraZeneca
- North Carolina AHEC Program
- NC DHHS, Office of Rural Health and Medicaid

- Clinical Protocols, Algorithms, Diagnostic/Screening Tools, County-Level MH Resources, Billing & Coding, Research
- Training Curricula (online and in person)
- 115 Trainings: Over 7,000 PCPs
- Online Training: 1,500 pts; Live Webinars: 1,000 pts
- Technical Assistance: 54 Practices
- 17 Pilot Demonstration Projects Across NC
A Broad Partnership

State Government
- Medicaid
- MH/DD/SAS
- Public Health
- Rural Health, Community Care of NC

Health Care Organizations
- NC Hospital Association
- NC Medical Society
- Governor’s Institute on Alcohol and Substance Abuse
- Mental Health Association of NC
- NC Community Health Care Alliance
- NC Council of Community Programs
- Carolinas Health Care System

Consumer Organizations
- NC NAMI
- ARC of NC

Professional Associations
- NC Academy of Family Physicians
- NC Pediatric Society
- NC Psychiatric Association
- NC National Assoc. of Social Workers
- NC Nurses Association
- NC Psychological Association

Medical Schools
- ECU Family Medicine
- Duke Dept. of Psychiatry
- Wake Forest Univ. Dept. of Pediatrics
State of NC: Transform ICARE into the NC Center of Excellence for Integrated Care

- Deploy ICARE’s tools, on-line training, techniques, and relationships to advance integrated care to:
  - Hospital EDs
  - Area mental health agencies and behavioral health providers (including reverse co-location)
  - Targeted case managers serving SPMI
  - Primary care practices
- Establish/adopt evidence-based clinical protocols and procedures to support integrated practice.
- Offer learning collaboratives and assist providers to implement integrated care.
Outcomes/Measures

• Medicaid data and chart reviews:
  – EDs: Use of behavioral health codes; disposition/referrals; length of stay in ED; incident reports of aggressive behavior; Rxns for opioids prescribed through ED; ED return visits, use of substance abuse and tobacco screens.
  – Medicaid patients w/ chronic MH/DD/SA: medical homes & annual exams.

• Improved HEDIS measures for SPMI Medicaid patients
  – Increased metabolic screenings for patients on atypical antipsychotics
  – Increased number of MH providers, PCPs, & EDs that adopt tobacco & SA screening
  – Increased number of targeted case managers who can deliver integrated assessments & care plans
Outcomes

• External Evaluator:
  – Number of primary care and behavioral health practices that integrate care
  – Pre-post site evaluations, patient and provider evaluations
Emergency Departments

Appalachian Regional Healthcare System
- Watauga
- Avery

University Health Systems of Eastern Carolina
- Hertford, Pitt

Haywood Regional Medical Center
- Haywood
- Jackson
- Swain

First Health of the Carolinas
- Montgomery
- Richmond
- Moore

Carteret General Hospital
- Carteret

Onslow Memorial Hospital
- Onslow
CHIPRA Connect

- State of NC subcontract to the Center of Excellence for TA to integrate primary care in pilot practices through 4 CCNC networks
- Focused on Children & Youth with Special Health Care Needs (CYSHCN)
  - PCP offices
  - Local health departments
  - Subspecialists
- Creating a true medical home for CYSHCN
CCNC Practices

Northwest Community Care Network
Surry, Forsythe

Sandhills Community Care Network
Richmond, Moore, Harnett

AccessCare Network Counties
Wayne

Community Care Plan of Eastern Carolina
Pitt, Beaufort, Pamlico
Governor Perdue’s Vision for Integrated Care…

• “My background in health care tells me it makes no sense to separate mental from physical care. The best research confirms that many patients have mixed mental and physical health issues.”

• She would like to “establish the national model for an integrated approach to behavioral and primary health services for patients with mental health, developmental disability and substance abuse problems.”
For more information: www.icarenc.org

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Collaboration
Affiliation
Innovation
Simple Logic # 1:

- If we invest our resources in prevention and chronic disease management we are more likely to keep people well;
- Being “well” involves more than physical health; it includes mental, behavioral, and social factors;
- If we keep people well they are likely to contribute more to the community and consume fewer health care resources over their lifetime.
Frequent users are defined as people who visit an ER five or more times a year.

An estimated $32 billion is wasted each year in the U.S. on inappropriate use of ERs when the same treatment from a primary care physician costs as much as 1/2 as in an ER.

Overall ED utilization rates in S.C. are increasing significantly faster than the national average and visits by frequent users comprise 21% of all visits to the ER.

The average total cost per patient incurred by frequent ER users in S.C. is over 15 times higher than the average cost per patient of non-frequent users.

Non-urgent use of the ER for ambulatory sensitive conditions is increasing rapidly and accounts for > 20% of all ER utilization.
Simple Logic # 2:

- A visit to the emergency room (ER) costs more than a visit to the doctor;
- A three-day hospital admission for uncontrolled diabetes or an asthma attack consumes more resources than all the costs associated with managing those conditions over an entire year; therefore,
- Providing the right care, at the right time, in the right setting will improve health outcomes and consume fewer health care resources.
Also known as Federally Qualified Health Centers or **FQHC**, community health centers were first funded in 1964 by the Office of Economic Opportunity.

“**The need is not for providing health care services to passive recipients; rather, the need is for the active involvement of the community in ways that will change their knowledge, attitude and motivation as it relates to their health and the health of the community**”
Community Health Centers: What They Are and Are Not

- FQHCs are not free clinics
- **They are a sustainable business model**
  - *From the beginning health centers have been expected to be sustainable community businesses that not only improve the health of those patients served, but also contribute the economic health and stability of the community.*
- FQHCs are not a state or federal agency or entity
- **Each FQHC organization is an independent, community-based non-profit corporation**
- FQHCs are not fully funded by the federal government
- **They are authorized under Section 330 of the Public Health Act to receive Federal grant funds which are used to offset the cost of providing care to uninsured and underinsured patients**
Health Center Revenue

Percent of Revenue

Federal Grant
Patient Revenues
Other Indigent Care
The Increasing Burden of Uninsured Patients:
Community Health Centers: What They Are and Are Not

- FQHCs are not a clinic for the poor
- They are a comprehensive high quality primary care practice with a proven history of improving health outcomes and providing care in a cost effective manner
  - Provide a wide range of enabling services designed to reduce barriers to care and address the social determinants of health
  - Excel at care coordination and chronic disease management
  - Have been collecting and reporting data on improved clinical outcomes since before 2000
Financial Impact

- Today, health centers save over $1,200 per patients annually in total care costs ($4,043 vs. $5,306 for non-health center users)
- The nation’s 1,200 health center organizations—which operate in 8,000 communities and serve as the health care home for over 20 million patients—provide over $20 billion in economic activity in their communities annually
- Health centers account for nearly 200,000 jobs in those 8,000 communities
Section 330 Health Center Program Expectations

- Community based and community oriented;
- Located in a Medically Underserved Area (MUA) or serving a Medically Underserved Population (MUP);
- Provide comprehensive primary and preventive care, including oral and mental health/substance abuse services to persons of all ages regardless of their ability to pay;
- Offer an income based sliding fee scale for all eligible patients;
- Ensure access to a full continuum of care including professional coverage when the health center is closed;
Section 330 Health Center Program Expectations
(continued)

- Provide a wide range of “enabling” services as needed to minimize barriers and positively impact health outcomes. These services include but are not limited to:
  - Case Management and Care Coordination
  - Language services
  - Transportation
  - Patient Education
  - Eligibility Assistance

- Employ (or contract with) qualified providers and maintain strict adherence to established credentialing criteria; and

- Maintain a comprehensive, proactive Quality Management Program including the systematic collection of data and implementation of evidence based chronic disease management protocols.
Benefits Associated with FQHC Designation

- Access to Federal grants
- Fair Medicaid/Medicare reimbursement;
- Access to favorable drug pricing under Section 340B of the Public Health Service Act;
- Coverage under the Federal Tort Claims Act (FTCA) in lieu of purchasing malpractice insurance;
- Access to providers through the National Health Service Corps
- Safe Harbor under the Federal anti-kickback statute for certain arrangements with other providers or suppliers of goods, services, donations, loans, etc., which benefit the medically underserved population served by the FQHC;
- Reimbursement by Medicare for "first dollar" of services rendered to Medicare beneficiaries, i.e., deductible is waived
The Benefits of Community Collaboration

- Expand and enhance the amount, type and quality of services available
- Enhance the continuum of care and reduce service gaps
- Expand access locations and patient bases
- Maintain and improve the ability to deliver care at an appropriate level of care
- Enhance and improve clinical, administrative and managerial capacities, resources, expertise and systems
- Minimize risks and reduce operational costs
  - “loss avoidance”
- Increase capital and financial support
Driving Forces: New Models of Care

- **Accountable Care Organization:**
  - Group of providers jointly responsible for the quality and cost of healthcare services for a population of patients
  - Combination of one or more hospitals, physician groups (primary care and specialty), and other providers
  - Financial incentives to meet quality benchmarks or cost-savings
  - Shared governance structure
  - Formal legal structure that allows organization to receive and distribute payments for shared savings to participating providers
  - Leadership and management structure that includes clinical and administrative systems

- **Patient-Centered Medical Homes:**
  - Personal physicians
  - Whole person orientation
  - Coordinated and integrated care
  - Safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements
  - Expanded access to care
  - Payment that recognizes added value from additional components of patient-centered care
Community Transformation Grants
- Funds to support evidence-based prevention and wellness services
- Goal is to reduce chronic disease rates, and to address disparities, especially in rural areas

Community-Based Collaborative Care Networks
- Grants to support community-based collaborative care networks to provide comprehensive coordinated and integrated health care services for low income populations
  - Consortium of health care providers with joint governance structure; must include a hospital and all FQHCs located in the community

Community Health Teams and Patient-Centered Medical Homes
- Grants or contracts with States to create “health teams” that contract with PCPs to provide primary care support services and to support patient-centered medical homes

Individualized Wellness Plan
- Funds to 10 FQHC grantees to provide patients with an individualized wellness plan designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment
New Models of Care: Payment and Delivery System Reforms

- **Center for Medicare and Medicaid Innovation (CMI)**
  - Begins January 1, 2011
  - $10 billion appropriated during FY 2011-2019
  - Tests innovative payment and service delivery models to reduce program expenditures while preserving or enhancing quality of care
  - Preference for models that improve the coordination, quality, and efficiency of healthcare services
  - Models should address the needs of defined populations for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures
New Models of Care: Payment and Delivery System Reforms

- **Medicaid Global Payment System Demonstration**
  - Up to five states
  - States may adjust payments to eligible safety net hospital systems or networks from a FFS structure to a global capitated payment model

- **Medicare Pilot Testing of Bundled Payments**
  - An eligible entity consists of providers and suppliers, including a hospital, physician group, a SNF, and a home health agency
  - Bundled payment would cover costs of all services furnished to a beneficiary during an episode of care

- **Medicare Shared Saving (ACO) Program**
  - Participating ACOs will be eligible to receive payments for shared savings if it achieves quality and cost containment standards
Range of Collaboration Options

- Referral agreement(s)
- Co-location
- Acquisition of primary care practices
- Management Service arrangements
- Lease of clinical personnel, administrative support staff, space and equipment
- Residency Training arrangements
- Emergency Room Alternatives programs a.k.a Medical Home Referral Collaboratives
- Formation of new entities
LAURENS COUNTY
COMMUNITY CARE CENTER

A collaborative project of Carolina Health Centers, Inc. and Laurens County Health Care System
Goals:

- Improve accessibility and affordability of primary care and reduce the demand for primary care in the LCHCS Emergency Department; thereby:
  - Improving health outcomes through more appropriate health management;
  - Redirecting the use of ER resources to the appropriate level of care; and
  - Minimizing financial losses.
Supporting Data:

- 30,000 visits to LCHCS Emergency Department annually
- 75% coded as Level I or Level II
  - Many patients have poorly managed chronic disease
  - Many patients present with mental/behavioral health symptoms
- Lower acuity patients present routinely from 10AM until 10PM
- Survey of ED patients

Findings:
- General shortage of primary care providers
- Large number of primary care providers limiting uninsured and Medicaid
- Lack of affordable primary care services
- Services not accessible when needed
Laurens County Community Care Center

- New primary care practice site of Carolina Health Centers, Inc.
- Co-located with the new LCHCS Emergency Department
- Full range of medical home primary care services
  - Behavioral health services provided through an existing integrated model with Beckman Center for mental Health with acute services provided through LCHCS ER/tele-psychiatry program
  - Oral health services provided through “voucher program” using local contracted dentists
- Non-traditional office hours
- Collaboratively developed referral protocols to facilitate patient receiving the appropriate level of care in the appropriate setting
- Care coordination and patient education to promote use of a primary care medical home
- Affiliation agreements with the existing medical community to ensure the integrity of existing patient/provider relationships
- Phased in implementation beginning mid-2011
A few critical success factors in collaborating with an FQHC

- FQHC are sustainable businesses with considerable expertise and economic impact
- Collaboration presents an opportunity to maximize FQHC benefits in your community
- An FQHC doesn’t have just one dance partner
- There is no one collaboration/affiliation model that fits all communities
- Success in the future does not necessarily require corporate integration – we can achieve the same outcomes through clinical integration and operation affiliation
UNIQUE COLLABORATION WITH A FEDERALLY QUALIFIED HEALTH CENTER
COLLABORATION TIME LINE

1. HISTORY
2. MEDICALLY UNDERSERVED POPULATION
3. EMERGENCY DEPARTMENT PROJECT
4. IMPROVING ACCESS
5. BUILDING MEDICAL HOMES
6. SPECIALTY SERVICES
7. MEDICAL STAFF REACTION
HISTORY

- TWO YEARS AGO APPROACHED BY CHC TO CONSIDER A COLLABORATIVE PARTNERSHIP
- 1989 - 9 BED ED FOR 12,000 ANNUAL VISITS
- 2010 - 9 BED ED FOR 31,000 ANNUAL VISITS
- BEHAVIORAL HEALTH HOLDS
- 16,000 RESIDENTS OF LAURENS COUNTY UNINSURED
MUP DESIGNATION

- FQHC IS A FEDERAL DESIGNATION FROM THE BUREAU OF PRIMARY HEALTH CARE AND CMS ASSIGNED TO PRIVATE NON-PROFIT OR PUBLIC HEALTH CARE ORGANIZATIONS THAT SERVE PREDOMINATELY UNINSURED OR MEDICALLY UNDERSERVED POPULATIONS.

- MUA vs. MUP
EMERGENCY DEPARTMENT PROJECT

- TOO MUCH USE AS A PRIMARY CARE MEDICAL HOME
- REDESIGNED PROCESSES
- ADD BEHAVIORAL HEALTH HOLDING ROOMS
- TELEPSYCHIATRY
- NEW ED – 19 ROOMS (3 BEHAVIORAL HEALTH)
- USE OF OLD ED?
IMPROVING ACCESS AND BUILDING MEDICAL HOMES

- For those patients who do not have a regular PCP, the FQHC is an opportunity to establish a medical home where comprehensive prevention, primary care and chronic disease management services are provided.

- Address acute care needs during non-traditional hours in non-ED setting.
SPECIALTY SERVICES

- OPPORTUNITY FOR ORTHOPEDICS
- OPPORTUNITY FOR PEDIATRICS
- OPPORTUNITY FOR OB/GYN
- OPPORTUNITY TO COORDINATE WITH PCP’S
MEDICAL STAFF REACTION

- Unclear understanding about FQHC’s competition!
- Existing RHC designations
- ED physicians role
- Collectively changing behavior of generations of patients and families who use the ED as their primary medical home
IMPLEMENTATION PLAN

- TEMPORARY SITE
- CHC GRANT APPLICATION
- TRANSITION TO FULL PRACTICE
- EMTALA???