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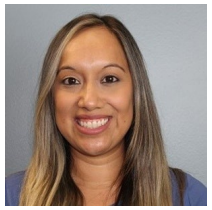
Lesson Objectives

1. Understand the separate systems of Health and Mental Health
2. Understand the role of Integrated primary and behavioral healthcare
3. Describe the Cost of Care & Health disparities of not treating the whole person
4. Understand the consequences of unmet – whole care needs
5. Describe SDOH and Health related disparities
6. Understand the metrics, methods and approaches to establish a behavioral health home
7. Describe some of the benefits of the Harris Center Integrated Behavioral Health Home from the outcome data and member experiences.

Integrated Health Homes & Value Based Care

Key Lessons and Outcomes

Dr. Stanley Williams, PhD Director of Integrated Health



Janeth Martinez, MA, LPC
Project Director Integrated Health Certified Community Behavioral Health Clinic (CCBHC) Expansion Program

Dr. Stanley Williams, PhD
Director of Integrated Health

Theresa Pettigrew - Beason, LPC-S
Practice Manager Optum Project Integrated Care Health Home

Texas Gulf Coast HFMA 2024 Winter Conference

The Harris Center

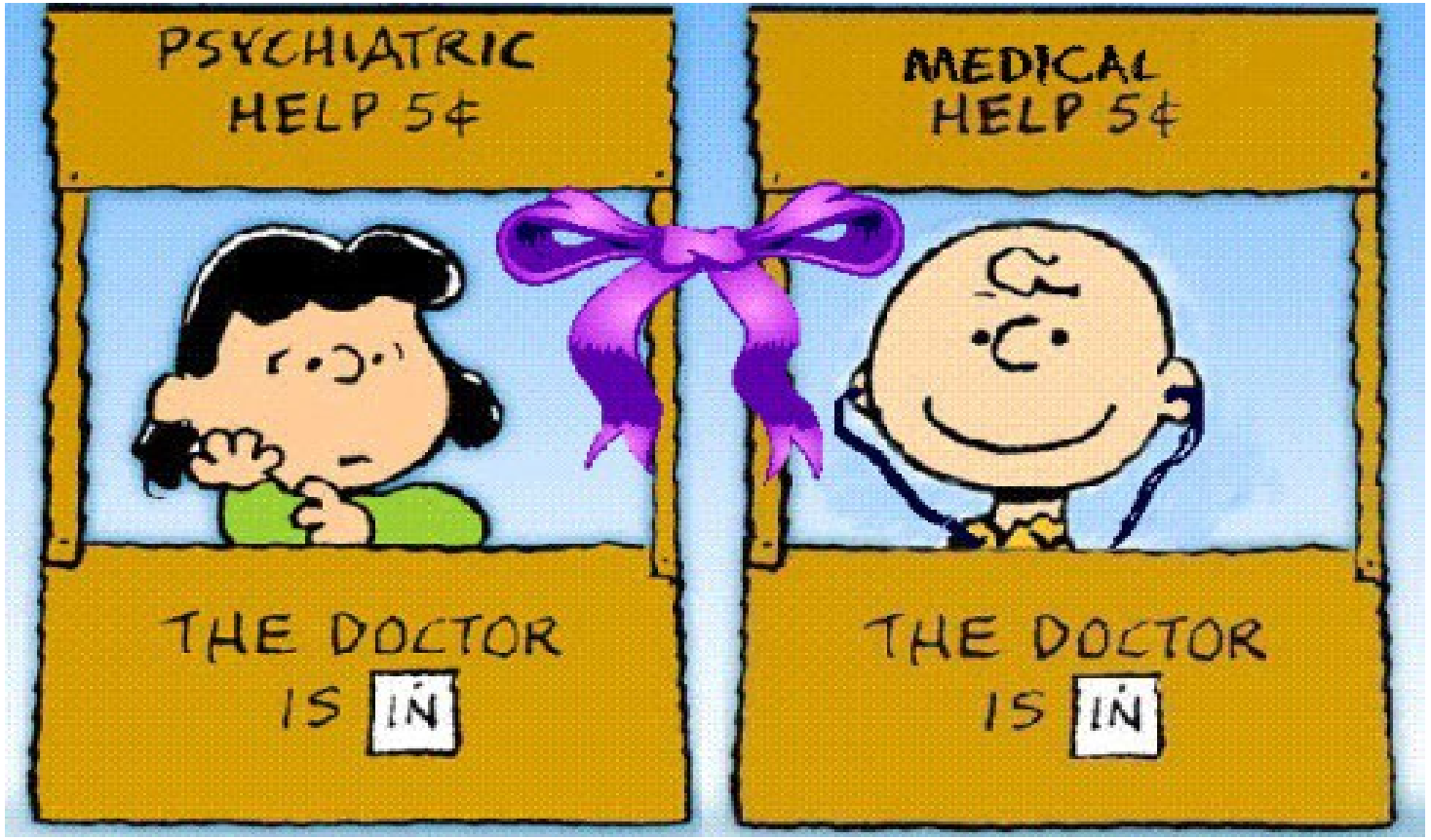
Houston, TX

As the largest behavioral and developmental disability care center in Texas, The Harris Center provides a full continuum of services to 88 sites across Harris County and serves over 80,000 individuals annually.

Services are offered in over 40+ languages to better serve one of the most diverse and multi-cultural communities in the nation.

The Harris Center is the state-designated Local Mental Health Authority and the Local Intellectual and Developmental Disability Authority serving Harris County, Texas.

Integrated Care's Legacy of Separate and Parallel Systems



Separate and Parallel Systems: Challenges

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Medical Care

Mental Health Care

A forced choice between:

- 2 kinds of problems
- 2 kinds of clinicians
- 2 kinds of clinics
- 2 kinds of treatments
- 2 kinds of insurance

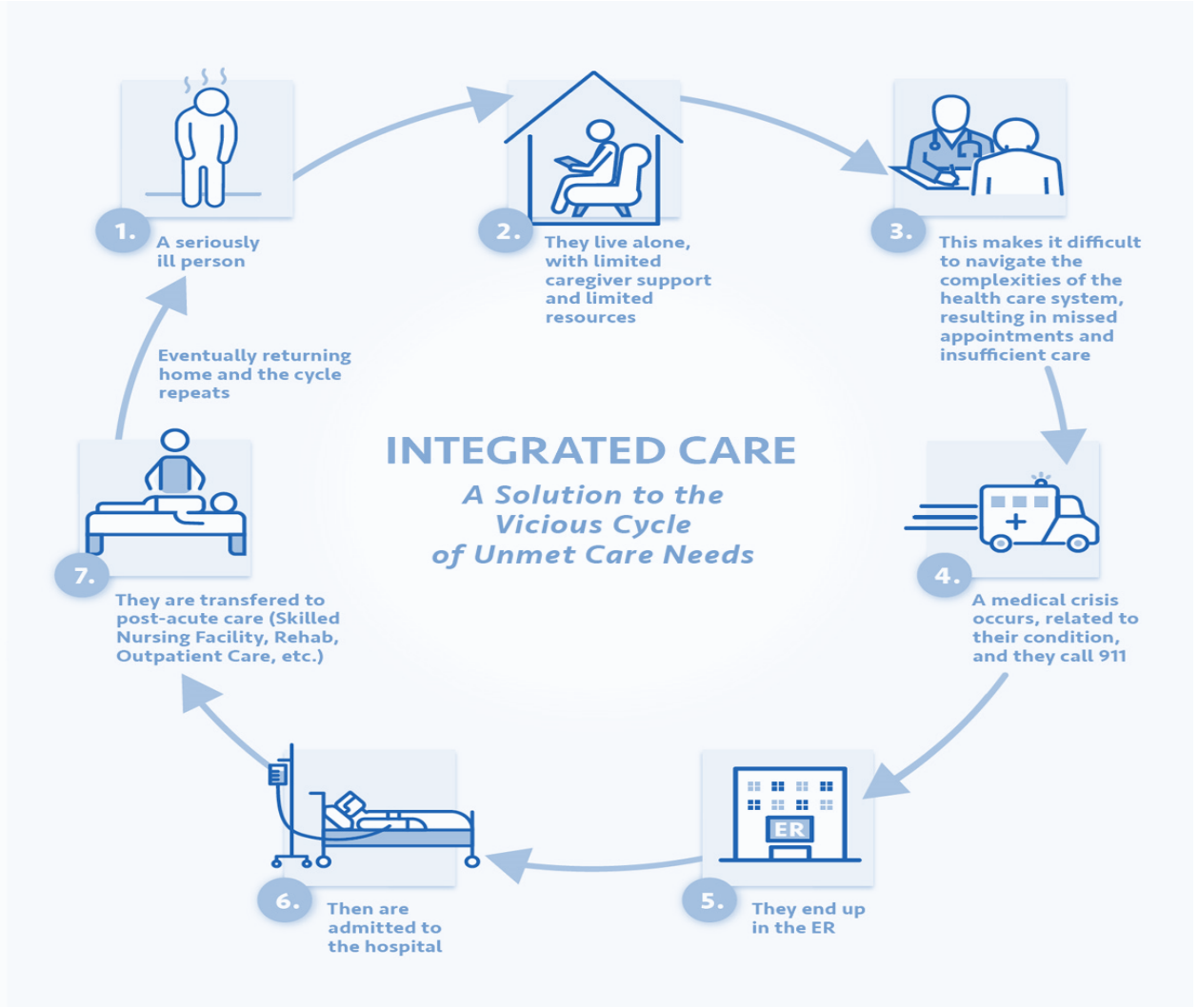
Integrated behavioral health leads to a better match of clinical services to the realities that patients and their clinicians face daily.

Original Source: CJ Peek 1996

People with Serious Mental Health & Co-Occurring Chronic Health Conditions – Vicious Cycle of Unmet Needs -

Some believe that the lack of proper care addressing SDOH and integrated health of people with behavioral health conditions results in Health Disparities

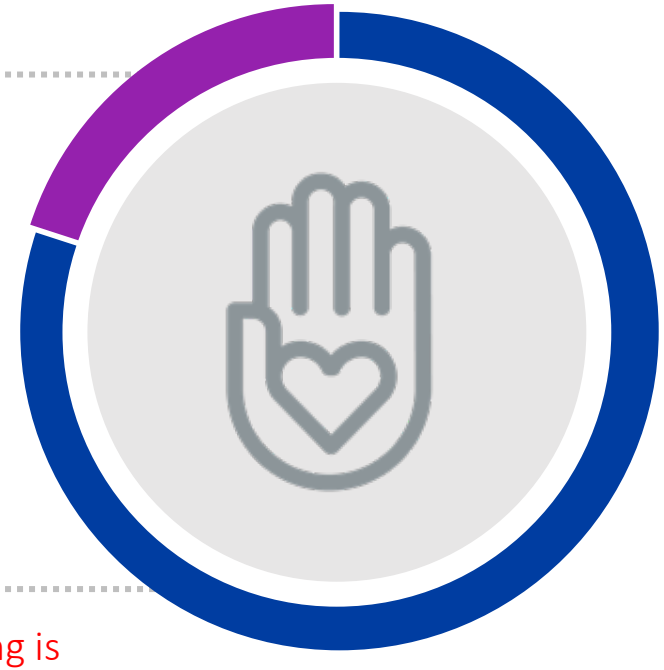
Improper Treatment Leads to Iatrogenic disease:
Any adverse conditions in a patient occurring as a result of treatment that does not incorporate the proper diagnosis, manner of treatment, failure to address conditions and problems.



Social Determinants of Health by the numbers

20%

of health outcomes can be directly attributed to clinical care[1]



80%

of health and wellbeing is tied to social and economic factors, physical environment and health behaviors[1]

91%

of Medicaid plans report activities to address social determinants of health[2]

19

states require Medicaid managed care plans to screen for and/or provide referrals for social needs[2]

85%

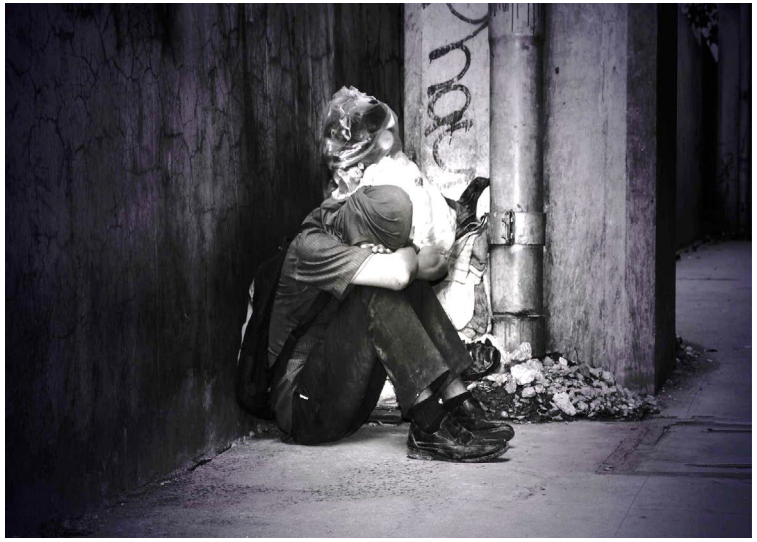
of physicians' report that unmet social needs lead to poorer health outcomes[3]

20%

of physicians are confident in their ability to address unmet social needs[3]

[1] Robert Wood Johnson Foundation, County Health Rankings, "Relationships between Determinant Factors and Health Outcomes"
[2] Kaiser Family Foundation, "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity"
[3] Robert Wood Johnson Foundation, "Health Care's Blind Side"

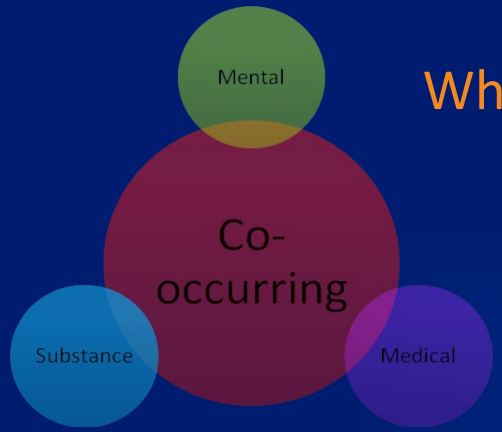
Unmet Integrative Health Needs Poor Access – Integrative Care –



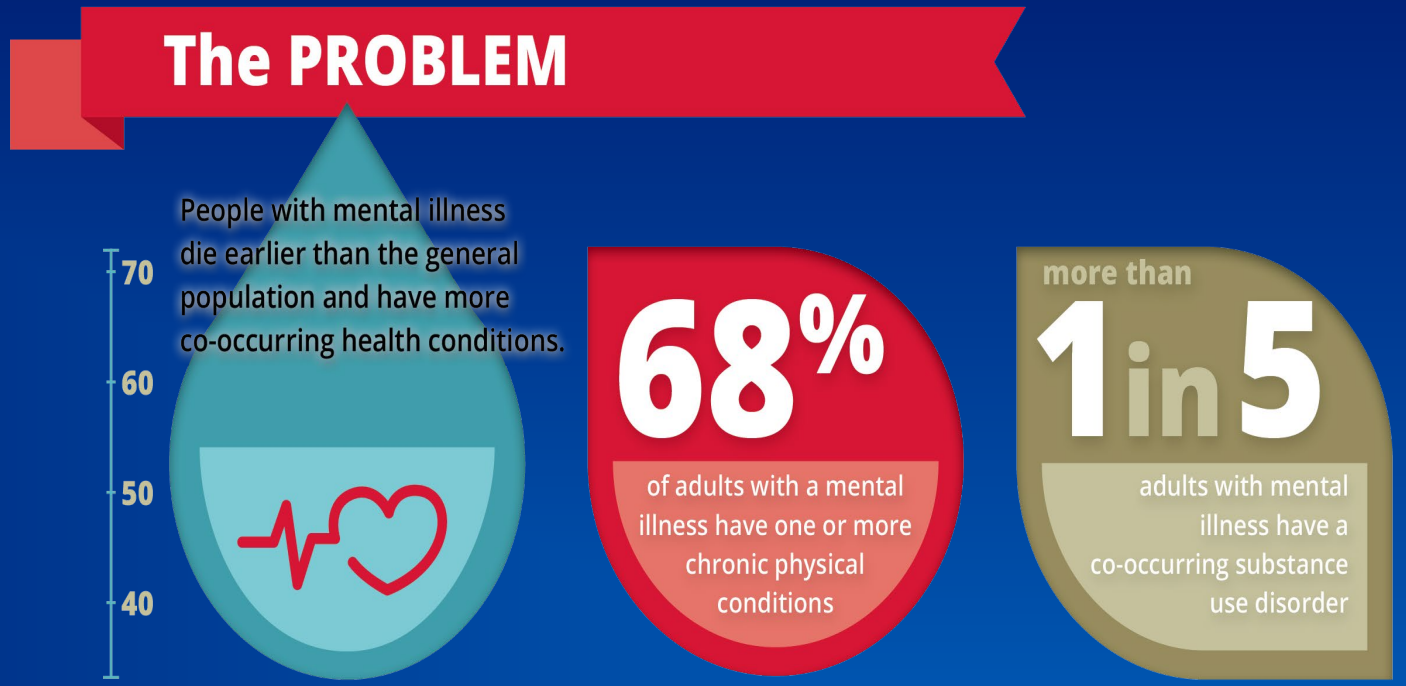
- 67% with a behavioral health disorder do not get behavioral health treatment[1]
- 30-50% of referrals from primary care to an outpatient behavioral health clinic don't make first appt[2,3]
- Two-thirds of primary care physicians (N=6,660) reported not being able to access outpatient behavioral health for their patients due to: Shortages of mental health care providers, health plan barriers, and lack of coverage or inadequate coverage, untreated substance abuse mental health services within health settings [1,2,3, 4]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom, Arch Intern Med. 1997;6:324-333.
3. Hoge et al., JAMA. 2006;95:1023-1032.
4. Cunningham, Health Affairs. 2009; 3:w490-w501.

Why Behavioral Health Practitioners Need Competency in Integrated Behavioral Health Care



- Individuals with SMI die on average at the age of 53 years old
- Have elevated (and often undiagnosed) rates of:
  - hypertension,
  - diabetes,
  - obesity
  - cardiovascular disease
- Patient Challenges- SMI hampers self-care, medication compliance, adherence to primary care & medical treatment plans



Chronic conditions and comorbid psychological disorders Milliman Research Report. July 2008

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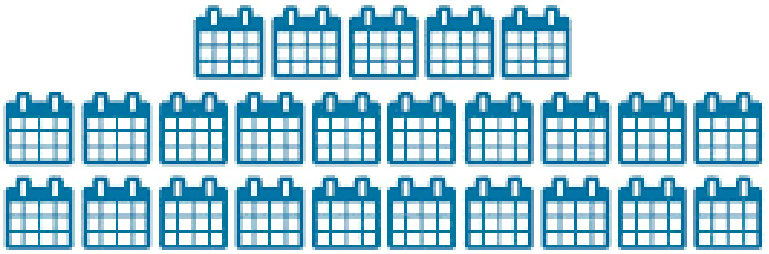
Health Disparities associated with unmet integrated health

- *Access problems*
- High rates of physical illness with mental illness
- Premature mortality
- People with mental illness receive a lower quality of care in primary care settings
- High cost of physical illness with mental illness

Definition of Health Disparities “Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific (racial and ethnic, cultural, gender) populations in the United States. ”

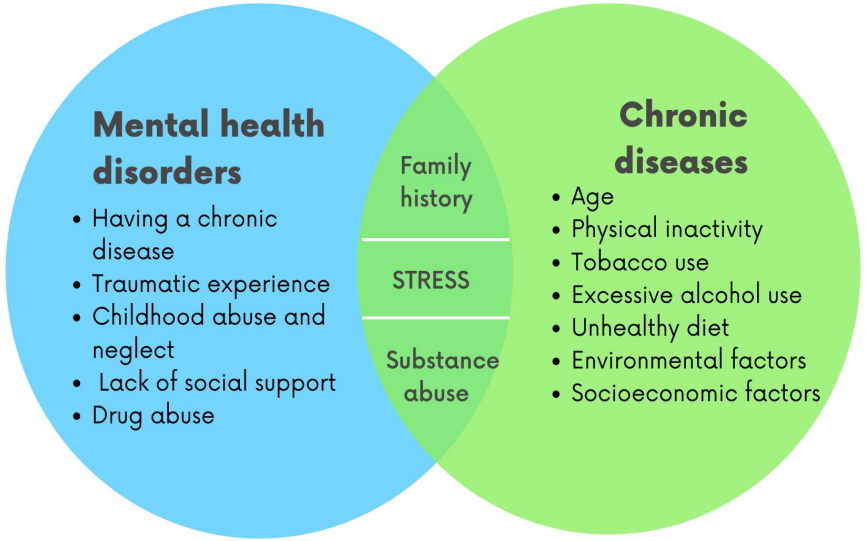
Populations in which disparities exist experience worse outcomes for chronic conditions, have higher health care cost, experience lower quality of life



25 years

Average span by which American adults with serious mental illness die earlier than others

– National Alliance on Mental Illness



Source: CDC, https://www.cdc.gov/chronicdisease/resources/infographic/chronic-diseases.htm

Rationale for Integrative Behavioral Health Home Approach

People with serious mental illness (SMI) are dying 25 years earlier than the general population.

2/3 of premature deaths are due to preventable/treatable medical conditions such as cardiovascular, pulmonary, and infectious diseases.

44% of all cigarettes consumed nationally are smoked by people with SMI.

See www.nasmhpd.org for Morbidity And Mortality In People With Serious Mental Illness report (2006)

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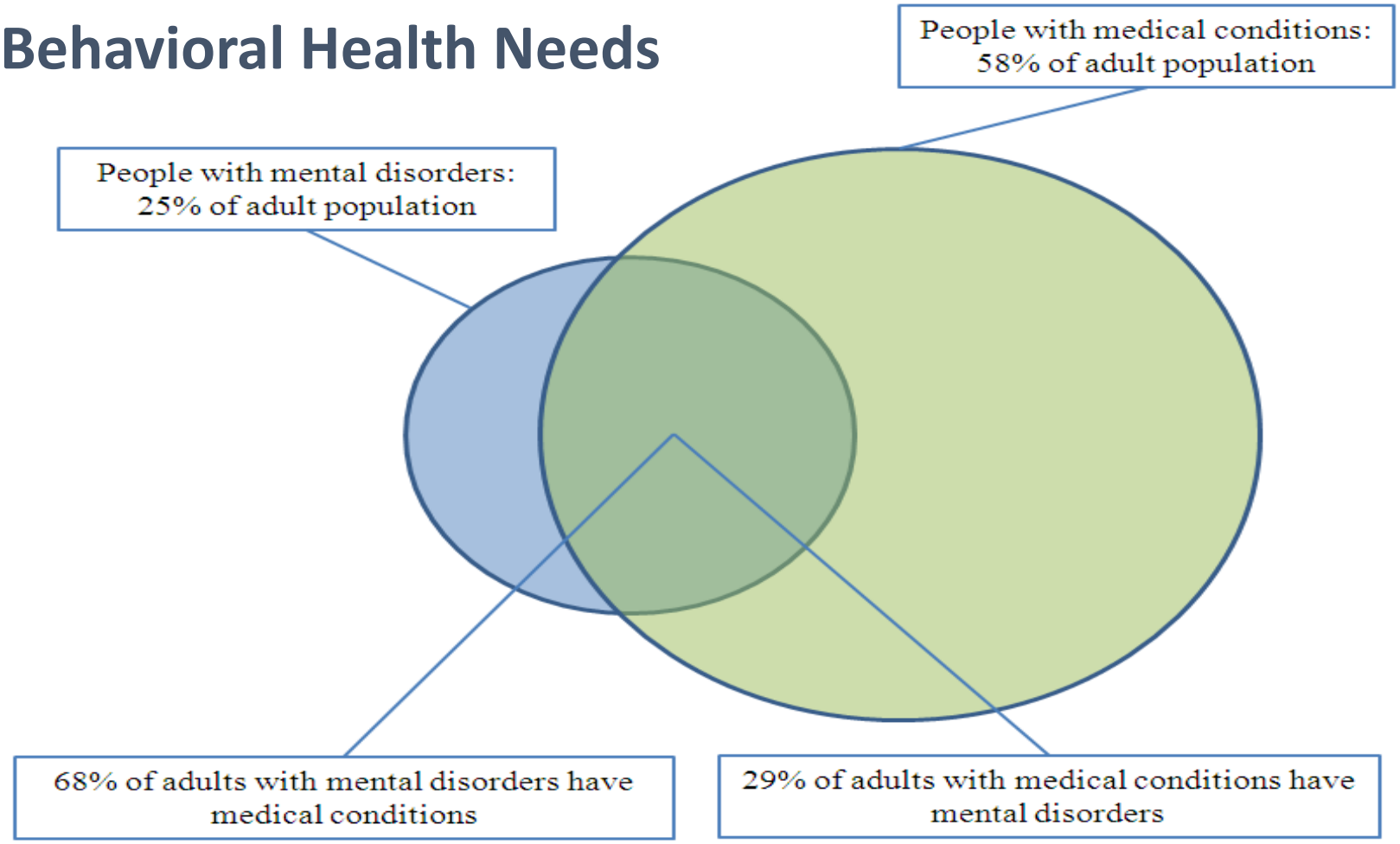
Unmet Behavioral Health Needs



Source: AHRQ, The Academy Integration Map. Accessed September 2014.
http://integrationacademy.ahrq.gov/ahrq_map

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Disproportionate Cost Burden

- Over half of all Medicaid beneficiaries with disabilities are diagnosed with mental illness
- For those with chronic conditions health care costs are as much as 75% higher for those with a mental illness – with the rates for those with a co-occurring substance use disorder resulting in a two to three fold cost increase
- Among those eligible for both Medicaid and Medicare 44% have 1 mental health diagnosis 20% have more than 1 mental health diagnosis[1] (Integrated Care Resource Center, 2011, p. 1).

Trends and Data Associated with Mental Health and Chronic Diseases

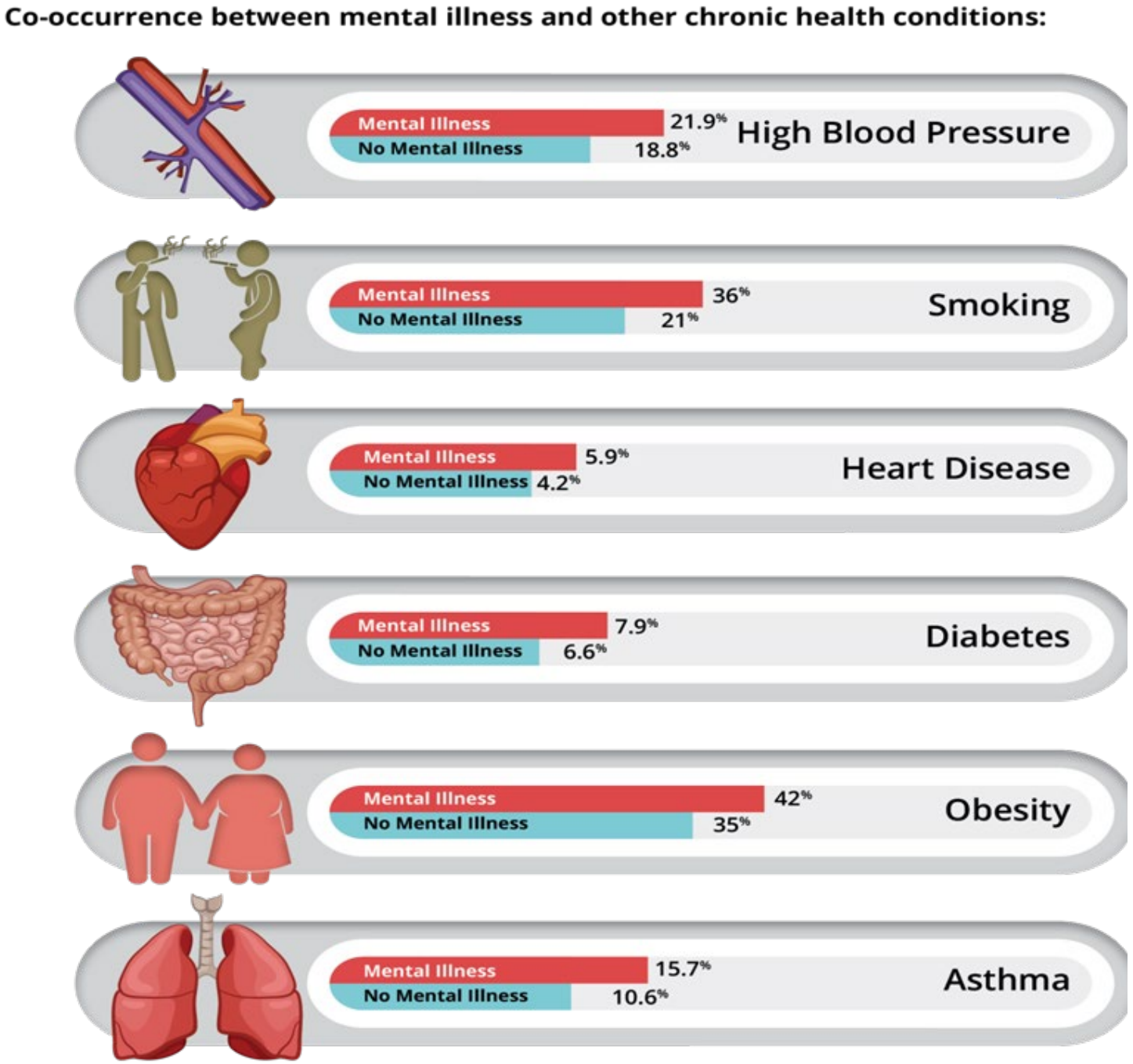
Annual Per Person Cost of Care
Common Chronic Medical Illnesses with Comorbid Mental Condition
"Value Opportunities"

Patient Groups	Annual Cost of Care	Illness Prevalence	% with Comorbid Mental Condition*	Annual Cost with Mental Condition
Arthritis	$5,220	6.6%	36%	$10,710
Asthma	$3,730	5.9%	35%	$10,030
Cancer	$11,650	4.3%	37%	$18,870
Diabetes	$5,480	8.9%	30%	$12,280
CHF	$9,770	1.3%	40%	$17,200
Migraine	$4,340	8.2%	43%	$10,810
COPD	$3,840	8.2%	38%	$10,980

Cartesian Solutions, Inc.™--consolidated health plan claims data

Co-Occurrence Between Mental Illness & Chronic Health Conditions

- Source: AHRQ, The Academy Integration Map. Accessed September 2014. http://integrationacademy.ahrq.gov/ahrq_map



Patient Experiences with SMI in Primary Care

Primary care is a first point of contact and continuing point of care for many individuals with mental health and/or substance use issues. Yet, individuals with SMI reported poorer access to and lower quality of the primary care received relative to those without mental health conditions

1. Benjamin-Johnson R, Moore A, Gilmore J, Watkins K. Access to medical care, use of preventive services, and chronic conditions among adults in substance abuse treatment. Psychiatr Serv. 2009;60:1676-9.
2. Kilbourne AM, McCarthy JF, Post EP, Welsh D, Pincus HA, Bauer MS, et al. Access to and satisfaction with care comparing patients with and without serious mental illness. Int J Psychiatry Med. 2006;36:383-99.

Primary Care Doctors Preferred Treating Depression and Anxiety and not SMI

- Primary Care Physicians expressed greater comfort **treating common diagnoses, such as depression and anxiety**, than serious mental illnesses (SMI). They also repeatedly cited patients with co-occurring personality disorders as the most difficult to treat (1)

1.Primary Care Physician Perceptions on Caring for Complex Patients with Medical and Mental Illness Danielle F. Loeb, MD1, Elizabeth A. Bayliss, MD, MSPH2,3, Ingrid A. Binswanger, MD, MPH1,4,5, Carey Candrian, PhD6, and Frank V. deGruy, MD, MSFM3

Poor Health Disparities for People with SMI Triggered Movement to Whole Care within Behavioral Health Treatment

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The Surgeon General's Report on Alcohol, Drugs, and Health found Integrated Care for primary care, mental health, and substance use-related problems to produce the best outcomes and provide the most effective approach for supporting whole-person health and wellness

https://ncbi.nlm.nih.gov/books/NBK424848

SAMHSA
Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration

NATIONAL COUNCIL for Mental Wellbeing®
HEALTHY MINDS • STRONG COMMUNITIES

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA), along with the National Council for Mental Wellbeing have stated that , "the solution lies in integrated care, the systematic coordination of general and behavioral healthcare. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs"

https://integration.samhsa.gov/about-us/what-is-integrated-care

Harris Center Survey – Determinates of Health Findings

"Social determinants of health (SDOH) are known to influence mental health outcomes, which are independent risk factors for poor health status, emotional wellness and physical illness."

Journal of the American Medical Informatics Association, 26(8-9), 2019, 895–899

Eight key DOH related findings from the Harris Center survey revealed the following:

The Harris Center, anticipating the potential of the significant and devastating impact of COVID-19 on direct behavioral health patient care developed and administered a survey entitled *Harris Center COVID-19 & Impact Social Determinants of Health.*[18] This survey was administered to patients by care managers through telephonic, socially distanced in person contact, and telehealth between April 2020 and April 2021. The survey was administered to 7,560 individual clients using a random number recruitment of active outpatient adult (81% adults) and children (19%) with SMI and or SED conditions.

***Food Insecurity**	34.69% Believed that they would run out of food
***Percent Uninsured:**	39.26 % Uninsured
Economic Insecurity	56.86% Found it difficult to pay for basic needs (i.e., food)
Feeling lonely & isolated:	54.16% Frequently felt lonely and isolated
***Fearful about the future:**	52.46%
***Can't keep up with medications:**	44.49%
***Lost access to health appointments:**	24.75%
***Have not seen a healthcare provider**	31.43% in last year

Barriers to Primary Care Doctors Treating Complex Conditions (SMI and Health Conditions)

- **Lifestyle and lived experiences Determinants of Health (DOH) factors** (isolation, access to transportation, employment, food insecurities, social biases) **impacting people SMI are barely considered in primary care.**

- **Primary care settings do not have the care management staff in community** to assist doctors with engaging patients with SMI with medication adherence, follow-up appointments, care plan and modifiable lifestyle factors important to improve health outcomes
- **Lack of integrative care for on-going side effects of psychotropic medications** (weight, high blood pressure, etc.) impacting SMI patients with hypertensive and diabetic condition either worsens conditions or cause patients not to take either primary care or psychiatric medications

Physical illness in patients with severe mental disorders.. Prevalence, impact of medications and disparities in health care p1World Psychiatry 2011;10:52-77 – cited by 2423

Integrated Behavioral Health Home Approach

By building an infrastructure around integrative health, SDOH, data directed clinical decisions that correlate to measures, we can create a bridge to improve health outcomes

Redefine specialty mental health and consider the whole person – not just mental illness, Include SDOH

Remove barriers that limit access to care and address health disparities

Improve overall health and well being of all vulnerable and at-risk behavioral health populations for preventable hospital and ER Admissions

Continuum of Physical and Behavioral Health Integration

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Traditional Specialty MH Care

Outpatient mental health/substance abuse counseling, residential, crisis services, case management

Certified Community Behavioral Health Clinic

Established standardized approaches to care and a new provider type for Medicaid as a result of standardized & required set of services (MH/SA services). Evaluations and measurements that include primary health screenings for chronic health – BP/BMI, and care coordination

Co-located Care MH & Primary Care - Separate EHR Provider

Level 4
Close collaboration onsite with some system integration - same space, same facility, consultation, referral to health provider

Level 5
Close collaboration-seek integrated systems together, daily huddles, care teams, defined rolls

Behavioral Health Home

- **Known as Patient Centered Medical Home, recognized as a payor model by CMS and MCOs**
- **Care Management: Addresses social determinants of health, barriers to care, improves health status**
- **Population-based and client-based cost-effective outcomes – through risk stratification, services directed based upon risk stratification results and analytics, reduce over utilization of preventable high-cost care, includes levels of primary care**

Integrated Care Behavioral Health Home - Plus

System Level Integration
System wide data integrated, one EHR, incorporates CCBHC, primary health, and behavioral services under one roof,

Note: Integrated Care is not a recognized payor model, however, under the patent centered medical home model, it is recognized by CMS and MCOs

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Integrated Health:
Primary Health Care Services & Certified Community Behavioral Health Clinic (CCBHC)

UNIVERSITY of HOUSTON

Primary Care Services – Partnership with University of Houston College of Medicine

Dr. Brian C. Reed M.D. Chair of Clinical Sciences
Tilman J. Fertitta Family College of Medicine
University of Houston

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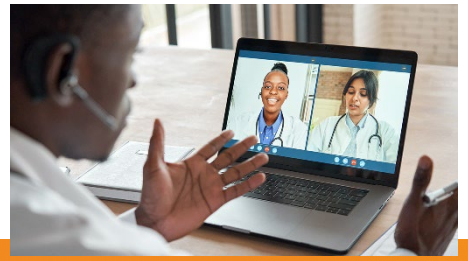
Enhancing Integrated Primary Care: Structured and Planned Communication



FRAMEWORK

- Primary Care Behavioral Health Staffing Meeting
- Team Huddles – multi-discipline (psychiatry, primary care, care mgr., care navigators, nursing , counselors)
- Primary Care weekly meeting
- Screen, treat, a range of conditions - low to moderate manageable within our basic clinic and basic formulary (examples- but may vary - smoking cessation, obesity, Elevated & Hypertension Stage 1, pre-diabetes and medication adhered diabetes)
- Curbside consultations – virtual team meetings
- Care Coordination with Community Primary Care Specialist and Primary Care Clinics

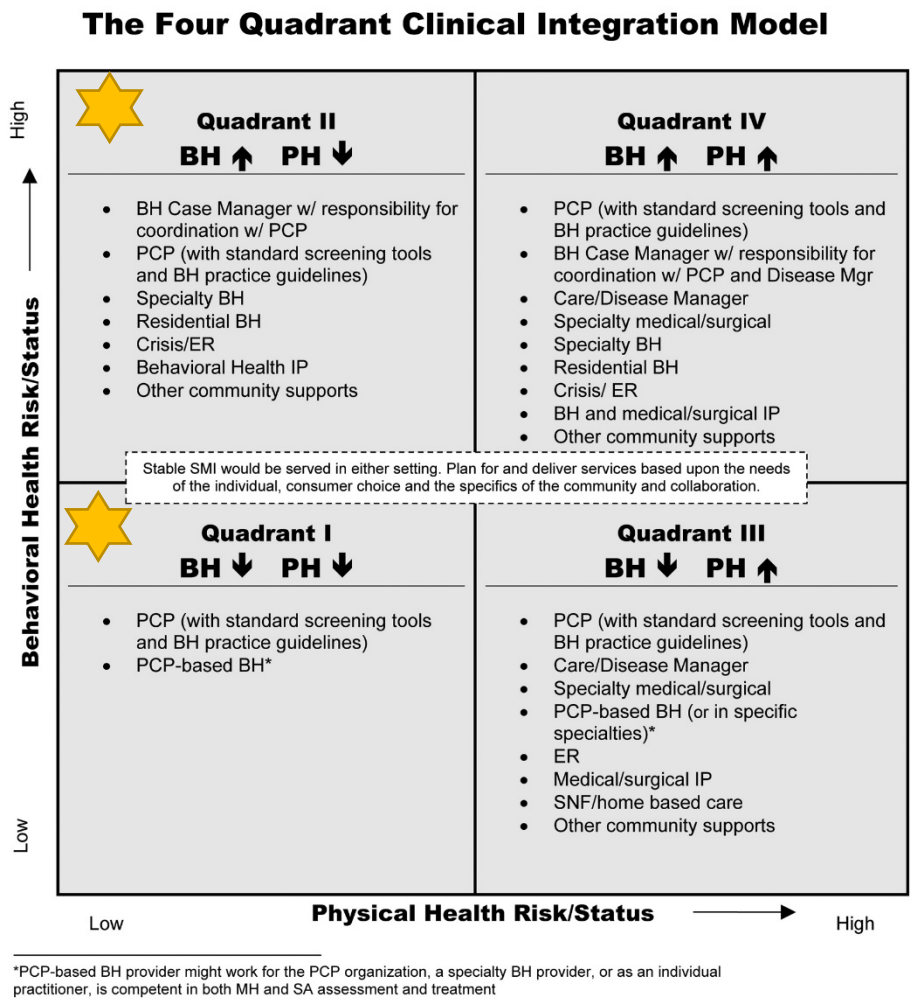
FUNCTION

Promote access to complex and chronic disease management

Promote communication within Harris Center BH and Primary care

Align and coordinate care of more complex chronic disease management & care with community primary care providers

Integrative Collaborative Care Framework



This Four Quadrant Model is a conceptual framework for population-based planning and understanding the diverse integration initiatives that are currently underway. It was developed by Barbra Mauer under the auspices of the National Council for Community Behavioral Healthcare (NCCBH);

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The Harris Center Health Home

Your Health and Wellness Partner

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What is a Behavioral Health/Medical Home?

Behavioral Health/Medical Homes Provide:

- Comprehensive and coordinated care in the context of individual, cultural, and community needs
- Medical, behavioral, and related social service needs and supports are coordinated and provided by provider and/or arranged
- Emphasize education, activation, and empowerment through interpersonal interactions and system-level protocols
- At the center of the health/medical home are the patient and their relationship with their behavioral health and primary What is a Behavioral Health/Medical Home? care teams and Social Determinants of Health Community Resources and Partners

What Authority Established Behavioral Health/Medical Home?

•Section 2703 of the Affordable Care Act Allows states to amend their Medicaid state plans to provide **Health Home Services** for enrollees with qualifying chronic conditions – Value-based care approach

CMS Expectations:

•Lower rates of emergency room use
•Reduce in-hospital admissions and re-admissions
•Reduce healthcare costs
•Decrease reliance on long-term care facilities
•Improve experience of care, quality of life and consumer satisfaction
•Manage health conditions & Improve health outcomes

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Why is The Harris Center a unique partner for a value-based care pilot?

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Care coordination already part of the model

In-built scale due to size of local mental health authority (specialized therapy)

Full continuum of services across crisis, outpatient, and jail

Experienced clinicians who naturally translated to care manager roles

Alignment with other agency-wide efforts (CCBHC, pursuit of primary care/reverse integration)

Current Development – Part of Harris County Health Exchange

EHF: Care Management Platform - & Primary care/Health Home Optimization

Compass Rose – EPIC EHR

Coordinated Care Management

Epic Overview

The comprehensive health and social care record in Epic moves healthcare beyond clinics and hospitals. Coordinated Care Management provides case management tools to roll out population health, social, and community related programs to improve a person's well-being through care management and outreach.

A Comprehensive View of Wellness

Coordinated Care Management can help your organization keep more people well. Use tools in Epic to address social determinants of health, map support networks, connect people to community services, and measure outreach and program effectiveness. If you're interested in installing Coordinated Care Management, talk to your Epic representative to discuss how these tools fit your needs.

Address Social Determinants of Health

With EpicCare, clinicians, social service providers, and community partners can capture a person's social determinants of health – such as isolation, depression, food insecurity, and barriers to reliable transportation. Social determinants can also be submitted directly in MyChart. Users have easy access to this information in the Epic chart and can use it, combined with medical information, to inform the care and services they provide.

With Epic's Coordinated Care Management license, you can use social determinants of health history to drive decision support, risk stratification, and analytics. These tools help you target outreach and program enrollment to the most vulnerable in your population, leading to improved health outcomes and reduced costs through prevention.

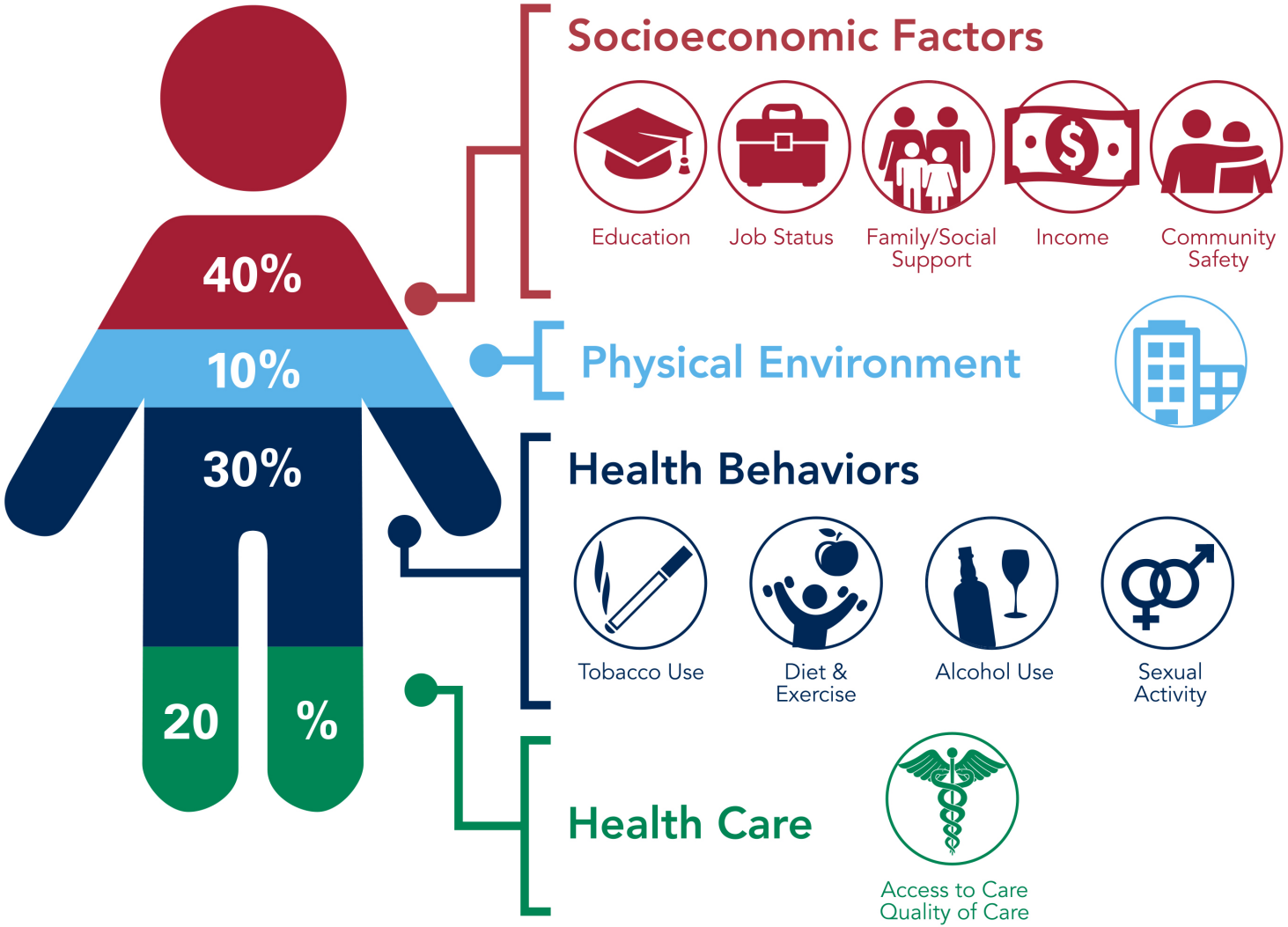
Coordinate Programs

With program management tools, you can organize and manage large-scale programs – like chronic care management and child welfare services – that benefit many different types of populations in your community. You can:

- Identify candidates for programs with decision support and reporting.
- Enroll program participants with referrals and applications, including a transparent application status visible in MyChart.
- Establish a program's targets and timelines in order to track the program's status relative to its goals.
- Track the services a person receives for each program he's enrolled in.
- Securely share a person's assessments and documents across multiple programs and provide confidential information specifically to program staff who need access.
- Manage staff workloads by visualizing program data like case load distribution by case manager and outstanding tasks by owner.
- Improve population health by enrolling consumers in structured programs, which include milestone tracking, integrated client plans, and actionable population reports with discrete, measurable outcomes.
- Providers bring care to people where they are with a mobile toolset for telehealth and home visits.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.



SDOH Impact

- **20 percent** of a person's health and well-being is related to **access to care** and **quality of services**
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes

Source: Institute for Clinical Systems Improvement; Going Beyond Clinical Walls: Solving Complex Problems, 2014 Graphic designed by ProMedica.

IMPACT OF SOCIAL DETERMINANTS OF HEALTH

Social determinants of health have tremendous affect on an individual's health regardless of age, race, or ethnicity.

Economic Stabilty:
- » Employment
- » Income
- » Expenses
- » Debt
- » Medical Bills
- » Support

Neighborhood & Physical Environment:
- » Housing
- » Transportation
- » Safety
- » Parks
- » Playgrounds
- » Walkability

Education:
- » Literacy
- » Language
- » Higher Education
- » Vocational Training
- » Early Childhood Education

Food:
- » Hunger
- » Access to Healthy Options

Community & Social Context:
- » Social Integration
- » Community Engagement
- » Support Systems
- » Discrimination

Health Care Systems:
- » Health Coverage
- » Provider Availability
- » Provider Linguistic & Cultural Competency
- » Quality of Care

Health Outcomes:

» Mortality » Life Expectancy » Health Care Expenditures » Health Status » Functional Limitations

American Hospital Association™
Advancing Health in America

Source: Adapted from Kaiser Family Foundation. Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. November 2015.

Social Determinants of Health ~ ICD 10 Code Cross Walk

PRAPARE
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

Social Intervention Response Categories

Code	Social Intervention Response
SI-RE	Racial/Ethnic Support Services
SI-FW	Farmworker Support Services
SI-VN	Veteran Support Services
SI-IN	Interpretation Services
SI-HS	Housing Support Services
SI-FC	Financial Counseling/Eligibility Assistance
SI-ED	Education Support Services
SI-EM	Employment Support Services
SI-FD	Food Support Services
SI-UT	Utilities Support Services
SI-CC	Child Care Support Services
SI-MH	Medicine or Health Care Support Services

Code	Social Intervention Response
SI-CL	Clothing Support Services
SI-PH	Phone Support Services
SI-OM	Other Material Security Support Services
SI-MT	Medical Transportation Services
SI-NMT	Non-Medical Transportation Services
SI-SI	Social Integration Support Services
SI-ST	Mental Health Support Services
SI-IN	Incarceration Support Services
SI-RF	Refugee Support Services
SI-ST	Safety Support Services
SI-DV	Domestic Violence Support Services

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This tool is a crosswalk between the PRAPARE tool and its corresponding ICD-10 Z codes in the electronic medical record system (EMR); view the 2022 ICD-10-CM Release. In addition to social risk factor data, it is important to code for social complexities using ICD-10 Z codes and dummy CPT codes to track, monitor, and close the loop on the services provided to patients with identified social needs. CPT codes, or procedural codes, describe what kind of "procedure" a patient has received while ICD codes, or diagnostic codes, describe any diseases, illnesses, or conditions a patient may have. PRAPARE/SDOH data & Social Intervention documentation is needed to demonstrate value to payers/stewards and seek adequate financing to ensure interventions are sustainable while creating an integrated, value-driven delivery system to reduce total cost of care. PRAPARE Assessment Tool available at https://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/

PRAPARE SDOH Domains/Constructs	PRAPARE Responses – Social Risk Factors	ICD-10 Z Codes	Z Code Description (New codes approved for publication on October 1, 2021)	Social Intervention (SI) for identified social need (these dummy CPT codes are optional):
Current Housing Situation	I have no housing	**Z59.0**	Homelessness (new subcategory)	SI-HS Housing Support Services
		Z59.00	Homelessness unspecified	
		Z59.01	Sheltered Homelessness	
		Z59.02	Unsheltered Homelessness	
Worried About Losing Housing	Yes	**Z59.81**	Housing Instability, housed (new subcategory)	SI-FC Financial Counseling/Eligibility Assistance
		Z59.811	Housing instability, housed, with risk of homelessness	
		Z59.812	Housing Instability, housed, homelessness in the past 12 months	
		Z59.819	Housing Instability housed unspecified	
Education	Less than high school	**Z55.5**	Less than high school diploma	SI-ED Education Support Services
Employment	Unemployed but seeking work	**Z56.0**	Unemployment, unspecified	SI-EM Employment Supportive Services
Other Needs/Financial Needs	Food,	**Z59.41**	Food Insecurity	SI-FD Food Supportive Services
	Clothing,	**Z59.6**	Low income	SI-CL Clothing Supportive Services
	Phone,	**Z59.5**	Extreme poverty	SI-PH Phone Supportive Services
	Utilities,			SI-UT Utilities Supportive Services
	Childcare,	**Z63.6**	Dependent relative needing care at home	SI-CC Child Care Supportive Services
	Medicine or any health care, Other	**Z59.8**	Other problems related to housing/economic circumstances	SI-MH Medicine or Health Care Supportive Services SI-OM Other Materials Supportive Services
Transportation	Yes, Medical &	**Z75.3**	Unavailability and inaccessibility of health-care facilities Unavailability and inaccessibility of other helping agencies	SI-MT Medical Transportation Services
	Yes, Non-Medical	**Z75.4**		SI-NMT Non-Medical Transportation Services
Social Support	1-2 times per week and less than once	**Z60.8**	Other problems related to social environment	SI-SI Social Integration Supportive Services
Stress	Quite a bit and very much	**Z73.3**	Stress, not elsewhere classified	SI-ST Mental Health Supportive Services
Incarceration	Yes	**Z65.2**	Problems related to release from prison	SI-IN Incarceration Supportive Services
Safety	No	N/A	If the patient's response is a NO, that is a flag.	SI-ST Safety Supportive Services
Domestic Violence	Yes	**Z63.0**	Problems in relationship with spouse or partner	SI-DV Domestic Violence Support Services
Refugee Status	Yes	**Z65.3**	Problems related to other legal circumstances	SI-RF Refugee Supportive Services
Country of Origin	Other than USA	N/A	PRAPARE smart form in eClinicalWorks (eCW)	eCW Enterprise Business Optimizer (eBO) reporting

Member Eligibility & Attribution

Member Eligibility and Attribution:
Who qualifies for the program?

Eligibility and Attribution Methodology:

- Highest needs members with SMI, SED, and/or SUD are the focus of the IBHH
- 3 gateways to qualify (below)
- Based on claims history and geo-proximity
- Assures attributed members encompasses enough volume for enrollment
- Assumes ~50% engagement rate, with some currently engaged in care

Descriptors	Values
Medical Spend Thresholds	$120,000+
Behavioral IP/Residential Spend Thresholds	$12,000+
ER Visit Thresholds	12+
Attributed Members	**~1,545**

About 1500 have been attributed to us to date

Approximately 25% are Harris Center Clients

We are providing health literacy, tracking, wellness newsletter for all 1500

We are only serving about 10% of Harris Center patients in our primary care. We have been asked by United/Optum if we can provide primary care support to all the members in the project since they have struggles with their existing primary care doc (SDOH/barriers)

The Harris Center Health Home

The Harris Center Health Home
Your Health & Wellness Partner

The Harris Center for Mental Health and IDD
Transforming Lives

1 Comprehensive Care Management

The initial and ongoing assessment and delivery of care management services to integrate physical, behavioral health, long-term services and supports, and community services.

2 Care Coordination

Organizing and facilitating access to care and monitoring progress toward goals through face-to-face and collateral contacts with the member, family, caregivers, physical care, specialty care, and other providers, and the secure sharing of information to promote safe and effective care.

3 Health Promotion

The facilitation of activities and services that educate the member and his/her supports about various health matters that can aid in disease prevention, wellness, improved condition management, and reductions in avoidable emergency room visits and hospitalizations.

4 Comprehensive Transitional Care

The facilitation of services for the member, family, and caregivers when the member is transitioning between levels of care.

5 Individual and Family Support Services

The coordination of information and services to support the member and their family or caregivers to maintain and promote quality of life, with particular focus on community living options – social determinants of health.

6 Community and Social Support Referrals

Providing information and assistance to refer the member and their family or caregivers to community-based resources that are needed to improve member wellness.

Review of Goals

The Harris Center Health Home

Goals

Improve overall wellness of members to include their self-management of conditions

Increased member participation in the health home program based upon enrollment rates for attributed members (target goal is 50% enrollment for all attributed members within a 12 month period)

- Reductions in avoidable hospital admissions and emergency room use
- Reductions in overall hospital readmission rates
- Reduced lengths of stay in the hospital when hospitalizations are necessary
- Improved rates for follow up after hospitalization (FUH) for behavioral and medical inpatient and ER visits • Improved adherence to recommended treatments (including medications and specialty care)
- Improved access to primary care, based on key metrics related (e.g., diabetes care)

Opportunity

One of Four behavioral Health Organizations participating in the National Pilot

Target 1500 of the highest risk Optum Members (costing approximately $100K in claims per member)

Only about 25% Harris Center clients

Partnership Details:

- Per member per month (PMPM) payment structure
- Total cost of care shared savings
- Performance measures as part of shared savings bonus payout

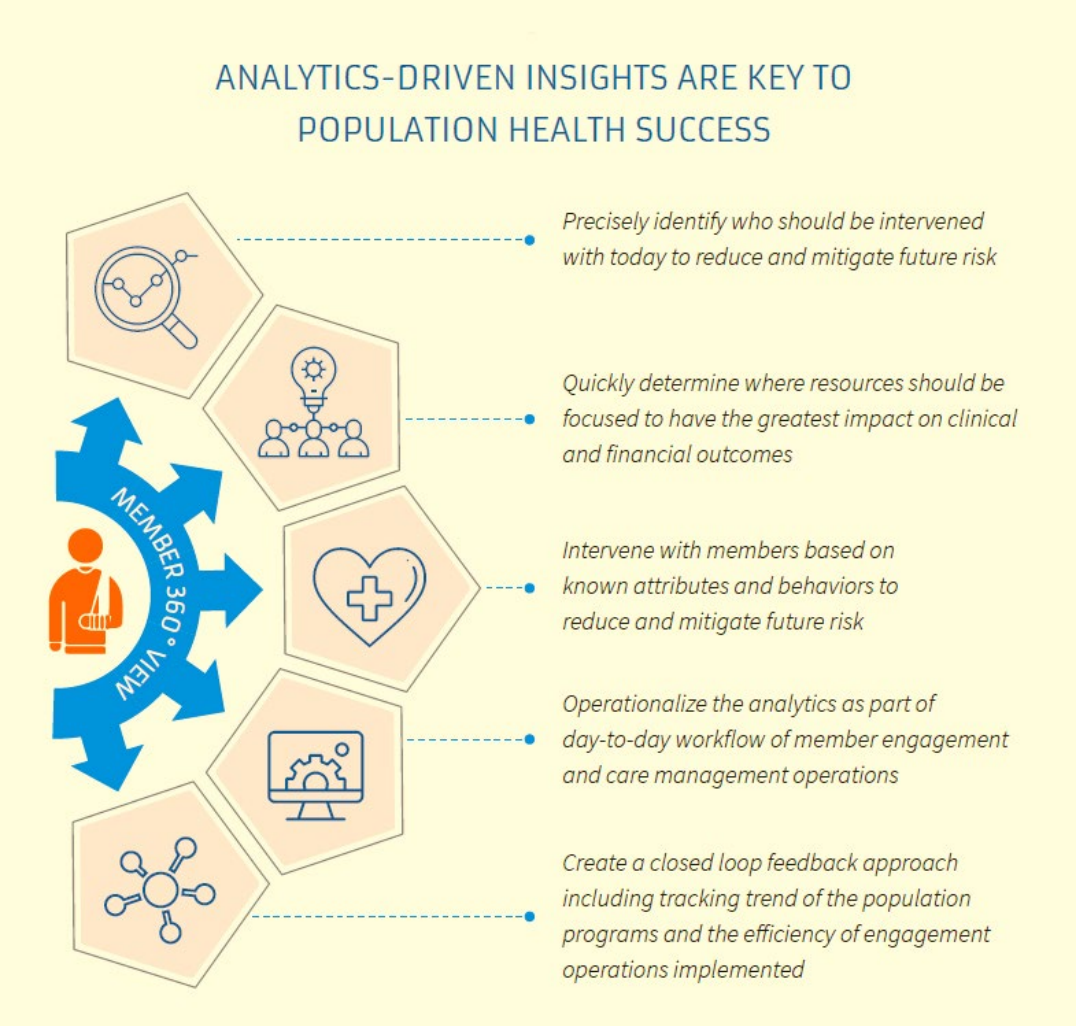
Health Home Measures

- Follow-Up After Hospitalization for Mental Illness (HEDIS® - FUH): 7-day
- Comprehensive Diabetes Care HH - Composite 1 (HEDIS® - CDC): Eye exam
- Child and Adolescent Well-Care Visits (HEDIS® - WCV)
- Plan All-Cause Readmissions (HEDIS® - PCR)
- Ambulatory Care: AMB HH (CMS)
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (HEDIS® - SSD)
- Inpatient Utilization General Hospital/Acute Care HH (HEDIS® IPU)
- Rate of Inpatient Behavioral Health Admissions - TPI (Custom)
- Medication Adherence: Mood Stabilizers, Anti-Psychotics and Anti-Depressants- MA-MS, MA-AP, MA-AD (Custom)

Reporting Only Measures

- Follow-Up After Hospitalization for Mental Illness HH (HEDIS® - FUH): 30-day
- Behavioral Health Inpatient Days - TPI-DAYS (Custom)
- 7- and 30-Day Inpatient Behavioral Health & Residential Treatment Facility Readmission Rate TPR-7, TPR-30 (Custom)

Utilizing Optum Portal – Data



1. Data-driven decisions
2. Identification of high-utilizer and assignments
3. Care coordination and collaborative contacts with patient care team
4. Gaps in Care and Social Determinants of Health

Concierge Medical

The HARRIS CENTER - Behavioral Health Home

Care Management Six Steps – Team-Based Care Model

1. Member Identification & Analytics

- Real-time Utilization data
- Population Health Risk Stratification
- Utilization of Community & Health Exchanges as part of data collection and analysis

2. Integrative Health- Care Management

- Weekly & monthly team meetings
- Care –based upon analytics and health outcome improvements
- Whole care approach with integrative health care plan addressing health, behavioral health team monitoring and outcomes for both health and behavioral health outcomes and bench marks.
- Care Coordination with other health providers, PCP, law enforcement, criminal justice system, SDOH resource referral and follow-up
- Best practices (stages of change, motivational counseling) behavioral change
- Member advocacy
- Non-traditional hours and scheduling

6. Health Coaching

- Health Promotions & Wellness Strategies
- Coaching and monitoring health outcomes
- Health system navigation
- Medication education

3. Physical Health/Healthcare

- Care Coordination with Harris Center Integrated Health Clinic, Community PCPs, other providers – hospital, ED
- Health Promotions, disease & medication management

5. Social Determinants of Needs

- SDOH Assessment – include strategies in individualized care plan
- Comprehensive resource list development & resource connections – monthly monitor resources for qualifications & accuracy
- Trained in SAMHSA SOAR program -

4. Integrative Behavioral Healthcare

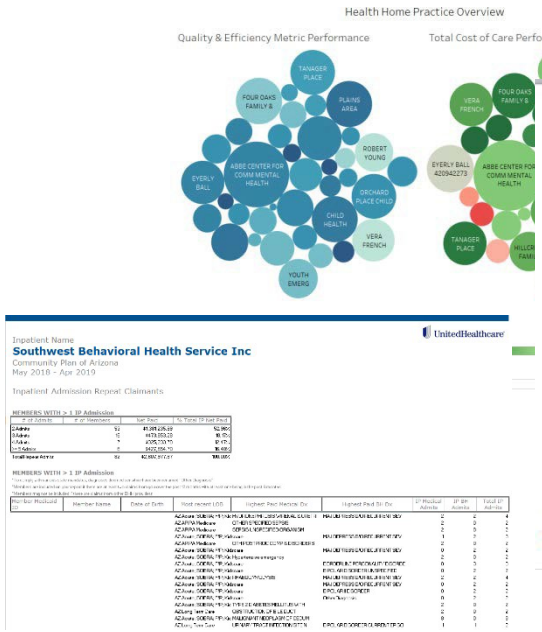
- In-person & televisual care
- Specialized treatment addressing mental health, substance use, criminal justice factors; SDOH; and integrative health

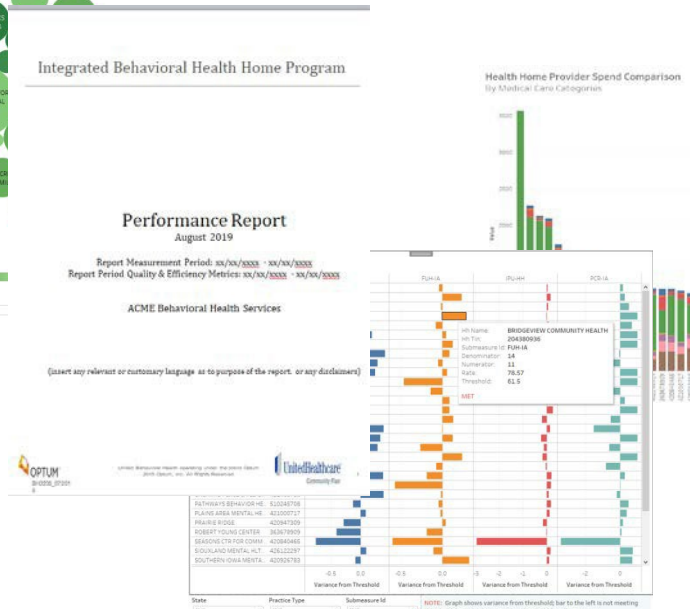
Health Home Reporting Capabilities

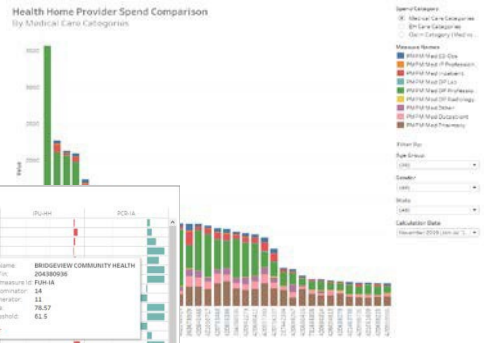
Member Identification & Attribution

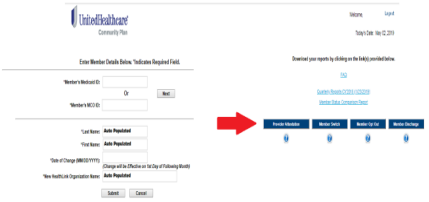
Provider Attestation Portal

Reporting



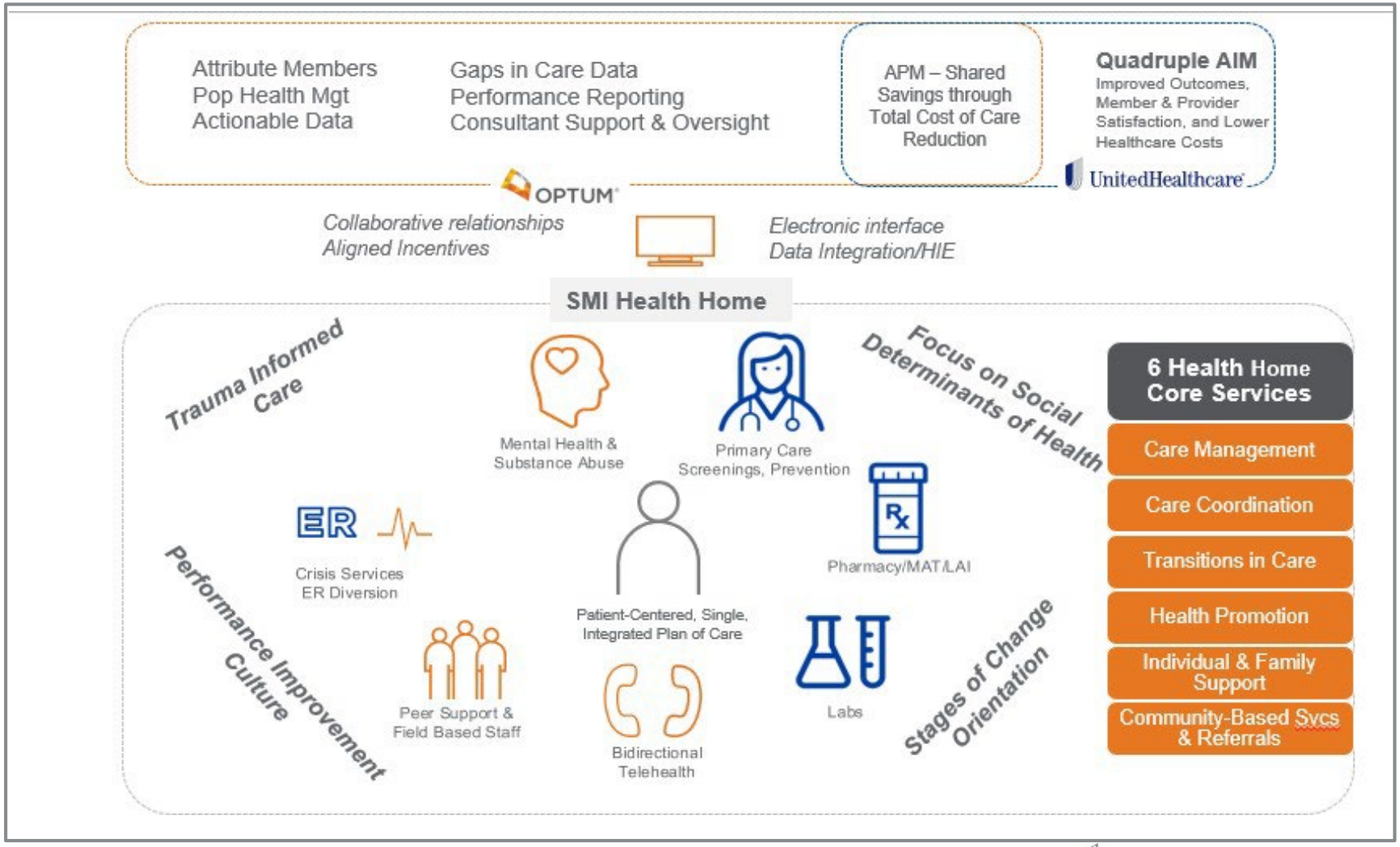






OPTUM™

Leveraging Partnership with Optum



United Behavioral Health operating under the brand Optum

Optum Reporting Suite, Roll-out Workflow and Decision-Making

Reporting Suite

Note: Reporting needs may change during the course of the pilot

Report Name	Frequency	Description	Delivery Mechanism
Daily Census Report	Daily	Report contains inpatient information for **all attributed members** on the roster, including admitting IP facility. Data contains a tab showing all admissions within the previous 30-day period	Provider Portal
Member Change Report	Weekly	Displays status changes for **all members** that occurred in the week since the previous Member Change Report was produced (new, enrolled, discharged, et al.)	Provider Portal
Pharmacy Refill Reminder Report	Weekly	Provides RX refill data for **enrolled** members 14 days before refill date, and 14 days overdue	Provider Portal
High-Cost Claimants and High Utilizers Report	Monthly	Identifies members based on medical/behavioral costs and utilization (counts) for frequent ER and IP utilization over a rolling 12 months	Provider Portal
Metric Performance Report with Member Adherence	Monthly	Gives HEDIS and other quality and utilization measures that are part of the VBP. Includes measurement **performance against targets** for the current reporting period **and member-level detail.**	Provider Portal
Provider Performance Reports	Quarterly – also serves as the Annual Report	Gives an overview of how providers are performing against metric targets and their current membership. Includes Total Cost of Care Summaries for medical and behavioral spend and tracks potential Outcome Payments.	Provider Portal
Invalid Billing Report	Monthly	Details all activity payments that were identified as having a potential billing error at the member level. Details remain on the report for 90 days.	Value-Based Practice Consultant – is not distributed

Team-based care -Daily Staff Huddle

- Review Optum Reporting Suite Portal
- Review daily & weekly reports
- Zero in on High utilizer list, admissions, assignments based upon risk stratification

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Pro-active engagements based upon scripts used by staff for ER Diversion, Self-management, & On-going engagements

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Sample Provider Checklist for Post-ED Follow-Up Visit Prior to the visit

• Review discharge summary
• If there are any outstanding questions, clarify with sending physician
• Initiate medication reconciliation with attention to the pre-hospital regimen
• Reminder call to patient or family/caregiver to: o Stress importance of the visit and address any barriers
o Remind patient/family/caregiver to bring medication lists and all prescribed and over-the-counter prescriptions
o Provide instructions for seeking emergency and non-emergency after-hours care

• Coordinate care with home health care nurses and case managers if appropriate

During the visit

• Say: Our clinic would like to be your medical home or home base helping you with all of your health care needs. We like to learn from our patients and families how we might improve the care we provide.
• Ask the patient/family/caregiver to share: o What would be helpful for you to get from today's visit?
o How did you decide the ED was the best choice in this situation?
o What medications he/she is taking and on what schedule?

• Perform medication reconciliation with attention to the pre-hospital regimen
• Determine the need to:
o Adjust medications or dosages;
o Follow-up on test results;
o Do monitoring or testing;
o Discuss advance directives;
o Discuss specific future treatments
• Instruct patient in self-management; have patient repeat back (offer the BP/weight Kit – for self-management
• Explain warning signs and how to respond; have patient repeat back
• Provide instructions for seeking emergency and non-emergency after-hours care; @ urgent care versus hospital if possible - have patient repeat back

Sample Conversation Starters for Encouraging Visits to Medical Home rather than the ED [For Patients with Recent ED Use]

Could be used for follow-up calls/visits for patients with recent ED use
• "I see that you have been in the Emergency Department recently. That must have been hard/scary for you. Would it be okay if we talked about this for a few minutes?"

If they say yes, continue...
• "Can you tell me a little more about this visit?"

Let them explain why they went to the ED. This will give you more information about what happened, etc. This will give you an "in" to find out why they went to the ED instead of your practice.
• *"How did you decide the ED was the best choice in this situation?"*
This gives the patient a chance to voice what they see as positive. It also may give you more information about what they might NOT know so you can fill in the blanks. Explain to the patient the benefits of being seen by their own provider.
• *"Could I share some information about how we handle urgent or after-hours calls?"*
If they say yes continue with:
• *"We hope you see us as your medical home or home base for your child's health care needs." [explain what a medical home is if needed].*
• *"As your medical home, we have an after-hours plan so you can reach us outside of business hours – you can start by calling the main number, it is XXX-XXX-XXXX."*
• *"What do you think about what we've talked about?"*

Preventative Call Script: General Practice Population Education

Provider and/or Nurse at end of visit and/or Front desk at check-out could use these to encourage all patients or parents to call the office, if needs come up in between planned visits.
• "Your next regular checkup/planned appointment is _____. If you need us before then, please call. We have our regular and our after-hours line, so you can get help whenever you need it."
• "Sometimes medication questions can come up after-hours, especially if you are feeling sick. If this happens, please don't hesitate to call us.
• Are you able to obtain weekly blood pressure readings or able to weight yourself as part of your healthcare monitoring?

Let them answer. Provide the brochure/information about calling the office first.
• "Could I share some information about how our practice handles after-hours calls?"

If they say yes, you can hand them the brochure and/or provide the after-hours information.
If they say they are unable to do health monitoring offer the weight scale/BP kits and set plan for self-monitoring

How Will We Track and Monitor

Optum | UnitedHealthcare Community Plan

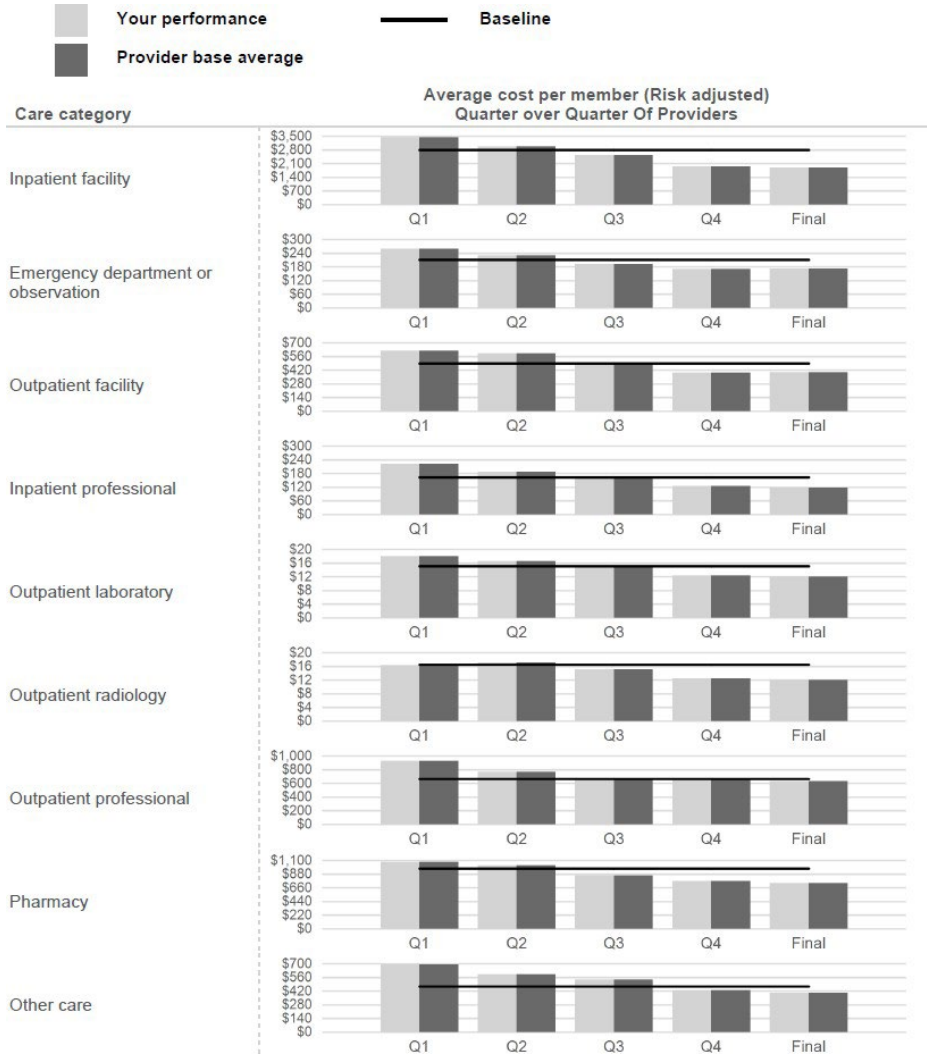
Integrated Behavioral Health Home Outcomes

Preliminary Reports Are Promising: 2021 Annual Performance Report

- Inpatient Facility, Pharmacy and Outpatient Specialty Professional tend to be the highest cost care categories
- Reductions in Inpatient and Pharmacy costs are the primary driver of the savings generated the first year

- **Average Total Cost of Care Per Member Prior to Program Start:** $5,077 per month

- **Reduction in total Cost of Care Per Member 1st Year:** $4,384 or Cost Savings of $693 Per Member Per Month



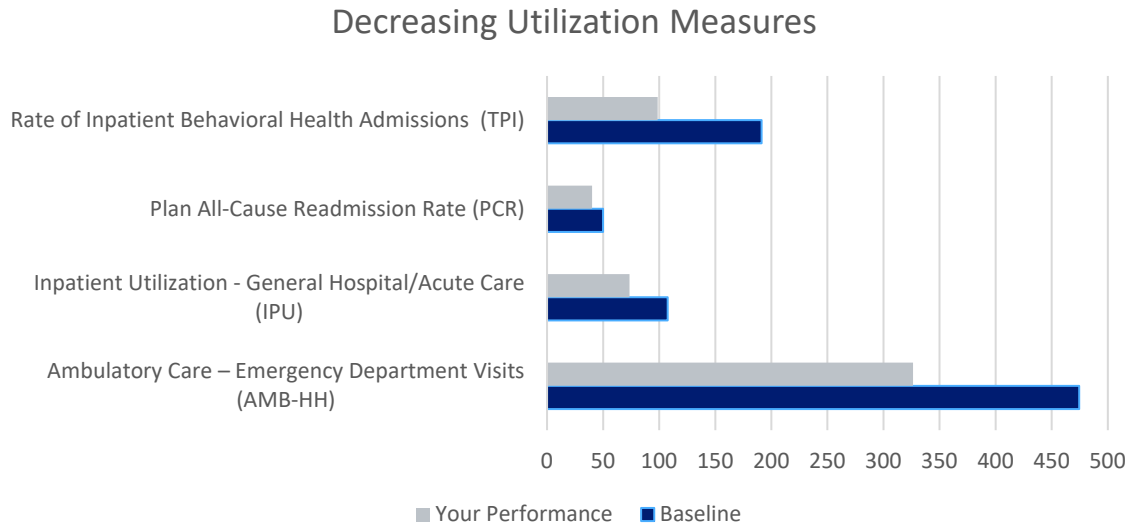
Behavioral Health Home Group Summary Report

Health Home TIN: 741603950
Health Home Name: Harris Center
Report Period: Jan 1, 2022 to May 31, 2022

Performance Measures:
The following data shows HEDIS and other standardized quality and utilization measures that are part of your value-based agreement for Health Homes and reflect measurement performance improvements against baselines for the current reporting period. Each measure requires at minimum of 30 observations to accurately measure your performance. Annual outcome payments are based on final measurement results and considers only those members who have been attributed to your program for a minimum of six (6) months during the measurement period. Each measure is worth a maximum of two points (.5 points for 3.00% - 4.99% improvement over baseline, 1 point for 5.00 - 7.99% improvement, and two points for 8.00% or more improvement

Utilization Measures	State	Denominator	Numerator	Baseline	Your Performance	Percentage Change from Baseline	Qualify for Points	Points
Ambulatory Care – Emergency Department Visits (AMB-HH)	TX_SEast	8,196	2,675	474.54	326.38	-31.22%	YES	2.0
Inpatient Utilization - General Hospital/Acute Care (IPU)	TX_SEast	8,196	603	107.54	73.57	-31.59%	YES	2.0
Plan All-Cause Readmission Rate (PCR)	TX_SEast	1,045	419	41.94%	40.10%	-4.39%	YES	0.5
Rate of Inpatient Behavioral Health Admissions (TPI)	TX_SEast	8,196	808	191.28	98.58	-48.46%	YES	2.0

***Decreasing "Utilization" measures are favorable**

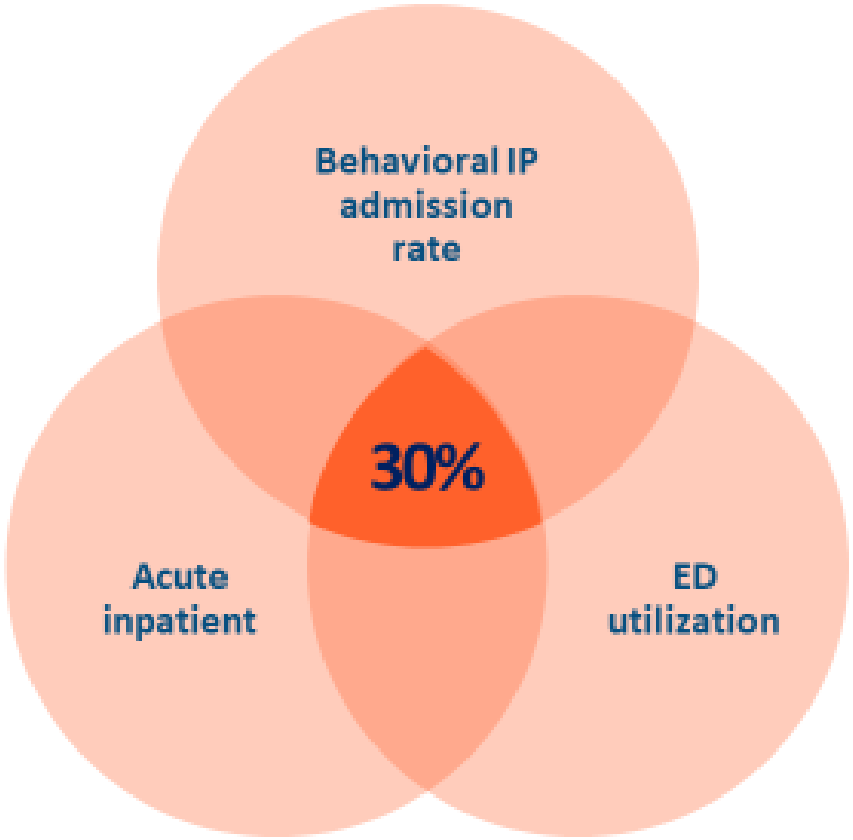


Success indicators: The Harris Center IBHH Measurement Year 1*

13.7% reduction to TCOC PMPM ($693 per attributed member)

Cost Savings $6,985,440

Based on medical and behavioral claims paid through June 2022 for **840 members attributed at least 6 months**



30% enrollment rate
Represents percentage of members opting into the program

17% reduction in acute IP
Based on frequency of medical admissions to IP facility

30% reduction in ED utilization
Based on frequency of visits to an ED

42% reduction in BH IP rate
Based on frequency of admission events to a BH IP facility

Measurement Year 1 is 1/1/21 – 12/31/21

Note: over 1200 engaged and enrolled with the Harris Center within the year – some received less than 6 months of services

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Thank You