



**TERRY  
REILLY**

*Your Health. Our Mission.*

**Integrated Behavioral Health and Primary Care  
&  
SHIP Quality Measures**

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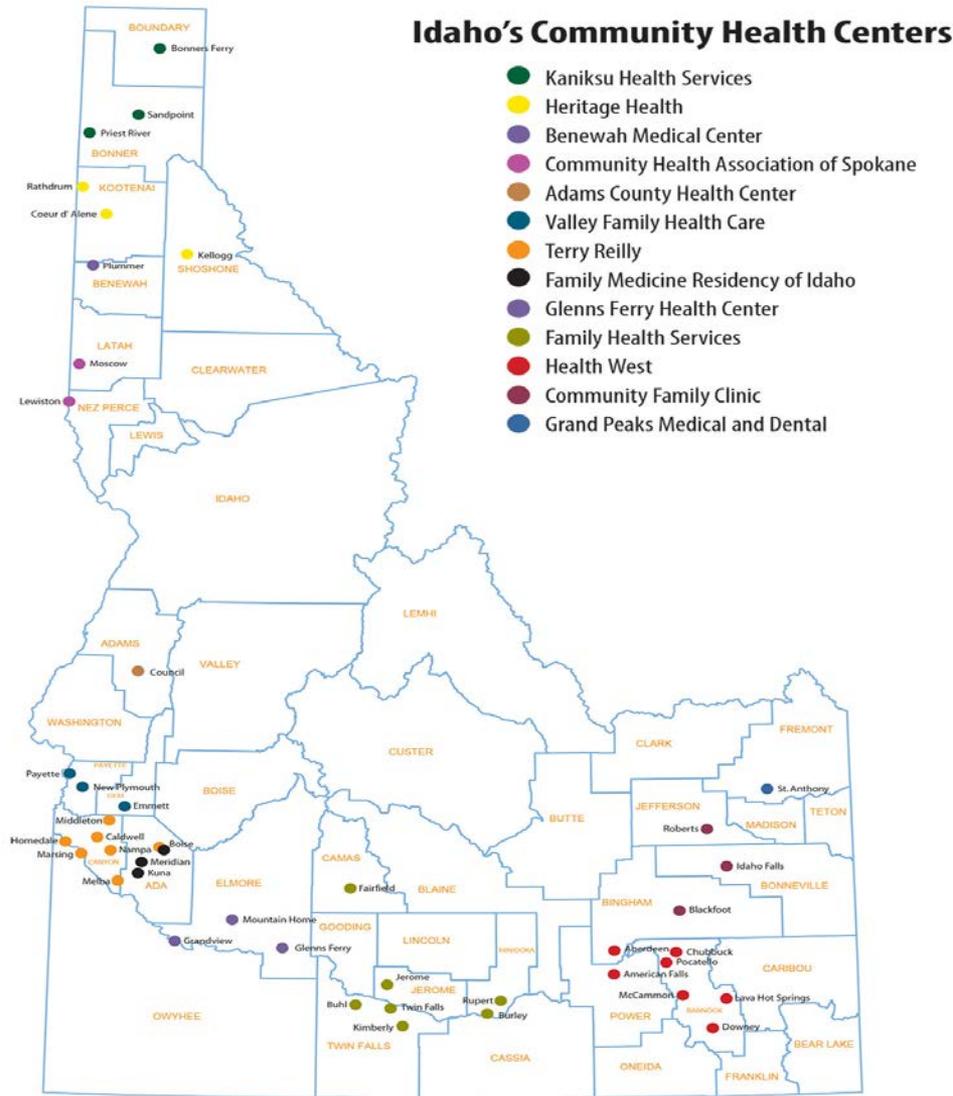


# Outline

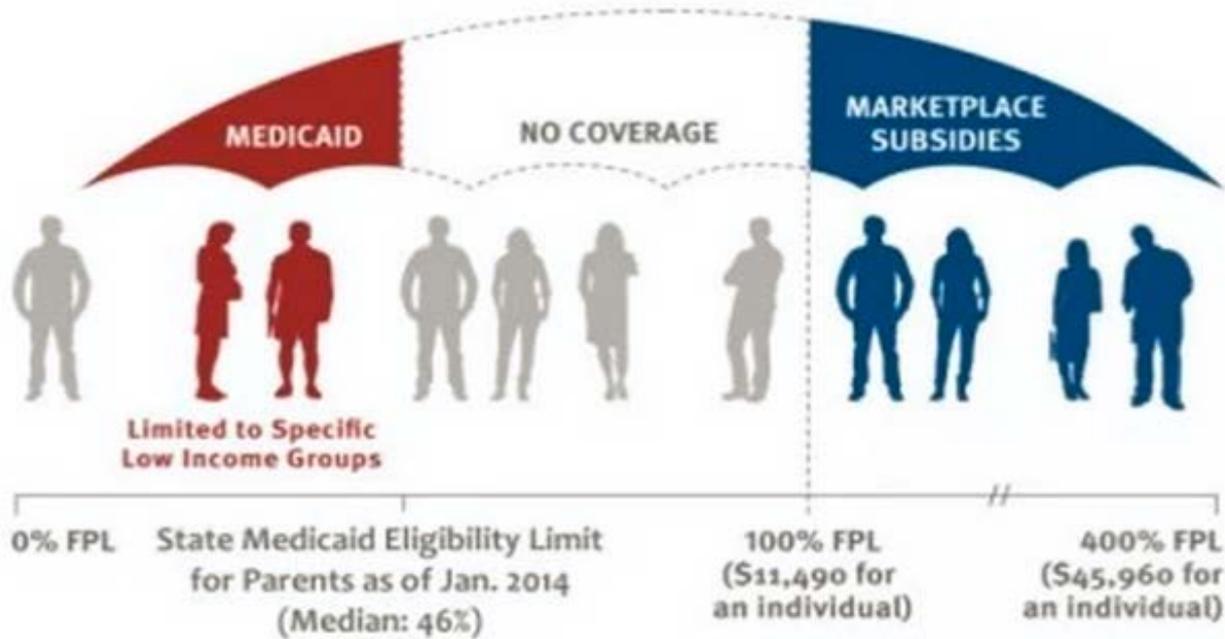
- Terry Reilly and Community Health Centers
- SHIP Integrated Behavioral Health-Primary Care
  - Terry Reilly example
- SHIP Quality Measures
- Please Feel Free to Ask Questions



# Idaho's 13 CHCs Serve 160,000 Idahoans



# Over 70,000 people need us



NOTE: Applies to states that do not expand Medicaid. In most states not moving forward with the expansion, adults without children are ineligible for Medicaid.





# Why should you care?

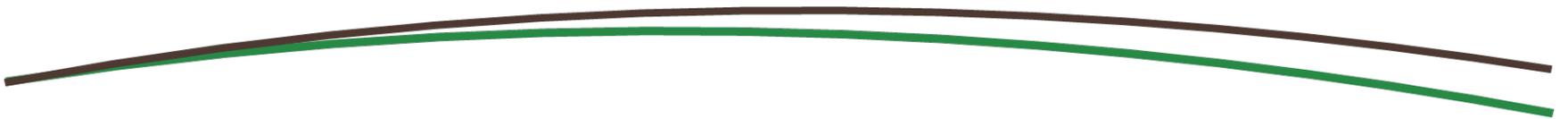
- Care received at health centers is ranked among the most cost-effective.
  - For each \$1 spent results in \$3 healthcare cost savings.
  - Without compromising Quality
- We reduce health disparities in our Idaho communities, big and small, that need us the most





# The new face of Healthcare SHIP

- Unsustainable Model, Cost and poor outcomes
  - US Ranked 38<sup>th</sup> Health Outcomes
  - We spend the most of any other country 19% GDP
- Healthcare Services is Shifting Away from fee for service (volume) to Value
- Being held accountable for Outcomes, Quality and Cost of Care
- Moving to an Integration of Coordination and Care



# Our Mission



*Terry Reilly, in the tradition of our founders, is a community health center (FQHC) dedicated to providing affordable, comprehensive health care to everyone in our community to improve health and quality of life.*

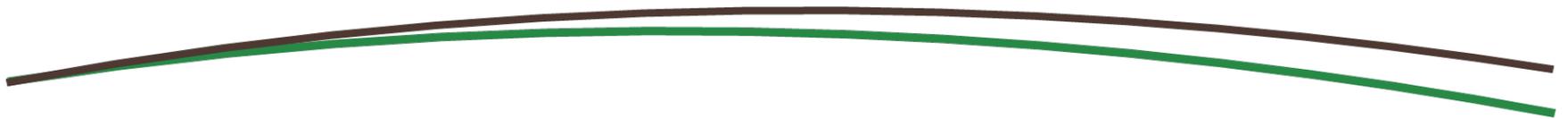
- Integrated healthcare for all, regardless of insurance, income or ability to pay.
  - Sliding fee scale (25%, 50%, 75%) based on income
  - Zero pay fund (100%)
  - Homeless Grants
- Language should not be a barrier to care
  - Over 40% of TR employees speak Spanish
  - All patient material is in both English and Spanish
  - Translation Services available for other languages



# Terry Reilly Community Health Center



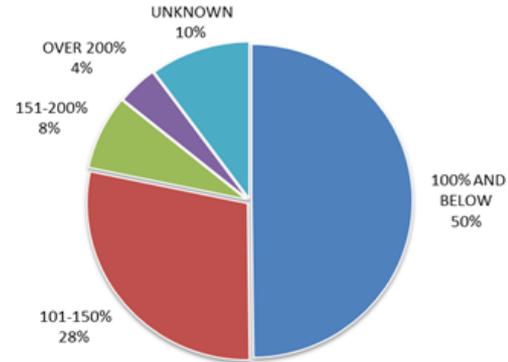
- Serving the communities of Ada, Canyon, and Owyhee Counties
  - 8 medical/behavioral health clinics
  - 5 dental clinics
    - 2 integrated with medical/ behavioral health
  - 5 specialty behavioral health clinics
  - Allumbaugh House: Detoxification/Mental Health Stabilization Facility



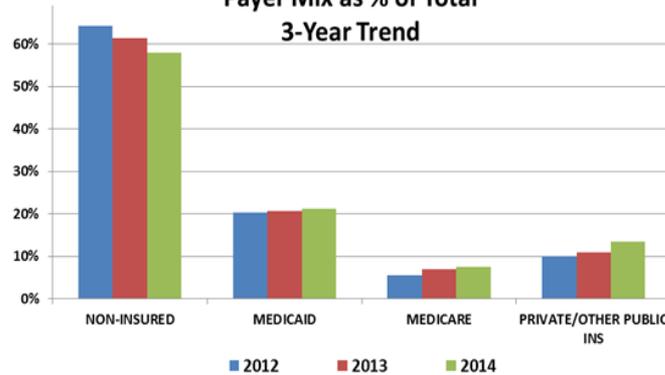
# Who we serve

In 2014, we served  
Nearly 30,000  
patients

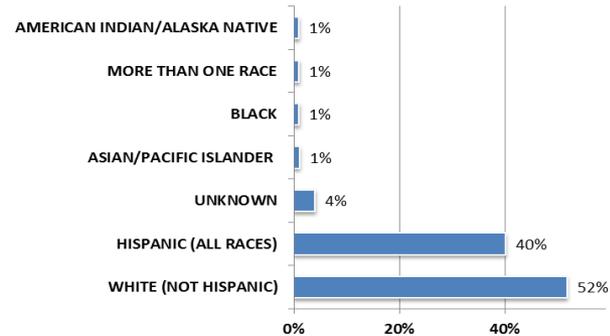
**2014 Patient Income as % of Poverty Level**



**Payer Mix as % of Total  
3-Year Trend**



**2014 Patient Race/Ethnicity**





# Who we are –

- Over 275 employees
- Counselors, Dentists, Front Desk staff, Hygienists, MAs, Management Staff, Physician Assistants, Pharmacists, Physicians, Nurse Practitioners, Psychiatric Nurse Practitioners, RNs, Volunteers



# Serving our Community



- Work with our community members
- Able to receive subsidized care to fully insured
- Provides a sliding scale fee structure for the poor and those in need (\$5.4M to date)
- We provide free care to the homeless community in Boise and Nampa
- Zero Pay Fund for those that need it most.





# What role do we play?

- Joint Commission Accredited Health Care Organization 2013
- The only CHC in Idaho to have that achievement!
- NCQA level III and Joint Commission accredited Patient Centered Medical Home

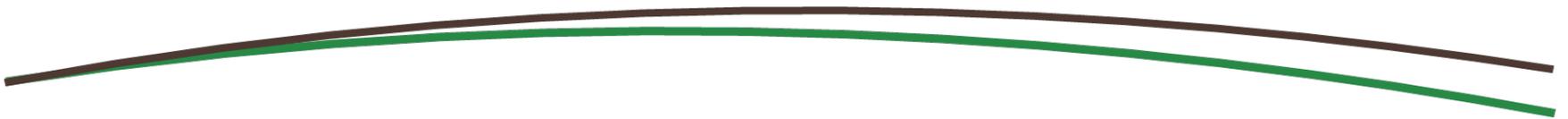


# SHIP

## Integrated BH-PC



- PCPs Provide >60% of diagnosis and medication management
- 50% of psychoactive drugs prescribed by PCPs
- PCPs, PNPs Refer patients for counseling
- Complicated MH patients need healthcare
- Rural Access to Care
- Tele-psychiatry
- Psychiatrist Shortage



# Why Integrated BH-PC?

- We need to do a better job helping them be healthy
- The Leading Cause of Disability for those with **Serious Persistent Mental Illness (SPMI)** is their mental illness
- The Leading Cause of Death and Disability for those with SPMI is Chronic Diseases
  - Coronary Artery Disease
  - Diabetes
  - COPD
  - Stroke



- 6 Levels of Collaboration/Integration  
SAMSHA-HRSA

Level 1: Minimal Collaboration

Level 2: Basic Collaboration at a Distance

Level 3: Basic Collaboration Onsite

Level 4: Close Collaboration Onsite with Some System Integration

Level 5: Close Collaboration Approaching an Integrated Practice

Level 6: Full Collaboration in a Transformed Merged Integrated Practice

- Six Levels of Collaboration & Integration for Behavioral Health (BH) and Primary Care (PC)

- Coordinated: key element is Communication

- Level I Minimal Collaboration

- separate facilities, separate systems; driven by provider need not patient need or issue ,don't meet in person, limited understanding of roles, BH & PC separate

- level II Basic Collaboration at a Distance

- separate systems, communicate periodically about shared patients, communication is driven by specific patient issues, appreciate others' roles as resources



# Heath et al: A Review and Proposed Standard Framework for Levels of Integrated Healthcare



## ❑ Co-located: the Element is Physical Proximity

### ❑ Level III Basic Collaboration on-site

- ❑ same facility but not same offices -- separate systems, communicate regularly about shared patients by phone or e-mail and meet occasionally in person to discuss cases, collaborations; driven by the need for each others services and a more reliable referral, feel part of a larger yet ill-defined team

### ❑ level IV Close Collaboration on-site with Some System Integration

- ❑ same space within the same facility, share some systems like scheduling, medical records, communicate in person as needed, collaborations; driven by the need for consultation in coordinated plans for difficult patients, regular face-to-face interactions about patients, basic understanding of roles and cultures



# Transformed integrated practice



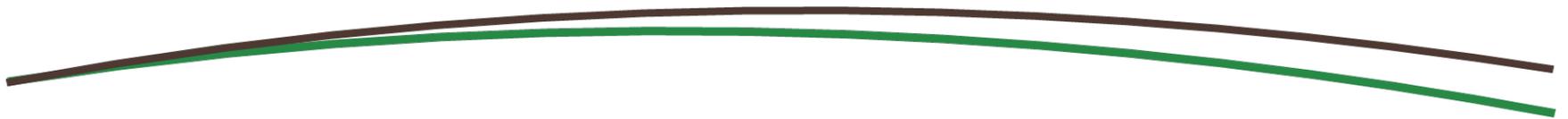
## ❑ Integrated: key element is Practice Change

### ❑ Level V Close Collaboration Approaching an Integrated Practice

❑ same space within the same facility with some shared space, actively seek system solutions together, communicate frequently in person, collaboration is driven by the desire to be a member of the team, regular team meetings, in-depth understanding of roles and cultures

### ❑ Level VI Full Collaboration in a Transformed/merged Integrated Practice

❑ same space within the same facility sharing practice space, function as one integrated system, consistent communication at the system team and individual levels, collaboration is driven by the shared concept of team care, have formal and informal meetings to support integrated model of care, have roles and cultures that blur or bend



## The Level of Integration Has Implications for:

- Clinical Delivery
  - Seamless & Coordinated
  - Shared guidelines
- Patient Experience
  - Patient Centered vs Clinician Centered
- Practice organization
  - Staffing, physical layout, teams
- Business & Payment Model



Terry Reilly has varying levels of integration within practices depending on clinic site



- Idaho's Rural Clinics

- Have limited behavioral health resources available
- Implications for all of Idaho to deliver BH services
- How do we ensure access to BH services?





# Transitions of Care

- Allumbaugh Hospital

Managed by Terry Reilly Health Services

Integrated and coordinated discharge planning and follow-up at Terry Reilly Boise clinic

Regular communication and meetings between AH and Boise clinic

EHR access for AH; documentation immediately scanned into electronic record by AH



# Transitions of Care

- AH & Psychiatric Hospital Discharges
  - Case manager reviews patients who are inpatient and require discharge follow-up
  - Psychiatric facilities communicate with our case managers to ensure needed follow-up
  - Patients are seen either by BH or PC depending on availability





## What does Integrated BH-PC Care look like?

- Pod Concept; physical co-location of BH & PC
- Most integrated behavioral health and primary care practice with the teams interacting on a continuous basis during delivery of care
- Allows for interaction and collegiality as well as curbside consults on a regular basis
- Include process improvement, and specific case reviews of complicated patients
- Same Shared Electronic Health Record



# How it works

- By having BH and PC integrated it allows:
  - patient needs can be met effectively by multiple disciplines that comprise the patient team
  - Patient with depression seen by psychiatric nurse practitioner and BP is elevated; primary care provider initiates BP management that same day.
  - Primary care provider has a patient that is suicidal; immediate access to a counselor who can do an assessment of the patient and determine disposition in concert with PC/PNP.



# SHIP Quality Measures



- Began in 2013
- Work Group
  - Comprised of providers, payors, DHW, Interested Entities
  - Met Monthly and developed quality measures
  - For this to be effective must have payors and providers working together

# Workgroup Wanted to Include



- Hospital measures
- Outpatient measures (Disease and Preventive)
- OB measures
- Pediatric measures
- Behavioral Health measures
- Cost measures

# By the end of Year 1

- The IHC will engage stakeholders in this discussion to ensure that a statewide solution is viable and acceptable to the different communities in Idaho
- Exciting to have Idaho establishing state-wide performance measures as we move toward population health
- Due to the lack of uniform reporting that exists today:
  - IHC will develop a baseline from the information currently available across payers and populations
  - An external organization with expertise in performance data collection, analysis, and reporting will assist the IHC in gathering and analyzing the data to establish a baseline

In Year 2, the IHC will select four core performance measures from the initial Performance Measure Catalog to be reported by all PCMHs in Year 2

- The statewide performance measures for Year 2 will include the three SIM measures: tobacco cessation intervention, weight assessment and counseling for children and adolescents, and comprehensive diabetes care

# Year 3

- In consultation with the IHC, RCs will identify additional performance measures from the Performance Measure Catalog to be collected from PCMHs in their respective regions in Year 3.
- The additional measures collected in Year 3 may vary from region to region depending on performance and regional health needs and will be informed by community health assessments and regional specific clinical data.

# First Year Measures



- **Tobacco Use Assessment**
- **Diabetes Measures**
- **Weight Assessment**



1<sup>st</sup> Year

## Performance Measures for Population Health



- **Tobacco use assessment (SIM):**
  - % of patients queried about tobacco use one or more times during the two-year measurement period
- **Tobacco cessation intervention (SIM):**
  - % of patients identified as tobacco users who received cessation intervention during the two-year measurement period.

## Performance Measures for Population Health



- **Adult BMI Assessment (SIM):**
  - % of 18 - 74 years of age who had an outpatient visit & who's BMI was documented during the measurement year or the year prior.
- **Weight assessment and counseling for children and adolescents (SIM):**
  - % of children, 2 - 17 years of age, whose weight is classified based on Body Mass Index (BMI), who receive counseling for nutrition and physical activity.

1<sup>st</sup> Year

## Performance Measures for Population Health



- **Comprehensive diabetes care (SIM):**
  - with the intent of preventing/reducing future complications of poorly managed diabetes
  - % of patients 18-75 with diabetes, with optimally managed modifiable risk factors
  - A1c<8.0%, LDL<100 mg/dL, blood pressure <140/90 mm Hg, tobacco non-use, and daily aspirin usage for patients with diagnosis of IVD

# Performance Measures for Population Health



- **Screening for clinical depression:**
  - % of patients aged 12 years and older screened for depression using a standardized tool and follow up plan documented
- **Adherence to antipsychotics for individuals with schizophrenia (HEDIS):**
  - The % of individuals 18–64 years of age with schizophrenia who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period

# Performance Measures for Population Health



- **Asthma ED visits:**
  - % of patients with asthma who have greater than or equal to one visit to the ED for asthma during the measurement period
- **Avoidable emergency care without hospitalization (risk-adjusted):**
  - % of patients who had avoidable use of a hospital ED



# Performance Measures for Population Health



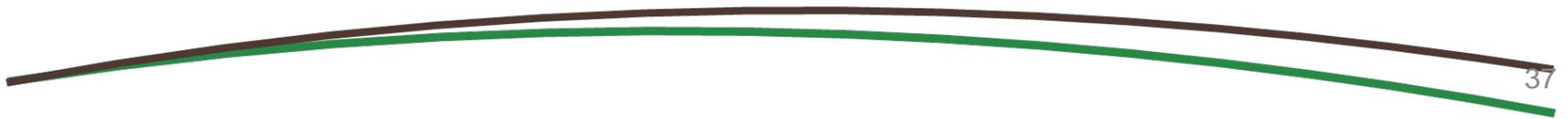
- **Readmission rate within 30 days:**
  - % of patients who were readmitted to the hospital within 30 days of discharge from the hospital
- **Acute Care Hospitalization (risk-adjusted):**
  - % of patients who had to be admitted to the hospital



# Performance Measures for Population Health



- Elective delivery:
  - Rate of babies electively delivered before full-term.
- Low birth weight rate:
  - # of low birth weight infants per 100 births.



# Performance Measures for Population Health

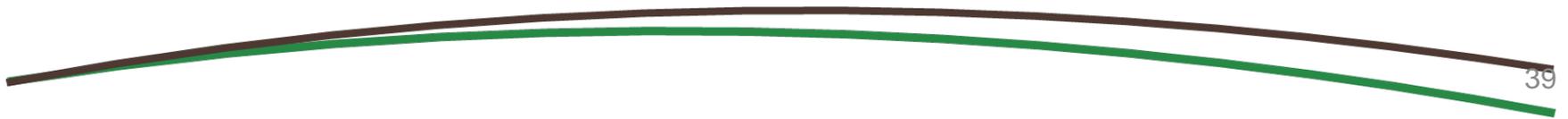


- **Access to Care:**
  - % who report adequate and timely access to PCPs, behavioral health, and dentistry (measure adjusted to reflect shortages in Idaho).
- **Childhood immunization status**
  - % of children 2 years of age who had:
    - 4 DtaP/DT, 3 IPV,
    - MMR, Chicken pox vaccine
    - 3 H influenza type B, 3 hepatitis B, 4 pneumococcal conjugate vaccines

# Performance Measures for Population Health



- **Non-malignant opioid use:**
  - % of patients chronically prescribed an opioid medication for noncancer pain (defined as three consecutive months of prescriptions) that have a controlled substance agreement in force (updated annually)



## Care Experience Measures:

- Patient Engagement:
  - % of enrolled PCMH patients reporting they are an active participant in their healthcare.
- Stakeholder Engagement:
  - Number of stakeholder forums occurring to inform, refine and improve delivery system model.



## Idaho's Cost Measures to Monitor Cost Savings Targets

- Appropriate Generic Drug Use: % of all generic fill rates.
- Re-hospitalizations: % of all hospitalizations.
- Acute Care Hospitalizations: % all acute hospitalizations.
- Non-Emergent ED use: % of all ED visits.
- Early Deliveries (in weeks 37–39 of gestation): % of total NICU admissions.

# QUESTIONS

