



# SAMHSA-HRSA CENTER for INTEGRATED HEALTH SOLUTIONS

## Demonstrating Value of the PBHCI Program

**WHAT'S  
YOUR  
STORY?**

# Components of Your Story

- Description of integration
- Background of your integration program
- Demographics of individuals receiving services
- Health improvement
- Consumer satisfaction
- Cost savings

# DESCRIPTION OF INTEGRATION

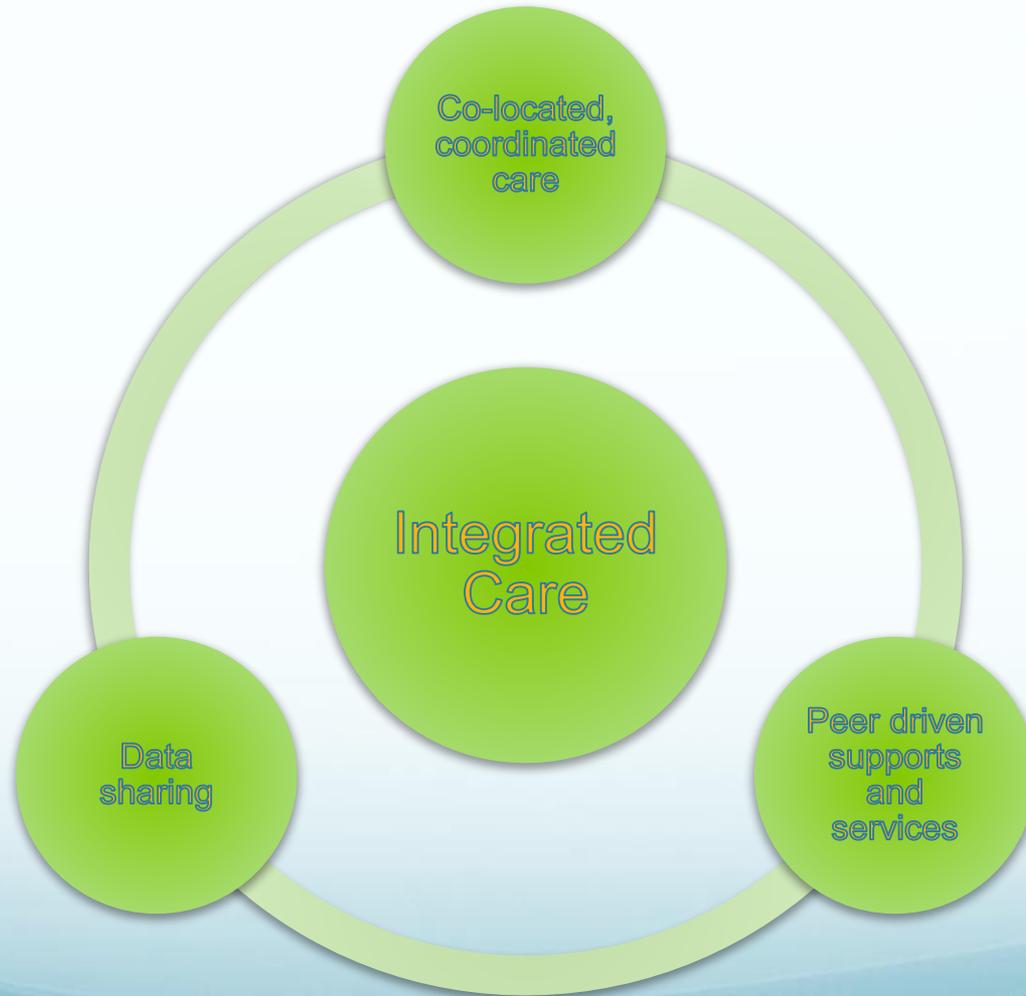
Questions to answer:

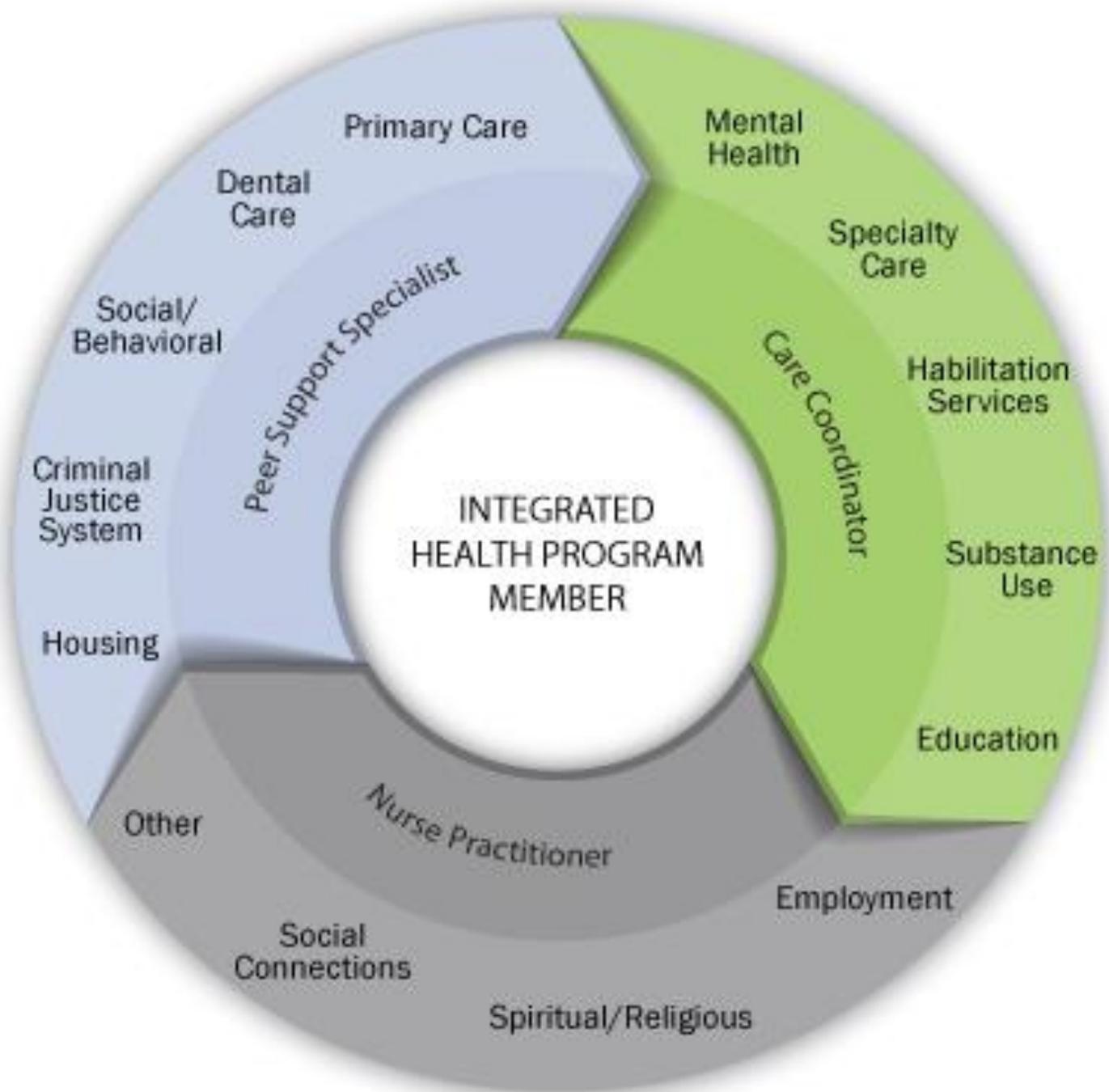
- What is integrated care?
- How does it fit into the ACA's Triple Aim?
- How does it save money?

Resources:

- PBHCI request for proposal
- [Integration.samhsa.gov](http://Integration.samhsa.gov)

# Principles





# Case Client

**SITUATION** This adult Asian woman with paranoid schizophrenia had been without health care for over five years. She presented with uncontrolled diabetes and hypertension.

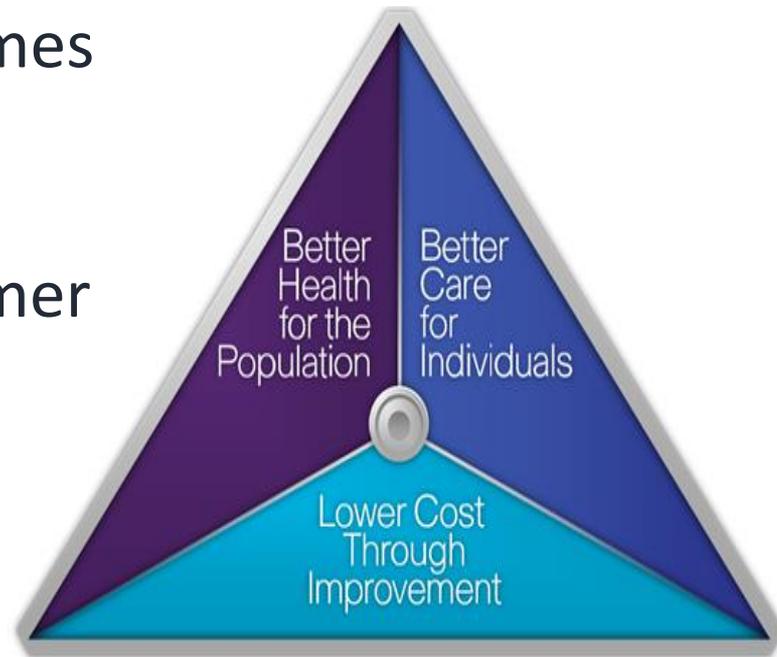
**OBSTACLES** Client had little English, although she understood more than she could speak. With limited resources, she would have sought routine care through emergency rooms or 24-hour clinics.

**ACTIONS** Through the collaborative effort of a psychiatrist, nurse, counselor, interpreter, and physician, client enrolled in HIP and had a full physical. She was subsequently diagnosed, treated, and educated for diabetes, hypertension, and high cholesterol.

**RESULTS** Client has attended diabetes education classes. She has better control her of diabetes, high blood pressure, and elevated cholesterol with diet, exercise, and oral medications.

# Communicating Success

- Improved Outcomes
- Lower Cost
- Quality & Consumer Experience



## Good News

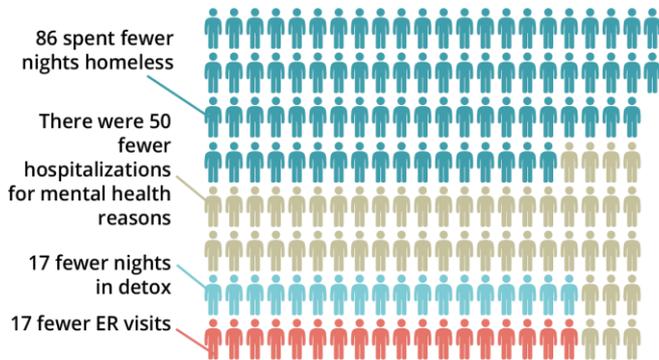
# Small Changes Make a Big Difference

- Blood cholesterol
  - 10% ↓ = 30% ↓ in CVD (120-100)
- High blood pressure (> 140 SBP or 90 DBP)
  - ~ 6 mm Hg ↓ = 16% ↓ in CVD; 42% ↓ in stroke
- Diabetes (HbA1c > 7)
  - 1% point ↓ HbA1c = 21% decrease in DM related deaths, 14% decrease in MI, 37% decrease in microvascular complications

\*2014 PBHCI Presentation by Dr. Joe Parks

- Stratton, et al, BMJ 2000
- Hennekens CH. *Circulation* 1998;97:1095-1102.
- Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.
- Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

One integration program\* enrolled 170 people with mental illness. After one year in the program, in one month:



This is **\$213,000** of savings per month.

That's **\$2,500,000** in savings over the year.

**Integration works.  
It improves lives.  
It saves lives.  
And it reduces healthcare costs.**

# BACKGROUND OF YOUR INTEGRATED CARE PROGRAM

Questions to answer:

- What is the staffing?
- Who is the target audience?
- Who provided funding?
- What do you hope to accomplish?

# Grant Funding



# Our Start: The Structure

## Peer Coaching

- Community Workers
- Contracted Peer Coaches

## Health Educators

- Individual and group interventions
- Designing and planning interventions

## Nurse Care Coordinators

- Coordinate care
- Disseminate clinical information
- Connect clients to services

## Primary Care

- Expand primary care services

# Our Challenges and Growth

## Initial Challenges

Hiring and Onboarding Staff

Training, development, and deployment of group and individual services

Development and standardization of processes

## Current Status

TW positions now filled

Groups and services active

Processes are standard

## Future Steps

Efficient use of staff as well as provide support

Evaluate and improve effectiveness of services

Review and improve processes to further reduce waste

# Services



# Processes

## Referrals

Eligibility

Welcome/Registration  
and Direct Referrals

Seamless and  
paperless

## Warm Handoff

TW Staff  
available  
during all  
Primary Care  
Clinic hours

## Labs

TW Clinical Teams

Labs done with  
primary care  
appointment

Primary Care  
schedules blocked to  
get TW labs

## Communication

Nurse care  
coordination

Weekly TW Staff  
Meetings (PC and  
BHRS)

Communication of  
progress at Central  
Med Staff Meeting

Informal huddles and  
discussions

Reminder calls

# Health Integration Project



## ATCIC Mission Fit:

- Goal 1a: Improved quality of life and care of consumers and their families through effective treatment and improved health outcomes
- Goal 2b: A complete continuum of highly effective, integrated, services leading to improved quality of life
- Goal 2a: A collaborative continuum of care built through meaningful public and private partnerships

# Health Integration Project



## Clinical Health Indicator Improvements

- All consumers in study had minimum of 1 year enrollment in HIP with a minimum of 3 appointments.
- Health Indicator measures were taken at first appointment and most recent appointment, then compared.
- Study only tracks consumers with measures outside of a healthy range at first appointment, since measures in a healthy range do not require treatment.

# DEMOGRAPHICS OF INDIVIDUALS RECEIVING SERVICES

Questions to answer:

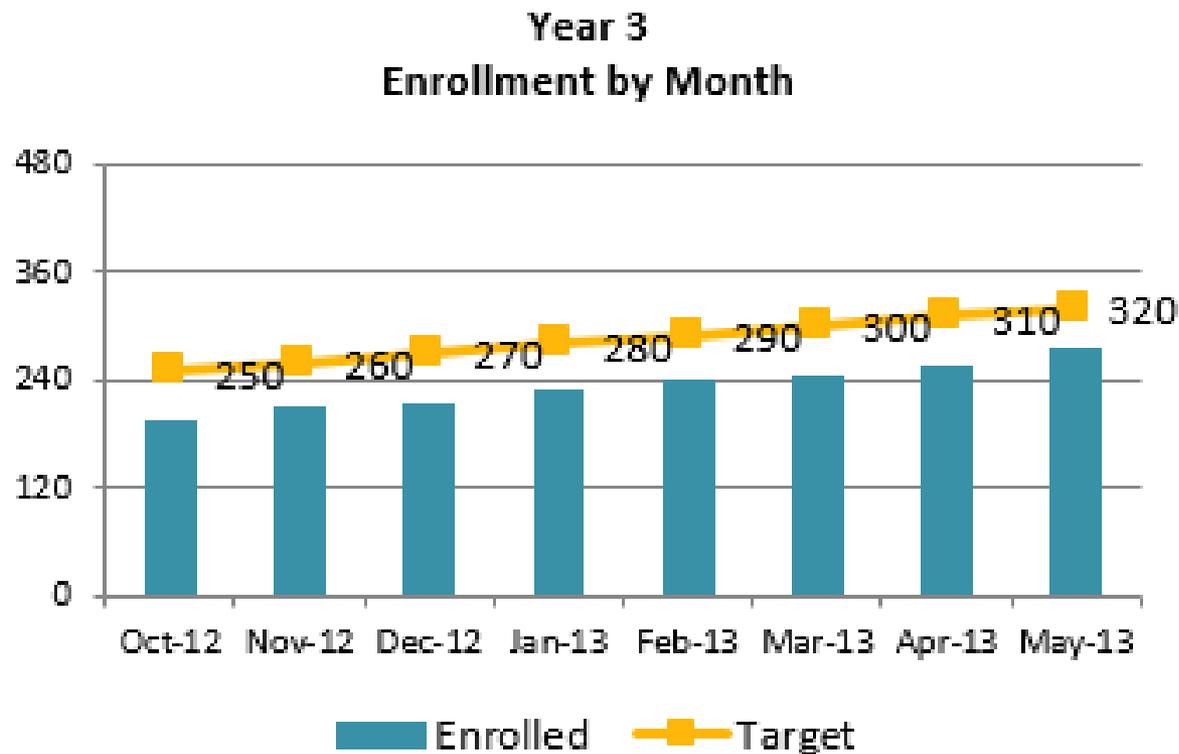
- Who is seen in your PBHCI clinic?

Resources:

- TRAC
- Your registry/EHR

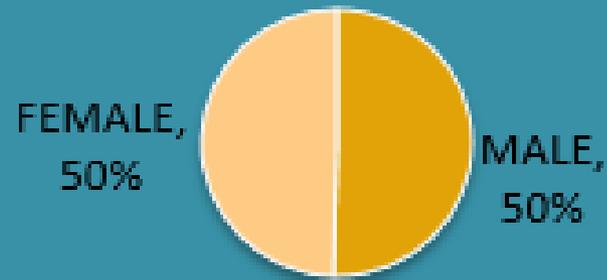
## Enrollment

A total of 275 individuals have been enrolled in Por Tu Salud. In order for the project to meet the enrollment target for the end of Year 3, 21 members should be enrolled for the next 4 months.

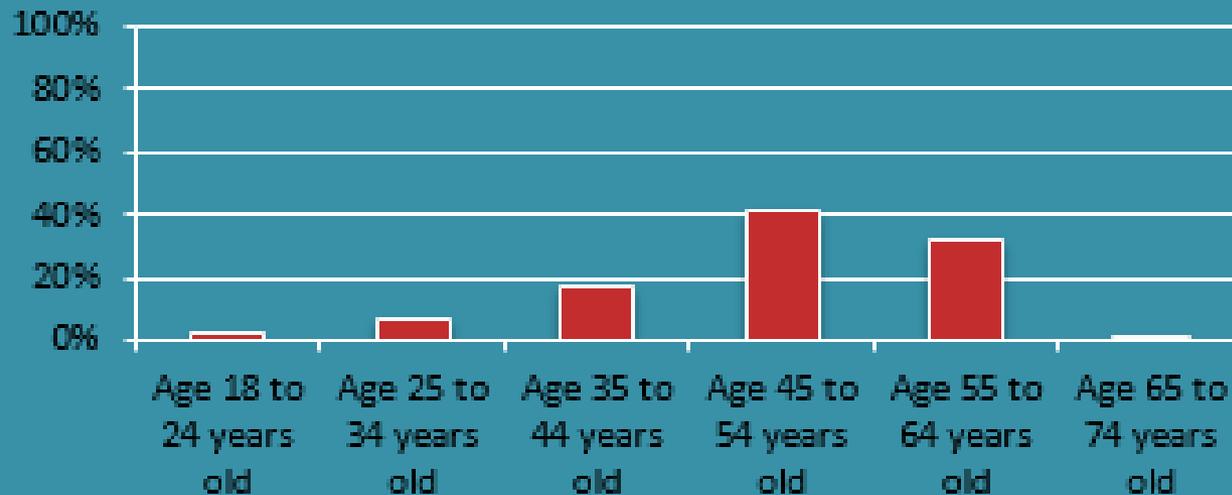


# Demographics

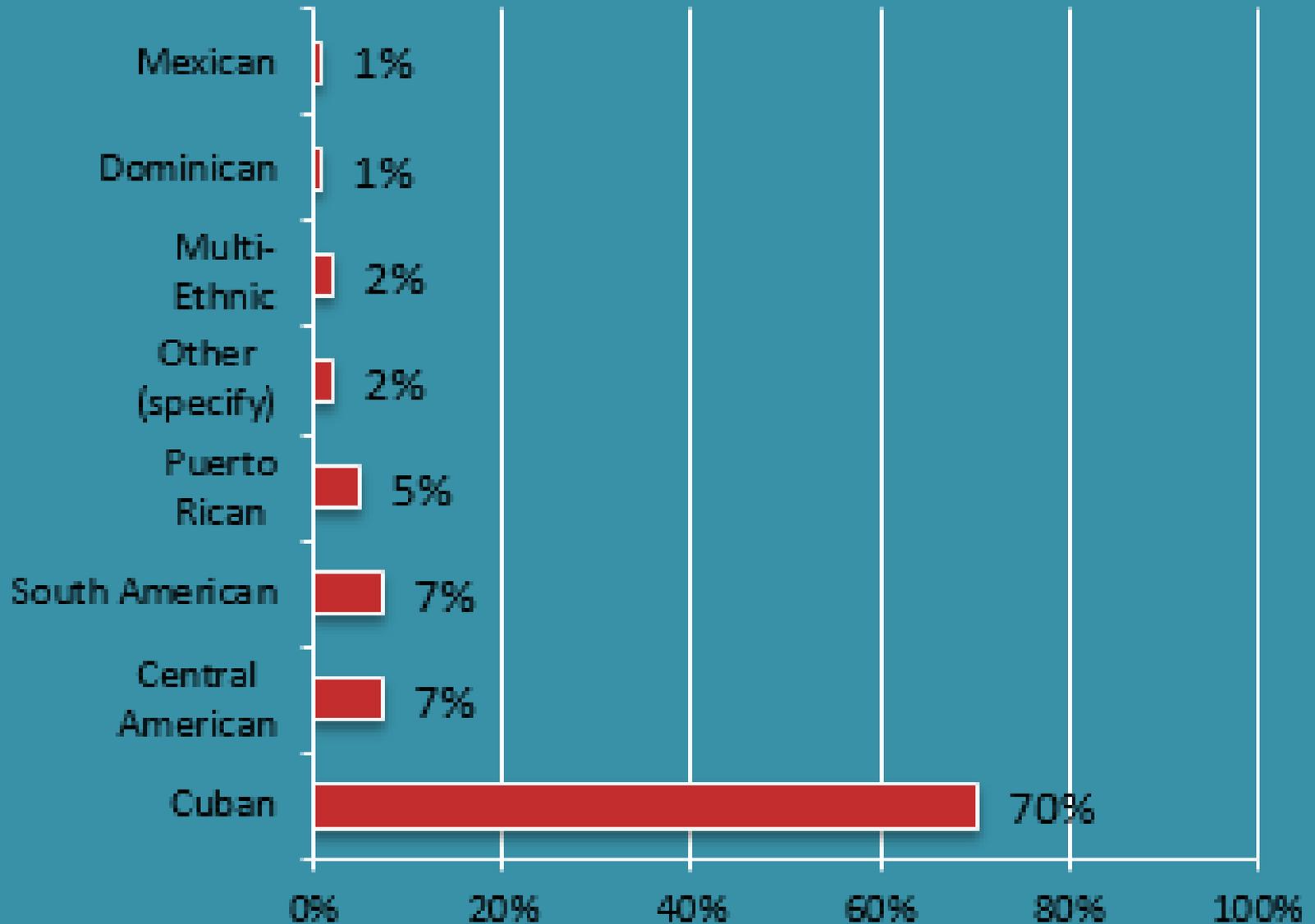
## Gender



## Age Group



# Ethnicity



# HEALTH IMPROVEMENT

Questions to answer:

- Which indicators are improving for your population?

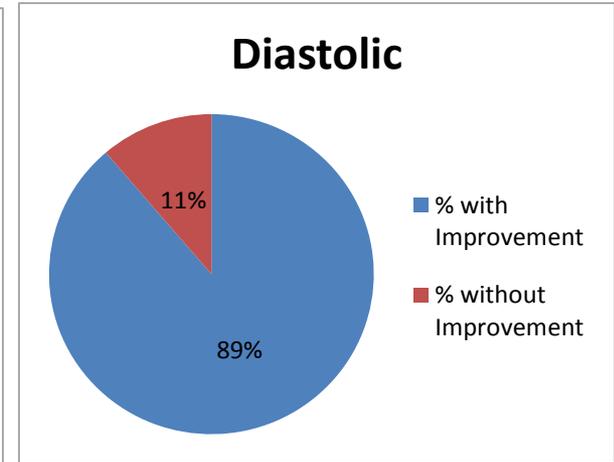
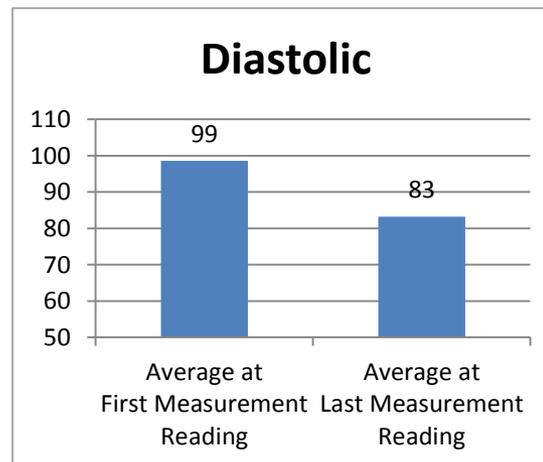
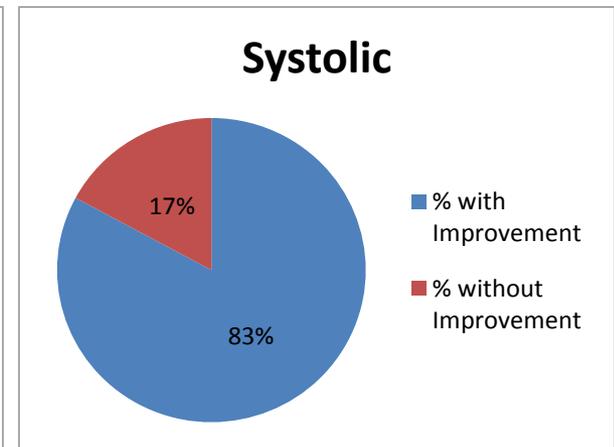
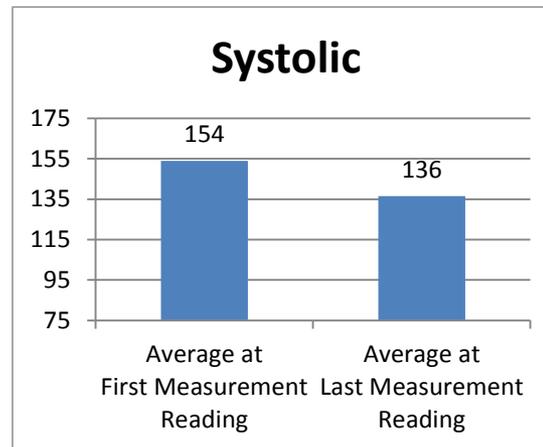
Resources:

- TRAC
- Your registry/EHR

# Health Integration Project

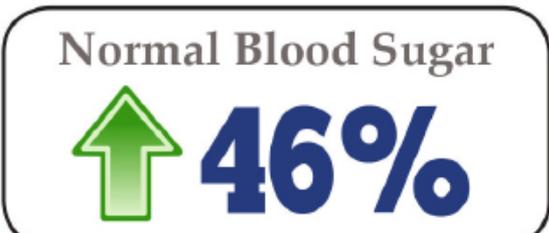
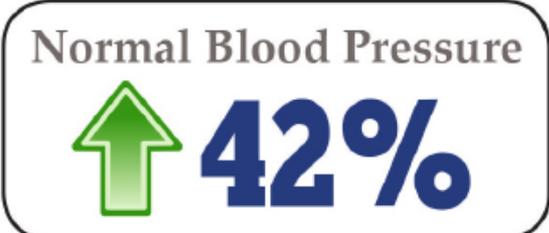
## Clinical Health Indicator – Blood Pressure

- Blood Pressure reading is systolic/diastolic.
- Consumers tracked with hypertension (140/90 and above) at first appointment.
- Average Change in measure 18/15.
- Average blood pressure fell from “hypertension” to “pre-hypertension” range.
- For every reduction of blood pressure by 20/10, risk of heart attack and stroke is cut in half.



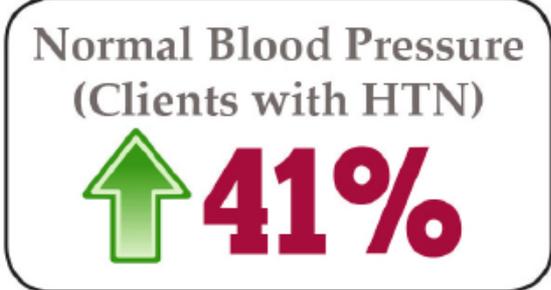
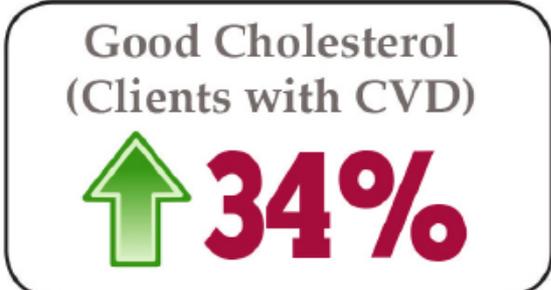
# DIABETES

3-YEAR OUTCOMES  
(FEB 2012 - JAN 2015)



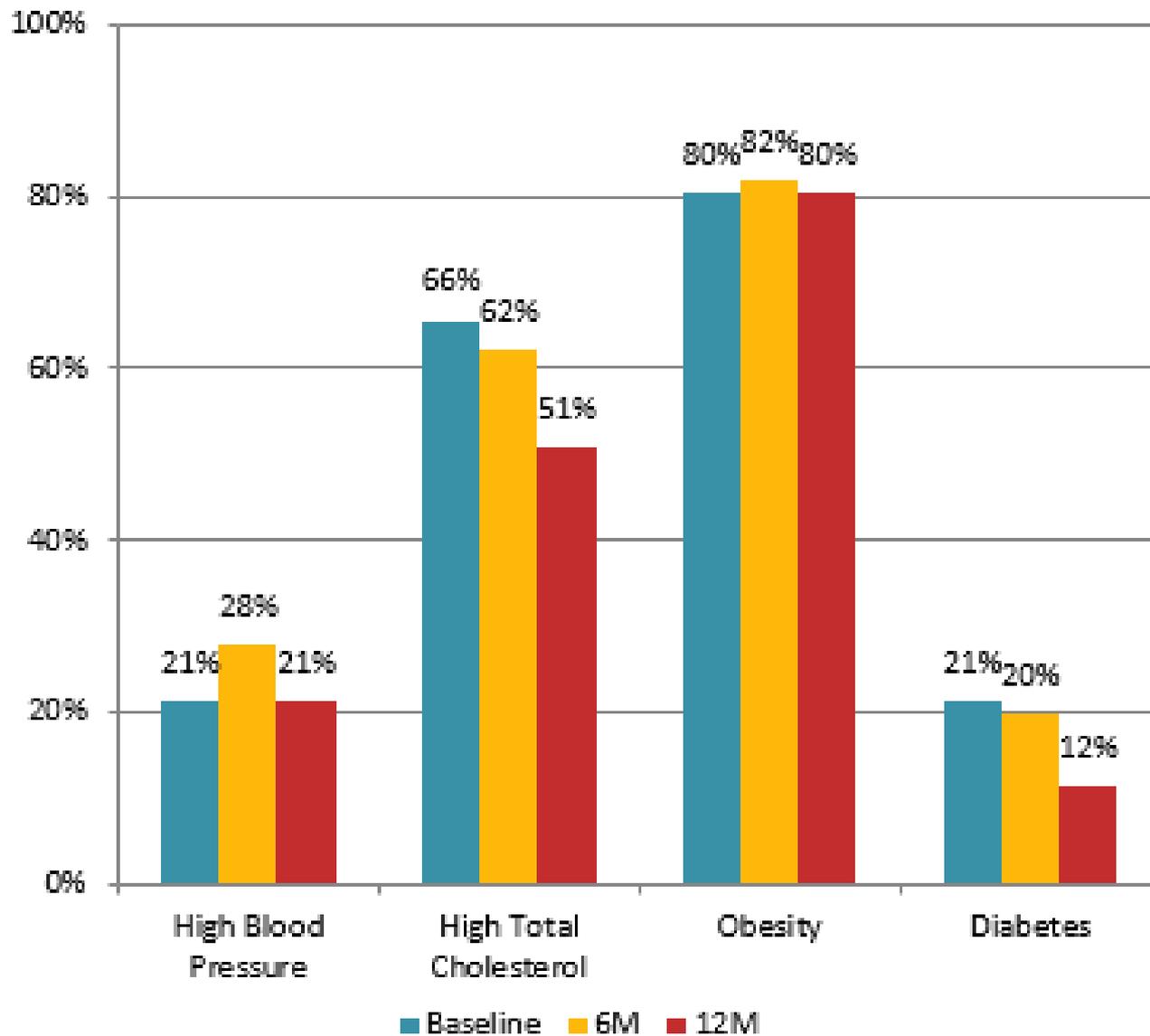
# HYPERTENSION & CARDIOVASCULAR DISEASE

3-YEAR OUTCOMES  
(FEB 2012 - JAN 2015)

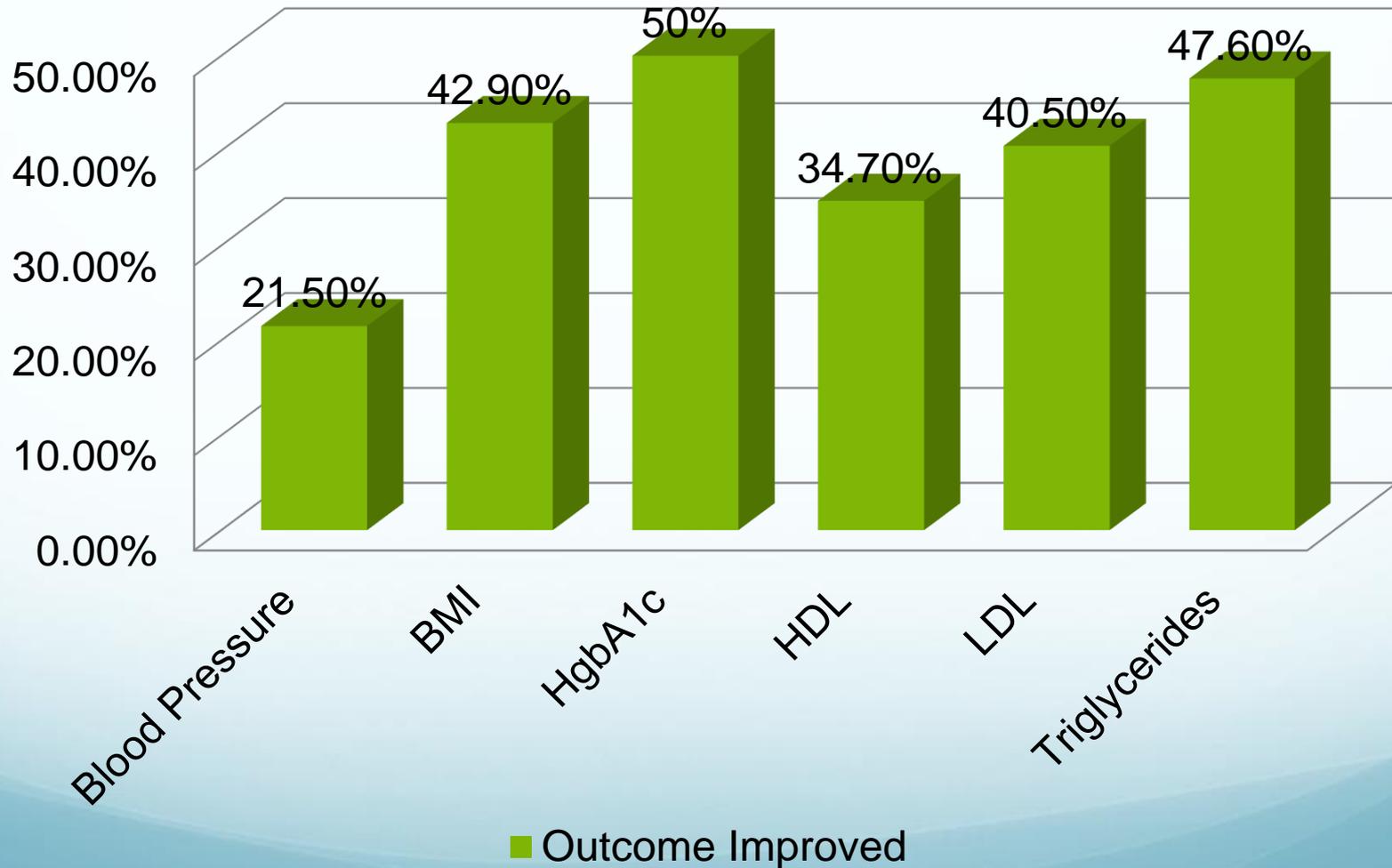


# Common Chronic Health Conditions at a Glance

N=61



# Health Outcomes: Improvement



# CONSUMER SATISFACTION

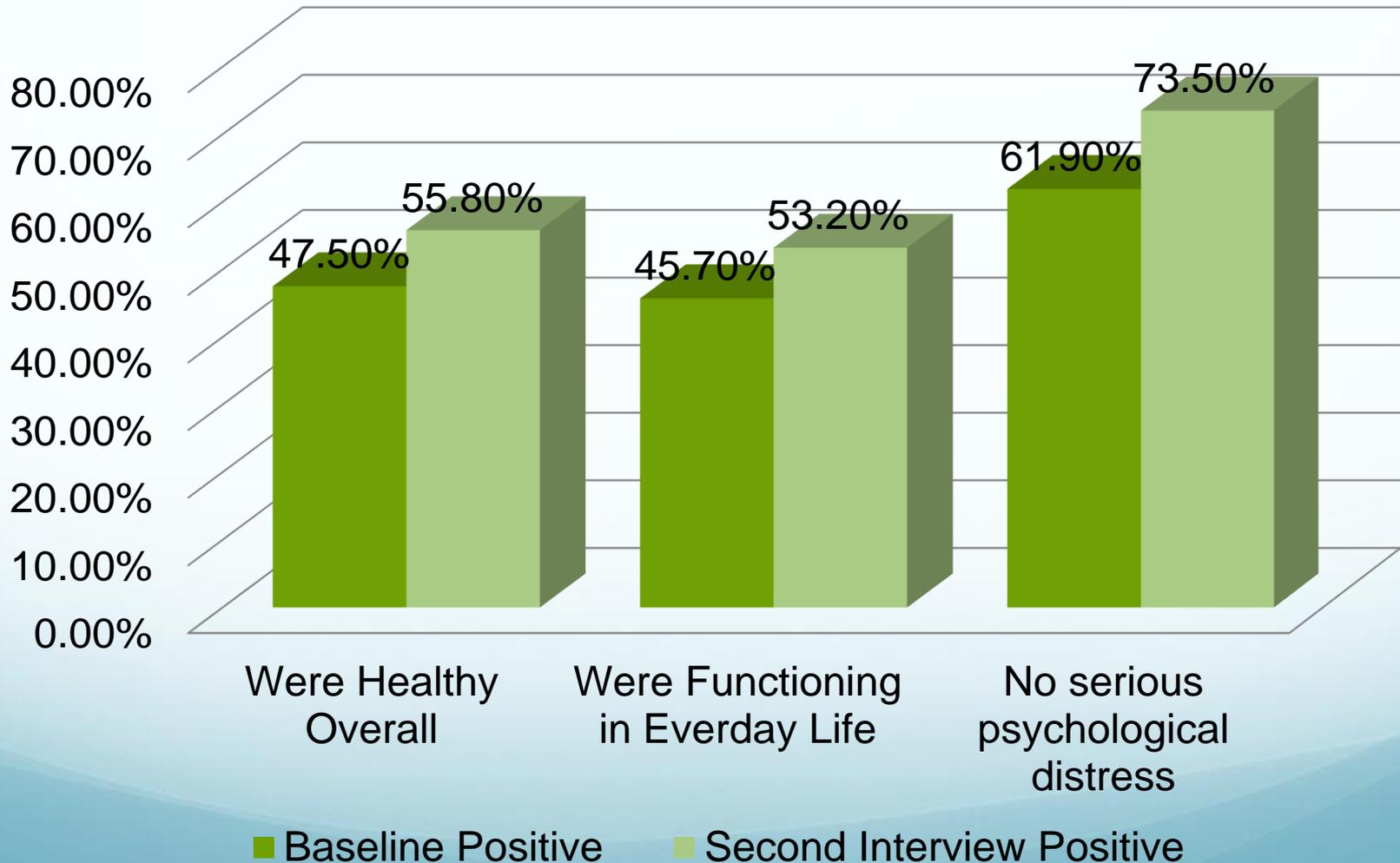
Questions to answer:

- Are consumers satisfied with the services they have received?

Resources:

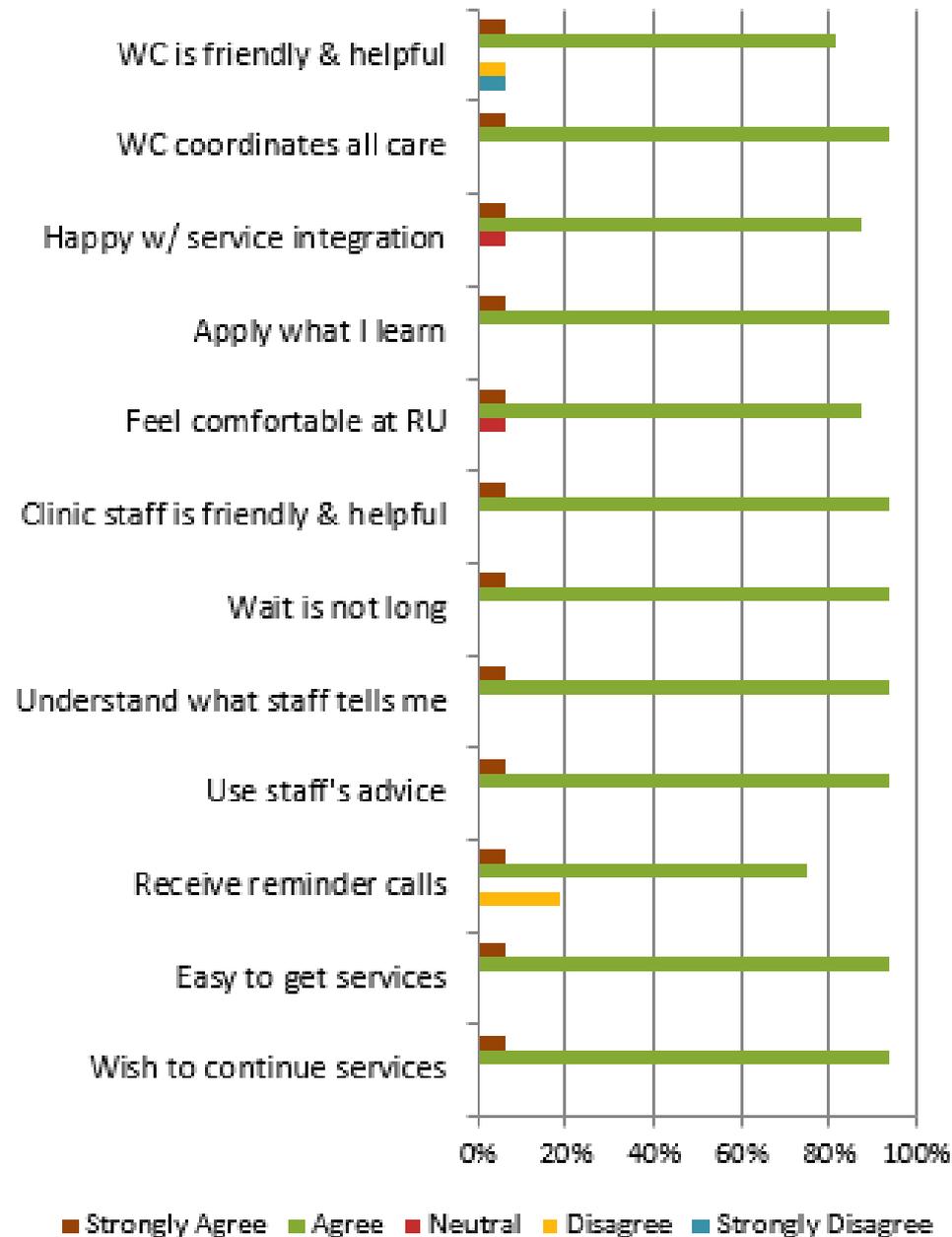
- NOMs interviews
- Consumer surveys and focus groups

# Client Outcomes: Functioning



# Satisfaction Surveys

N = 16



# COST SAVINGS

Questions to answer:

- How much did the new services cost?
- What was the reduction in more expensive services such as ER and inpatient hospital stays?

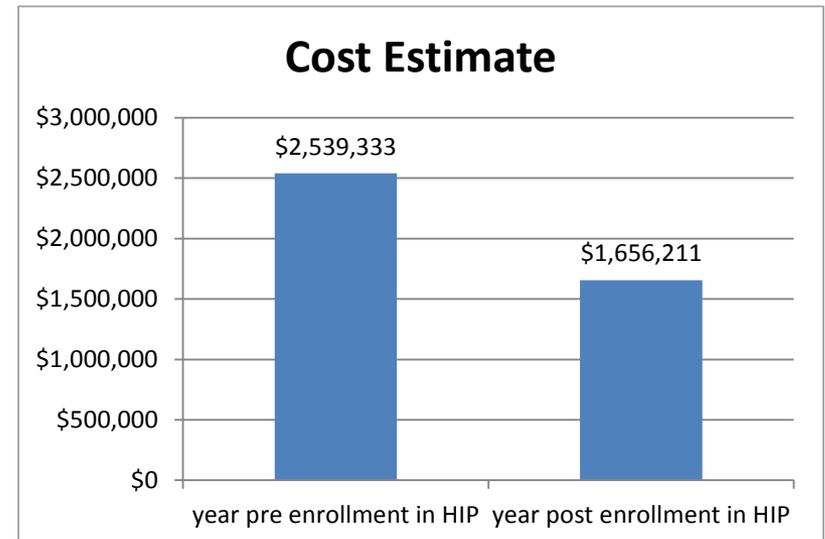
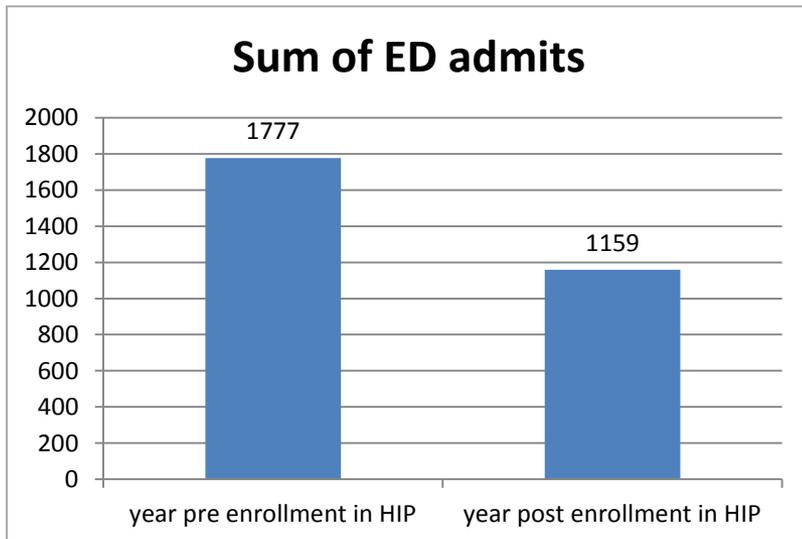
Resources:

- NOMs interviews
- Internal billing records
- Partnership with emergency department
- Medicaid claims data

# Health Integration Project

## Hospital Usage

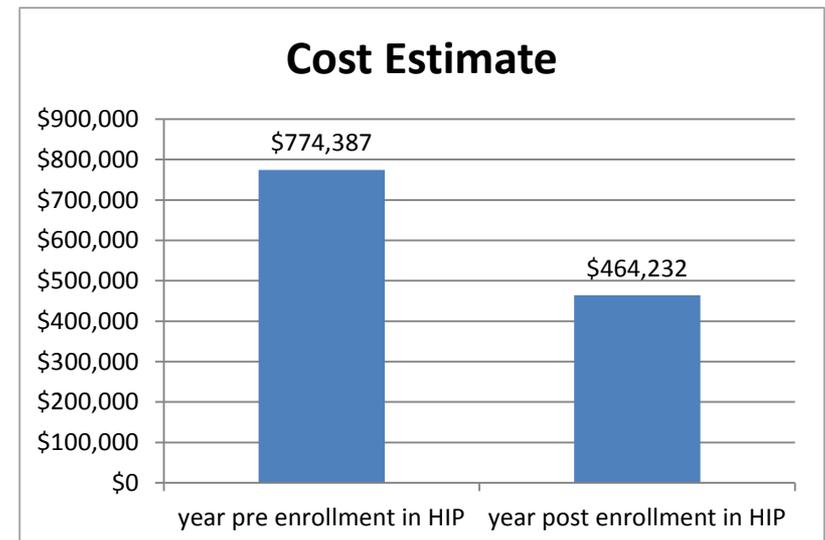
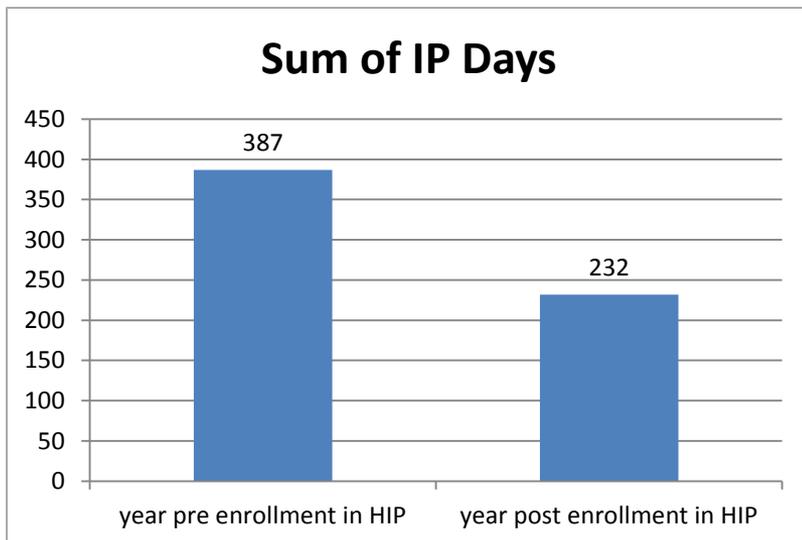
- ED admits
  - 342 consumers
  - 618 less ED admits in year post HIP enrollment
  - Average of \$1429 per admit
  - Estimated annual savings \$883,122



# Health Integration Project

## Hospital Usage

- Inpatient days
  - 114 consumers
  - 155 less inpatient days in year post HIP enrollment
  - Average of \$2001 per inpatient day
  - Estimated annual savings \$310,155
- Total Estimated Annual Savings \$1,193,277



# Healthcare Utilization Financial Data

## Acute/Inpatient vs Outpatient Charges

◆ Inpatient/Acute Charges    ■ Outpatient Charges



REDUCTION IN  
HOSPITALIZATIONS  
IN THE FIRST YEAR

 **9.1%**

(CMHC HEALTH HOME CLIENTS)

**COST SAVINGS**

(YEAR ONE)

Missouri Health Homes have saved **\$30,996,642.**

# DISCUSSION

What information do you think is most important to present to stakeholders?

What information is readily available to you?

What information would you like to uncover in the near future?