Pittsburgh Mercy Family Health Center

PBHCI Cohort 7

J. Todd Wahrenberger MD MPH
Medical Director

No Disclosures
COLLEGIALITY, COLLABORATION, OFF-STAGE NO ONE IS THE EXPERT – WE ARE
Brie Reimann, MPA
Deputy Director
SAMHSA-HRSA Center for Integrated Health Solutions
SETTING THE STAGE:
TODAY’S PRESENTERS

Dr. Todd Wahrenberger, MD, MPH
Medical Director & Family Medicine Physician
Pittsburgh Mercy Family Health Center

Alicia Kirby, MBA
Director of Integrated Services
Pittsburgh Mercy Health System
(Mercy Life Center Corporation)
Questions?
Please type your questions into the question box and we will address them.
POLL QUESTION 1

Our organization currently uses a risk stratification model to triage patients.

- True
- False
- Not Sure
POLL QUESTION 2

We understand the essential elements associated with risk stratification.

➢ True
➢ False
➢ Not sure
PITTSBURGH MERCY LEGACY
A HERITAGE OF HOPE

“We will lead care and service that transforms lives and discovers new possibilities, constantly putting people at the center of everything we do.”

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INTEGRATED PRIMARY CARE: PITTSBURGH MERCY HEALTH CENTER

PMHS Patient Population:

- In 2010, 33,000 individuals were receiving BH or ID care at PMHS - 50% were not receiving any routine primary care
- Chronic co-occurring SMI and Medically complex with high risk social determinants

Replicating the ACT model in Primary Care

- Highly engaging team meets the patient where they are in their lives
- Multidisciplinary and cross-community
- Rapid review of highest risk patients for enhance case management

Reverse Integration

- Community Mental Health Center embedding Primary Care within its programs
TEAM BASED POPULATION MANAGEMENT

Our Team

- Primary Care Provider
- Consulting Psychiatrist
- Care Manager
- Peer Support Coach
- Tobacco Cessation
- Medical Assistant
- Social Service Program

General Population
- Treatment resistant or Diagnosis Uncertain

SMI #1
- Loss to follow up
- Wanting to get back in to specialty care

SMI #2
- Loss to follow up
- Awaiting specialty care – capacity issue

SMI #3
- Refusing Specialty care

Drives our team

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GENERAL CONCEPTS FOR RISK STRATIFICATION

The Secret Sauce

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TRIAGE

Triage (/ˈtriːəʒ/ or /triːˈɑːʒ/) is the process of determining the priority of patients' treatments based on the severity of their condition. This rations patient treatment efficiently when resources are insufficient for all to be treated immediately.
BIG PICTURE

- **Biologic**: Chronic Disease, Stability, Medical Complexity, Compliance, Diagnostic Uncertainty
- **Psychological**: SMI, Stability, Compliance, Diagnostic Uncertainty, Treatment Resistant
- **Social**: Meaningful Activity, Social Supports, Housing, Safety
- **Health System Engagement**: Appropriate Utilization, Hospital And Payor Data
# PMFHC Risk Stratified Patient Care

<table>
<thead>
<tr>
<th>Level I</th>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
<th>Health Services / Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No Active Medical Problems</td>
<td>Good Coping Skills, No Mental Health Concerns</td>
<td>Meaningful Work/Activities, Stable Housing, Supportive Relationships</td>
<td>Insured, Good Access to Care, Good Treatment Experience, Good Communication with Medical Team</td>
</tr>
<tr>
<td>Level II</td>
<td>Clear Diagnosis, Mild Symptoms, No Impairment in Function, Low Risk for Morbidity/Mortality</td>
<td>Mild Mental Health Symptoms that do not interfere with Functioning, Good engagement with system</td>
<td>Stable Housing, Job, but no Activities, Mild Interpersonal Problems but has Support, sometimes Unreliable</td>
<td>Some Limitations to Care, Financial, Cultural, Geographic</td>
</tr>
<tr>
<td>Level III</td>
<td>Moderate Health Symptoms that interfere with Functioning, Chronic Disease present and Not Well Controlled</td>
<td>Moderate Mental Health Symptoms which interfere with Functioning, Non-Adherence to Treatment and Engagement, Hostility</td>
<td>Moderate Social Dysfunction, Unemployed, but has Leisure Activities, Poor Social Supports, Unstable Housing</td>
<td>Poor Coordination, Communication, Mistrust of Health System, Limited Insurance</td>
</tr>
<tr>
<td>Level IV</td>
<td>Severe Symptoms that interfere with Function, Multiple Diseases, Difficult to Diagnose &amp; Treat (Non-Physical Reasons), High Risk for Morbidity &amp; Mortality</td>
<td>Severe Mental Health Symptoms that interfere with Function, Criminal Behavior, Minimal Coping Skills, Not Engaged with System</td>
<td>No Housing, Unemployed, No Leisure Activity, No Family or Friend Support</td>
<td>No insurance, No Coordination of Care, Very Fearful &amp; Distrustful of Health Care System, Unwilling to Engage with Treatment</td>
</tr>
</tbody>
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ANALYSIS

• Don’t get “analysis paralysis”
• Pick a level and move along
• Use technology
• “Dummy” billing codes
• Split up the population into smaller teams depending on geography, services, etc.
EVIDENCE BASED

• Follow the ACT Team Model
• Meet regularly (or at least as much as you can)
• Team – who is team?
• Make it brief – fast, organized and actionable
• Set outputs
• Do one thing – Find the patient, change a treatment, add a service, get everyone on the same page.
DIVERSIFYING OUR TEAM

Letting the population drive how you use The Team

Consulting Psychiatry
- Treatment Resistance
- Could this be Bipolar?
- D&A masked as MH
- Personality Disorders
- Somatization
- Borderline
- Obsessive Compulsive

Care Management
- Engagement
- Drug & Alcohol Counseling
- CBT
- Brief Intervention
- Chronic Disease Education
- Housing and Social Support

Peer Support Coach
- Empathy – shared experiences
- Social Supports
- Building Independence
- Engagement

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THE FLYWHEEL PRINCIPLE – JIM COLLINS

- Be persistent
- Be persistent
- Be persistent
ACCESS TO PRIMARY CARE

Community Visits

Same Day Appointment

24 hour Call Coverage

Daily Calls for “Frequent Flyers”
MEASURING OUTCOMES

PMFHC participants experienced 67% fewer psychiatric hospitalizations

Table 1. Psychiatric hospitalizations for PMFHC and non-PMFHC participants (7/2013 to 7/2014)

<table>
<thead>
<tr>
<th># of stays</th>
<th>PMFHC participants (n= 84)</th>
<th>non-PMFHC participants (n=73)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>76</td>
<td>38</td>
</tr>
<tr>
<td>1</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Average</td>
<td>0.143</td>
<td>0.782</td>
</tr>
<tr>
<td>Range</td>
<td>0 - 4</td>
<td>0 - 4</td>
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</tbody>
</table>

Table 2. ALOS, Median LOS, and Range of Stays (in days) for PMFHC and non-PMFHC participants (7/2013 to 7/2014)

<table>
<thead>
<tr>
<th>Measures (days)</th>
<th>PMFHC participants n=8</th>
<th>non-PMFHC participants n=37</th>
</tr>
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<tbody>
<tr>
<td>Average</td>
<td>15.6</td>
<td>39.4</td>
</tr>
<tr>
<td>Median</td>
<td>10.5</td>
<td>30.5</td>
</tr>
<tr>
<td>Range</td>
<td>1 - 47</td>
<td>3 - 113</td>
</tr>
</tbody>
</table>

PMFHC participants spent significantly less time in psychiatric hospitals within the past year
MEASURING MEDICAL COSTS

Pre and Post Hospital Utilization – Per Member Per Month

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre-PMFHC PMPM</th>
<th>Post-PMFHC PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Medical...</td>
<td></td>
<td></td>
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<tr>
<td>Inpatient Surgical...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Level 1-3 Home...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ED Level 4-5 Home...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BH Detox/Rehab</td>
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</tbody>
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QUESTIONS, COMMENTS?