Partners in Recovery

HealthBI

Treating Mind and Body:

How Partners in Recovery Increased Primary Care for Behavioral Health Patient Populations

Leanette Henagan, Chief Health Integration Officer, Partners in Recovery
Sherry Westlake, Vice President Sales, HealthBI

HealthBI™

Solving the Challenges of the Last Mile in Care Delivery

Sherry Westlake, VP Sales, HealthBI

Evolution of Population Health

HealthBI

MILE 1 — **P4P CONTRACTING**

- Incentivizes proactive care
- Identifies goals (spend/quality)

MILE 2 — **MEMBER RISK STRATIFICATION**

- Disease registries
- Gaps in care
- Predictive logic

MILE 3 — **PROVIDER WORKFLOW**

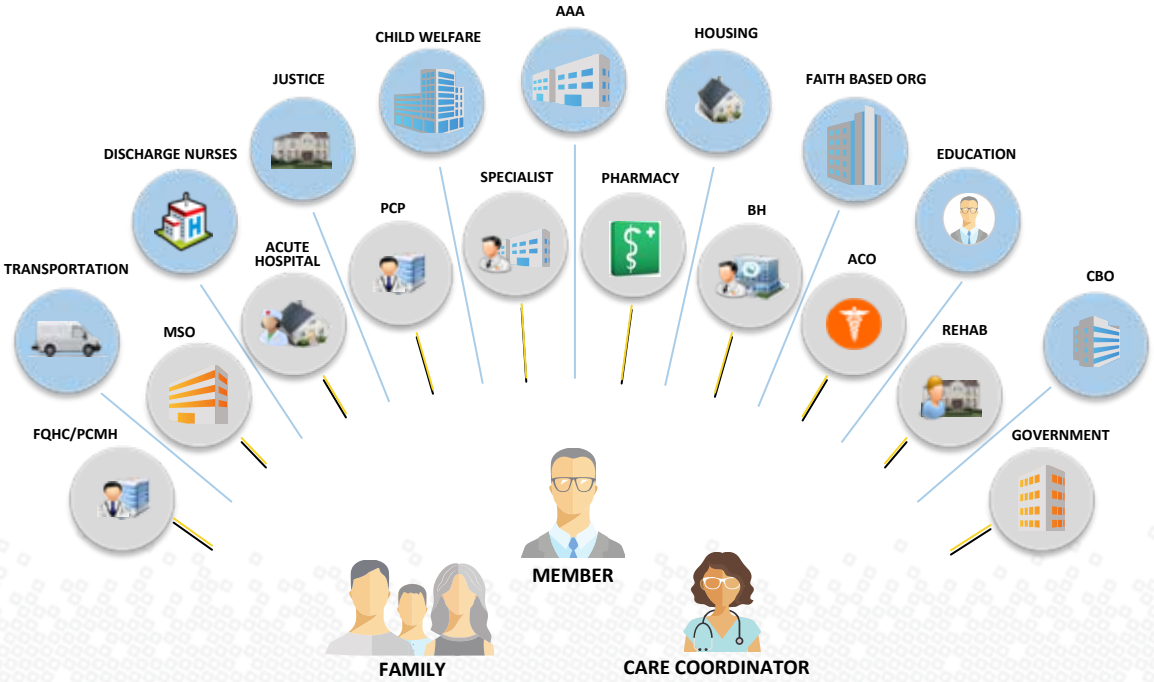
- EMR/ Interoperability
- Care coordination
- Integrated delivery models

Solving Last-Mile Challenges

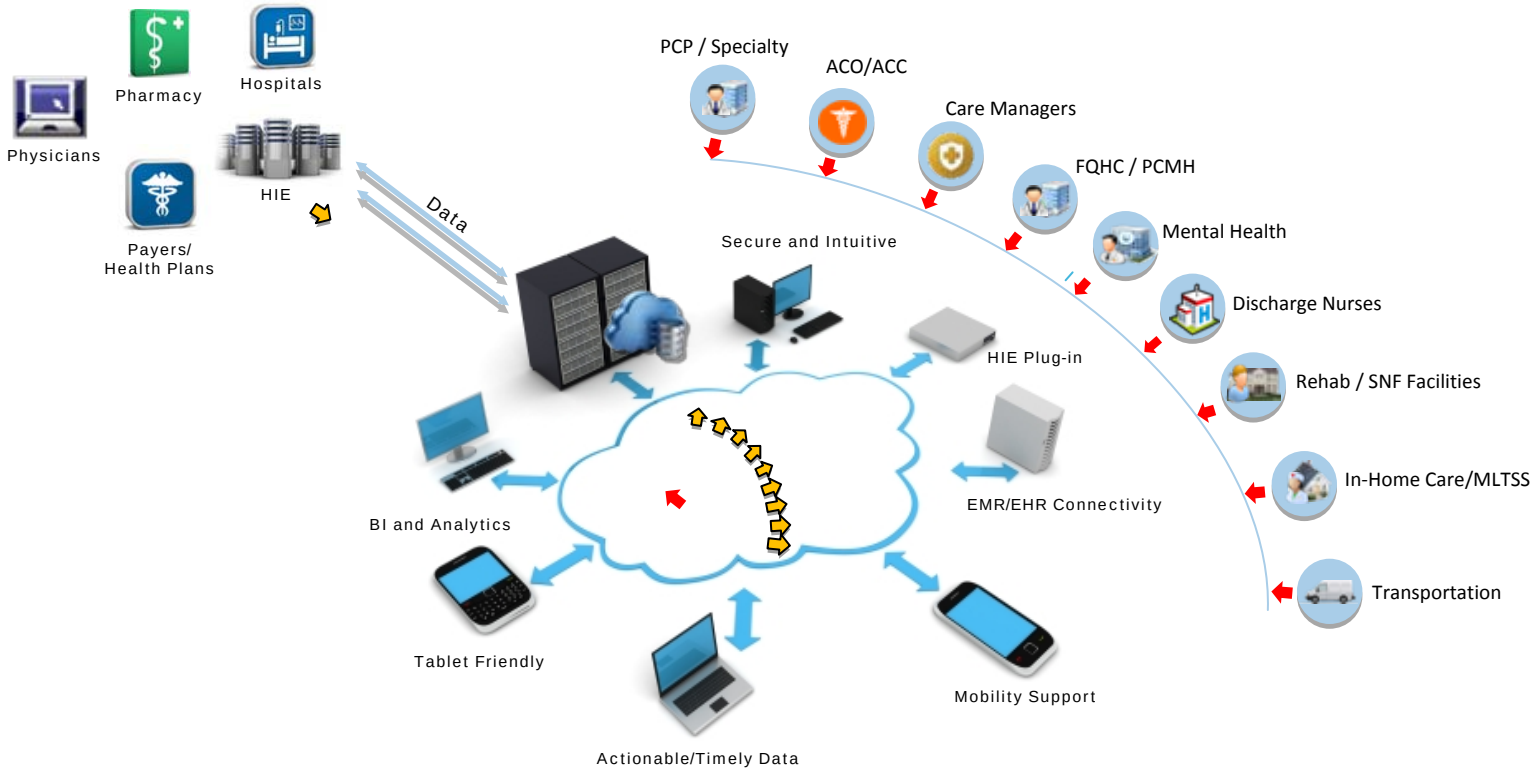
HealthBI

- 5 STAR Care Coordination across Health Continuum
- Data Interoperability, Agility & Support
- Lower Cost of Delivery & Administration
- Activity & Performance Tracking
- Alignment with Quality Measures: STAR/HEDIS
- 360º Patient Insight

Virtually Integrated Care Teams



Care Team Connection & Workflow



Who is HealthBI?

- **Experience & Track Record**
  - Since 2011 with large national payers
  - Medicare, Medicaid, Commercial
- **Built for Scalability**
  - 95M+ transactions per month
  - 10,000 CCDs per hour
  - 150+ EMRs
  - 20,000+ concurrent users
  - 180,000 ADTs per month
- **Results**
  - 18% reduction in hospital admissions per 1000
  - 19% reduction in PMPM
  - 25% decrease in readmits within 30 days
  - 22% reduction in ER admits per 1000
  - 30% increase in primary care visits
  - $350 million in cost savings & incentives
  - HEDIS quality improvements

50 states

22 million lives

62,000+ sites

Last Mile of Care = Efficient Delivery

1. Empowering providers with tailored, next- generation population health management solutions
2. Clinical collaboration across the provider continuum
3. Align providers with progressive, value-based contracts focused on cost and quality
4. Physical – Behavioral – Social integration for patients

Treating Mind and Body:

How Partners in Recovery Increased Primary Care for Behavioral Health Patient Populations

Dr. Leanette Henagan, DBH, LCSW, LISAC,
Chief Health Integration Officer

Partners in Recovery Mission

Partners in Recovery

PIR was created in 2009 by three longstanding behavioral health providers in Maricopa County.

130 years combined experience:
innovative & recovery-oriented services

Mission:

“Transforming Lives Through Passion, Innovation and Action.”

Vision:

“All people have an opportunity to choose where and how they will live, learn, work, and play.”

What is the Targeted Investments Program (TIP)

Partners in Recovery

1115 Waiver renewal authorized $300M in Targeted Investments focused on:

Integration of physical and behavioral health care

Increase efficiency of service delivery for members with behavioral needs

Improve health outcomes for Medicaid members

Distribution of Funds

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Estimated Distribution of Funds Across Each Strategic Focus Area per Year

Focus Area	Year 1	Year 2	Year 3	Year 4	Year 5
TI Overall	6.7% $19 M	23.3% $66.5 M	30.0% $85.5 M	22.3% $66.5 M	16.7% $47.5 M
Ambulatory (Primary Care & BH Services)	92% $17,480,000	92% $61,180,000	92% $78,660,000	92% $61,180,000	92% $43,700,000
Justice	5% $950,000	5% $3,325,000	5% $4,275,000	5% $3,325,000	5% $2,321,000
Hospital	3% $570,000	3% $1,995,000	3% $2,565,000	3% $1,995,000	3% $1,425,000

Quality and Access Milestones

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Pediatric Milestone Checklist

MILESTONE CORE COMPONENT	DESCRIPTION	DUE DATE	RESOURCE / TOOL	OWNER	DATE COMPLETED
1	Utilize BH Integration Toolkit and Practice-Specific Action Plan to Improve Integration and Identify Level of Integrated Healthcare	5/31/18	Integrated Practice Assessment Tool (IPAT) TAB 1 https://azahcccs.gov/PlansProviders/TargetedInvestments/		
8	Utilize the Arizona Opioid Prescribing Guidelines for Chronic Pain				
2	Part 1: Identify High-Risk Members and Develop an Electronic Registry				
	Part 2: Identify Criteria is Being Used and Recorded				
3	Part 1: Utilize Practice Care Manager(s) for Members Included in the High-Risk Registry				
	Part 2: Demonstrate the Care Manager(s) Have Been Trained to Use Integrated Care Plans				
4	Implement the Use of an Integrated Care Plan and Develop Communication Protocols with MCO's and Providers				
5	Screen all Members to Assess SDOH				
6	Identify Community-Based Resources				
7	Screen all Members for BH Disorders				

Adult Milestone Checklist

MILESTONE CORE COMPONENT	DESCRIPTION	DUE DATE	RESOURCE / TOOL	OWNER	DATE COMPLETED
1	Utilize BH Integration Toolkit and Practice-Specific Action Plan to Improve Integration and Identify Level of Integrated Healthcare	5/31/18	Integrated Practice Assessment Tool (IPAT) TAB 1 https://azahcccs.gov/PlansProviders/TargetedInvestments/		
8	Utilize the Arizona Opioid Prescribing Guidelines for Chronic Pain	5/31/18	Arizona Department of Health Services TAB 8 http://azdhs.gov/documents/audiences/clinicians/clinical-guidelines-recommendations/prescribing-guidelines/az-opioid-prescribing-guidelines.pdf		
2	Identify Members Who are High-Risk and Develop Electronic Registry	6/30/18	High-Risk Registry Protocol TAB 2		
	Demonstrate Use of Identific tion Criteria and Document Members in Registry	9/30/18			
3	Utilize Care Managers for High Risk Registry	7/31/18	Practice Care Manger, EHN Transition Care Team & EHN Ambulatory Care Team TAB 3		
	Demonstrate that Care Manager(s) are Trained in Integrated Care	9/30/18	EHN & TIP Sponsored Trainings TAB 11		
4	Implement Integrated Care Plan	9/30/18	EHN Integrated Care Template TABS 4 EHR Care Plan American Academy of Family Physicians https://www.aafp.org/fpm/2015/0100/fpm20150100p7-rt1.pdf		
5	Screen all Members to Assess SDOH	9/30/18	EHN Health Access Survey (SCRA), PRAPARE TAB 5 National Association of Community Health Centers http://www.nachc.org/wp-content/uploads/2016/09/PRAPARE_Paper_Form_Sept_2016.pdf		

How Did We Get Here?

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- Facility build-out
- Licensing changed
- Uptraining of staff
- New clinical & operational work flows
- Provider collaboration

How Did We Get Here?

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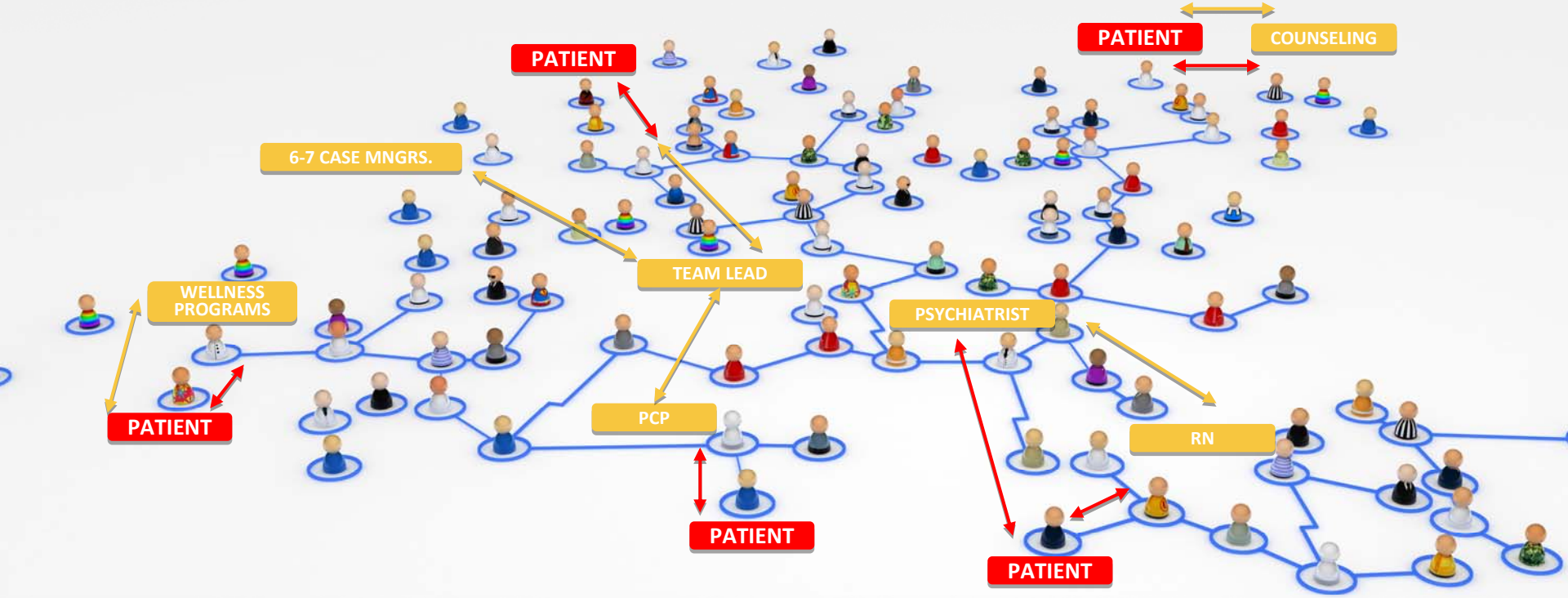

Staffing Model (BEFORE) – Traditional Clinical Team

How Did We Get Here

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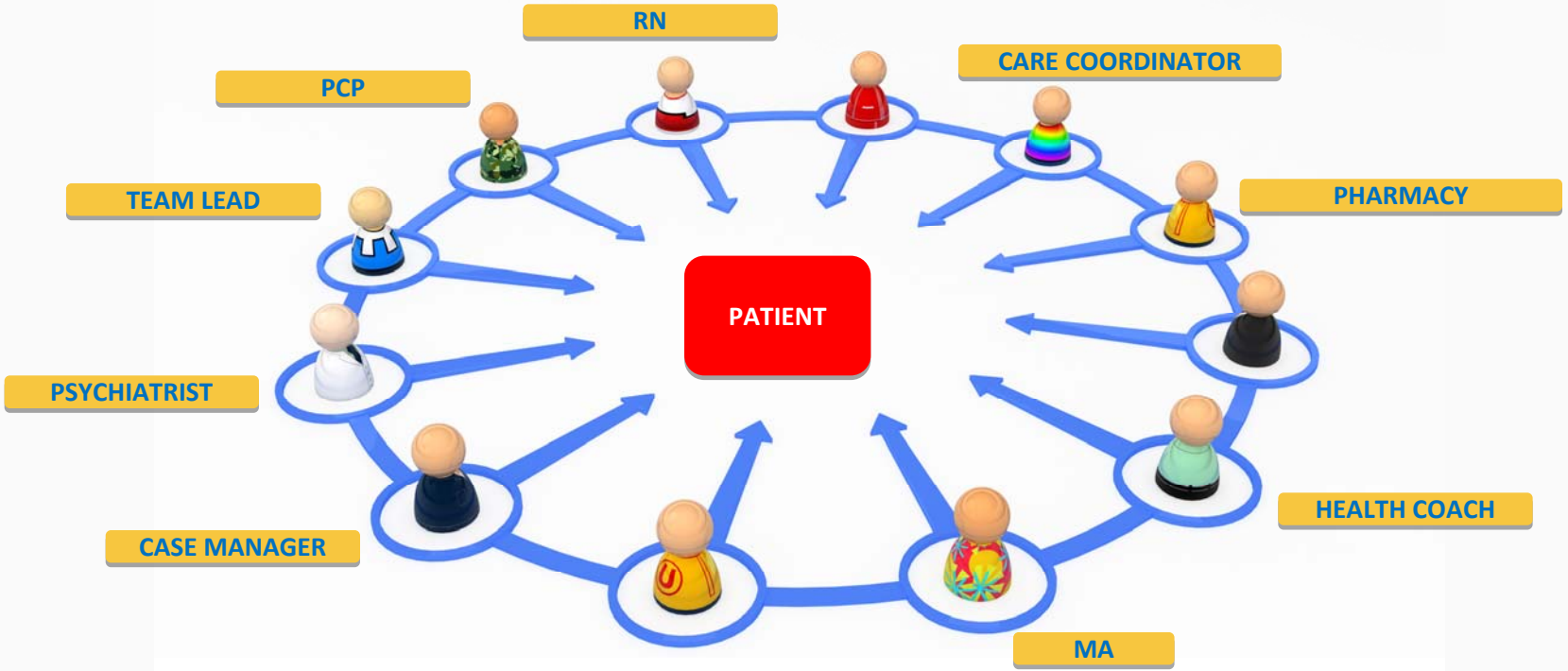

Staffing Model (AFTER) – Collaborative Care Team

All the Right Information in One Clean View

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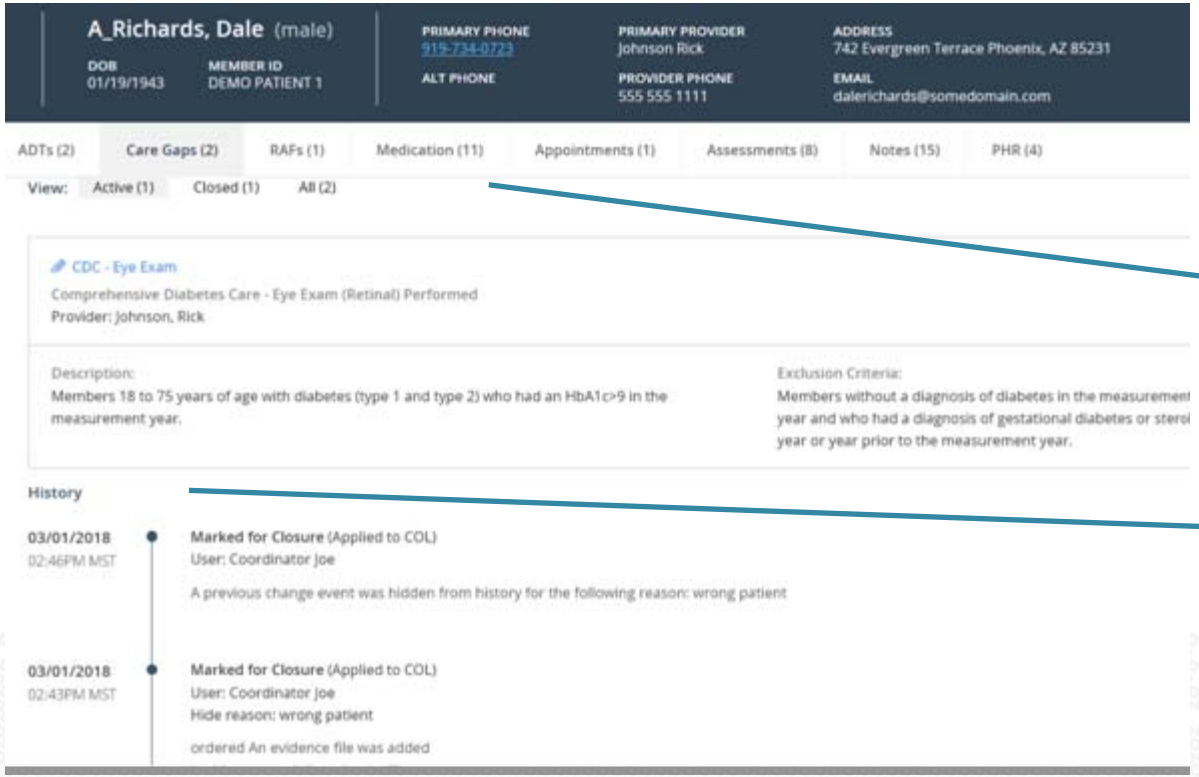

- ADT Events
- Care Gaps
- Medications
- Consolidated Notes
- Appointments
- Assessments

Timeline View of All Activities, Notes and Events

Efficiency for Open Gaps and HEDIS

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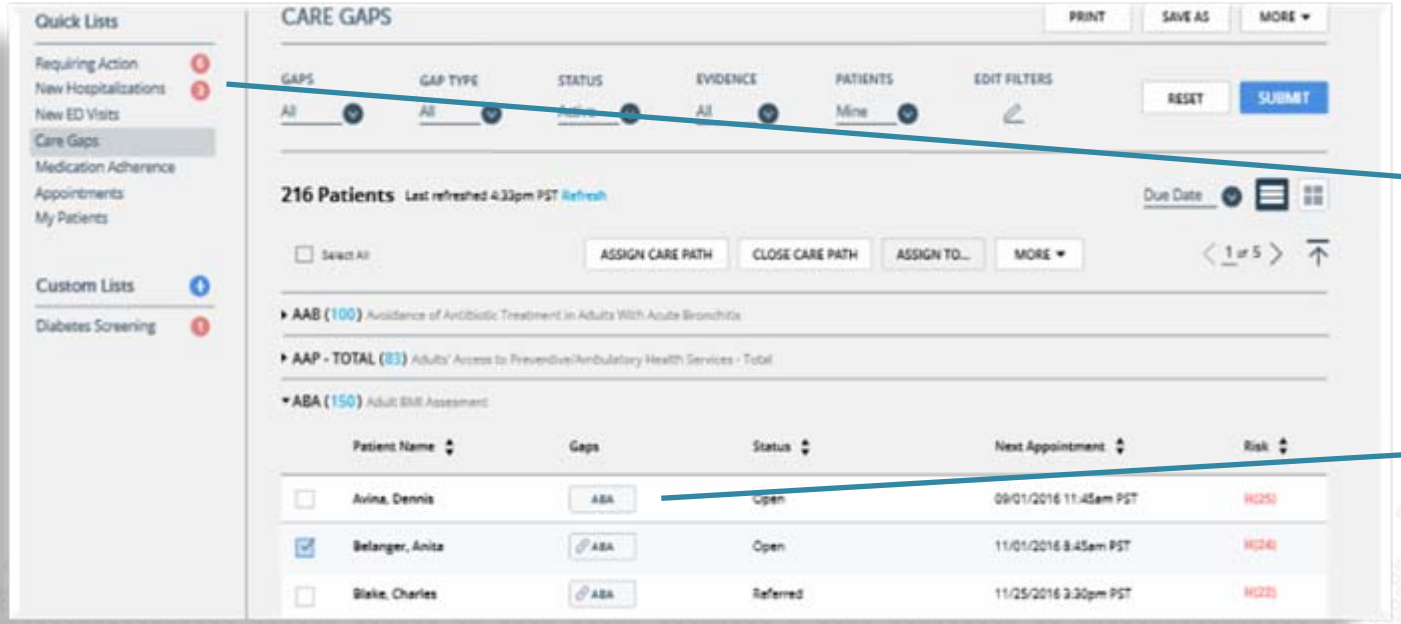

- Quick Links
- Custom Filters
- Risk/Priority

- Open Gaps and HEDIS

Redefining Healthcare Goals

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- Identification of high-risk populations
- Support Integrated Care Teams
- Clinical decision support
- Improve quality, patient experience
- Reduce cost

Statistics

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32%

Increase in completed wellness care activities

- ✓Diabetic eye exams
- ✓HbA1c3 labs
- ✓Colorectal screening
- ✓EPSDT well visit (18-25 year olds)
- ✓PAPs
- ✓Mammogram
- ✓Chlamydia screening

“ …Without a data-sharing technology tool, we would have not been able to achieve our *integrated health goals or incentives.* The platform has been successful for our two main objectives: Better access to care for our patients, and reducing our costs for care delivery.”

Case Study - Story of Lola

Partners in Recovery

51 ED visits in last 12 months

- Consistently seen by Pain Management
- Med reconciliation
- The family factor
- Decrease cost
- Increase in routine care
- Increase in health literacy
- Increase in patient activation

Questions & Answers

Together We Thrive

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