Integrating Physical and Behavioral Healthcare in PROS

NYAPRS PROS Academy 2014

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Advanced Health Network

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Healthy Lives – Healthier Communities

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The Advanced Health Network is an IPA (Independent Practice Association) dedicated to being a leader in the delivery of clinically integrated healthcare and social services.

MHA Nassau County

* **MHA Nassau is a $10 million agency including PROS, Peer, Health Home, and Residential.**
* **2010: MHA converted Clubhouse, Employment and Supported Education programs to PROS.**
* **PROS clinic was the first foray of the agency into providing clinical treatment services.**
* **In 2012 PROS Awarded an OMH grant to integrate Physical Health Care into a Behavioral Health setting.**

ACCESS TO PRIMARY CARE

* 19% of "high cost – high need" Medicaid recipients had NO visits to Primary Care in a year.
* 13% had 1 – 2 visits.

IMPLICATIONS

* (1) People used the ER as "Primary Care"
* (2) People waited until they were really, really sick and had catastrophic conditions (that could have been prevented)

Primary Care???????

* **Prior to the Medical Grant Project many PROS members reported having a primary care physician, but could not recall his or her name, nor could they recall the last time they had a physical exam.**

HOWEVER……

* We do know that our consumers are engaged with us in our PROS programs.

Geriatric Mental Health

* **MHA going back to clubhouse days had been active in developing a "Senior" Track that focused on:**
* **> Light Exercise**
* **> Learning about the impacts of Aging**
* **> Nutrition ("Healthy" Lunches)**
* **> Health focus (i.e. Use of Scale and Self-Blood Pressure Monitor)**
* **This learning was carried over to PROS**

Grant Overview

* Funding came from NYS Office of Mental Health to integrate healthcare into a behavioral health setting.
* Originally targeted adults age 55+, but age restrictions were relaxed due to sustainability issues.

PROGRAM DESIGN

* The grant paid for a PC (Physicians Corporation) who is affiliated with the local “safety net” hospital (Nassau University Medical Center) who provides a primary care MD one day a week each to the MHA PROS.

GRANT KEYED ON……

* **Tobacco**
* **Blood Pressure**
* **Diabetes**
* **Obesity**
* **Depression**
* **Alcohol**

Program Operations

* **Doctor with bilingual medical assistants came to PROS 1 day a week.**
* **MD attended morning PROS staff meeting to discuss member's care with staff – staff shared their feedback as well.**
* **After the medical visit, MD provided staff feedback through use of an intranet system. (Results, next appointments, specialty care etc.)**

Operations (cont'd)

* **1 PROS staff was assigned as the Project Coordinator**
* **Managed appointments**
* **Reported Data to OMH**
* **Liason with Medical Practice**
* **PROS Advisors completed initial packet with member.**

Operations

* **If a member had an urgent medical need on a day when the MD was not in the PROS, the member could access the MD in the regular practice office.**
* **MD and practice available for after hours calls in urgent situations.**
* **If member "graduated from PROS", they could continue with the MD at the regular practice location.**

Operations

* **After the health assessment, if a chronic condition was noted, if the consumer elected the MD as their primary care physician, the condition was treated, and had a follow-up visit within 3 months (usually less).**
* **If not the primary care physician, the MD would reach out to the Primary Care Physician and would seek to coordinate care. – Consumer still got 3 month follow-up.**

Operations

* **PROS Liason scheduled regular appointments, including visits to review results from labs or specialty care, for prescription refills, and when consumer reported being ill.**

Operations

* **Initial visits scheduled for 1 hour. (Many members have difficulty recalling past / present medical history, medications etc.)**
* **Follow-ups are scheduled for 30 minutes to allow for more time for discussions, questions, coordination, encouragement etc.**

Starting Up:

* **Buying medical equipment**
* **Physical Space**
* **Data Collection and reporting to OMH**
* **Incorporating assessments for depression (PHQ-9) and alcohol misuse (Audit-C)**
* **Insuring medical service time not billed to PROS "Program Time".**

Coordinated Care

* **Integration with Health Home**
* **While the MD and PROS Psychiatrist shared an office space, they were scheduled to work different days.**
* **However, several time a a year they wind up working on the same day and can have “face-to-face” collaboration on complex situations.**

Specialty Care

* **While compliance with specialty care was a challenge (as will be discussed later), members who had not received regular primary care were also in need of specialty care: Gynecology, Dental, Cardiology, Neurology, Dermatology, Gastrology, Endocrinology, ENT, GI, Nutrition, Labs, Mammography, Colonoscopy, Podiatry, Pulmonology, Opthamology, and X-Rays.**

Changing Agency Culture

* **Upon referral, the consumer (referral source) invited to utilize the "1 stop shopping approach" (PROS, PROS Clinic, Medical)**
* **This is often valued by Hospital D/C Planners.**
* **Encouraged Health Home and Residential to also refer to the Medical clinic.**
* **Presentations to both staff and consumers.**
* **Young PROS staff are "growing up" in integrated care model.**

Statistics

* **During the 2 year grant 129 members had over 400 visits. (Note – the grant allowed for "augmented care" where the consumer did not need to "elect" the MD as their Primary Care Physician)**
* **Of the approximately 80 members who had elected the MD as their Primary Care Physician, there were zero hospital admissions for medical reasons!**

Statistics

* **OMH "fed back" the MHA statistics and indicated that MHA had over 90% of its members with co-occurring conditions.**

Statistics

* 33% of total members seen in the clinic have hypertension
* 60% of members with hypertension were also obese
* 50% of members seen in clinic were obese
* 59% of the members referred to the nutritionist complied with the visit

Statistics

* 50% of members seen in clinic were obese
* 59% of the members referred to the nutritionist complied with the visit
* Of that number nearly 50% lost weight with an average of 9 pounds
* Of those that were non-compliant with the nutritionist – 100% gained weight with an average of 6 lbs.

Challenges:

* **While member have had good "show rates" for the primary care session in PROS, their compliance with specialty care has been challenging – About 40% "No Show" Rate**
* **Afraid to find "something is wrong with me"**
* **Trauma history related verbal/physical/sexual abuse (i.e. Feel safe in PROS setting, but not in outside settings) –Specialty Care can be invasive.**

Challenges: Sustainability

* **Cost of providing the service is about $1000 a day**
* **Medicaid / Medicare / Managed Care does not pay those costs.**
* **Program made a decision not to "cut corners" (i.e. shorten visits to 15 min., use an NP in place of an MD etc.)**

Sustainability

* **MHA is using an annual allocation from United Way to support cost of MD now that the grant has expired.**
* **Agency is providing financial support.**
* **Local Safety Net Hospital (NUMC) provides support to the PC**

Future

* **Many DSRIP PPS did choose the DSRIP project involving co-located care. MHA is hoping to be supported through DSRIP.**
* **Safety Net Hospitals may be more amenable to supporting this effort.**
* **Many local, private MD practices are being "bought" by hospitals.**

Preparing for the Future

* **HARP is "Health and Recovery Plan" with an integrated PMPM (Per Member – Per Month) for the MCO of approximately $2500. Of this figure, historically $500 is spent on medications, $1000+ is spent on healthcare, and a little less than $1000 is spent on BH Care.**
* **Integrated Care is attractive to payers with opportunity to save $ on healthcare costs.**