Integra ServiceConnect℠

Supporting People with Serious and Persistent Mental Illnesses in their Communities
Presented By:

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Agenda

- Need for Program
- ServiceConnect℠ Program Description
- Program Goals & Objectives
- Implementation Method
- Obstacles/Barriers
- Program Results
Need for Program

- Histories of over-reliance on emergency behavioral health services and the most intensive levels of care.

- Difficulty complying with treatment plans or engaging in sustained, effective outpatient care, commonly suffer from chronic co-morbid medical problems, and account for a substantially disproportionate share of total healthcare costs for payers.
Need for Program

- These members share a common profile:
  - They are difficult to locate and contact—traditional telephonic CM has limited utility with population
  - Serious MH accompanied by severe medical conditions require assistance to access medical & social services
  - They make disproportionate use of intensive inpatient services— inpatient claims often represent 80% or more of their total BH claims
  - They comply poorly with outpatient follow up care after hospital discharge
Need For Program

- Persons with serious mental illness Consume disproportionate levels of health care expenditures
- Have higher rates of Chronic Disease
  - Cardiovascular disease
  - Diabetes
  - Respiratory disease
  - Infectious disease
- Have higher rates of Modifiable Risk Factors
  - Smoking
  - Alcohol consumption
  - Poor nutrition / obesity
  - Lack of exercise
  - “Unsafe” sexual behavior
  - IV drug use
Need For Program

More likely to

• Develop medical illnesses
• Develop them at a younger age
• Die sooner from them

50%-90% of people with SMI have one or more chronic medical illness

• Rates are higher with comorbid substance use

1 Gold KJ, Kilbourne AM, Valenstein M: Primary care of patients with serious mental illness: your chance to make a difference. J Fam Pract 2008; 57:515-525

ServiceConnect℠ Description

• A program designed to help persons with severe and persistent mental illness function more effectively in their communities by providing the day-to-day support needed to reshape costly and ineffective patterns of health service utilization.

• Helps these individuals reduce reliance on emergency and inpatient BH services by connecting and keeping them engaged with community-based services and resources.
Goals of Program

• Reduce and eliminate Barriers to HEIDIS 7-day follow-up appointments

• Prevent readmissions - identify root cause and eliminate barriers.

• Reduce recidivism

• Improve continuity of care - collaboration with behavioral health providers and PCP

• Improve member compliance with medication and behavioral health and physical health

• Improve the Quality of Life for members
Objective of Program

Manage costs by connecting members with affordable & accessible community services & resources

• Field-based: local, on-the-ground team, 24/7 access
  • Licensed clinical Team Leader/Clinical Case Manager
  • BA-level Community Service Coordinators
  • Focus- social risk factors, compliance, services coordination
  • Psychiatric Medical Director oversight

• Onsite assessment, interventions – in homes/residences, facilities

• High-touch - trust/bonding, close monitoring, communication

• Active coordination/collaboration with health plan UM, CM teams
Program Framework

Four-Stage Model for Member Wellness

1. Assessment
   - 2 Weeks
   - Integrative Assessment
   - Motivation to Change
   - Community Referrals
   - Assignment of CM
   - Identify Barriers
   - Commitment

2. Development of Service Plan
   - 2 Weeks
   - Service Plan Development
   - Understanding Diagnosis
   - Wellness & Recovery
   - Behavior Management
   - Address Health Issues
   - Address Barriers

3. Implementation and Monitoring
   - 6 Months
   - Support
   - Referrals
   - Monitoring
   - Problem Solving
   - Service Plan Review
   - Individual Meetings

4. Maintenance and Evaluation
   - 2 Months
   - Responsibility
   - Empowerment
   - Self-Regulation
   - Healthy Lifestyle
   - Self-Management
   - Service Evaluation
Program Implementation

- Best Practices
- Person Centered Care
- Motivational Interviewing
- Assessment - Brief Psychiatric Rating Scale (BPRS)
- Family Education and Support
- Collaboration with other agencies, hospitals, medical professionals
Program Implementation

• Locate, engage most challenging, highest need members

• Meet onsite with participants, families, friends and evaluate needs
  • Identify, address issues driving avoidable ED, IP utilization

• Develop individualized intervention plans

• Arrange for, coordinate community-based services
  • OP, IOP, in-home
  • Social, housing services
  • Accompany, provide transport if needed (OP, pharmacy)

• 24/7 accessibility - crisis contacts/interventions

• Track admissions and facilitate timely, effective IP discharge planning
Identify, Locate and Engage Members

DIFFICULTY

IDENTIFY  FIND  ENGAGE
Finding & Engaging Members

NEED TO GO TO THEM
Persons with complex illnesses are high-risk, high-cost populations, generally requiring physical and behavioral health interventions.

We Assist With:

- Coordinate their physical/mental health care needs
- Improve knowledge of and access to the full continuum of community-based, low-cost health care services
- Educate and Advocate for members and their families
- Improve compliance with mental and somatic treatments as well as medication adherence
Obstacles/Barriers

- Lack of resources
- Emergency room to get meds without co-pay
- Drug seeking
- Poverty
- Medical issues
- Basic needs-food, shelter
- Other Agency goals in Conflict - Hospitalization
- Housing-Payee issue
Obstacles/Barriers

- Need for respite services (family & friends are worn out, tired)
- Lack of appointments within 7 days
- Noncompliance
- Lack of relationship with behavioral health and other providers
- Need for reminders, follow-up, transportation
- Lack of knowledge regarding available resources and how to access them
Components of Successful Program

1. **Local presence** - collaborate with members, families, providers
   - Find & engage challenging members
   - 24/7 crisis stabilization to avoid unnecessary ER, IP admissions

2. **Tie compensation to specific, measurable results**
   - Ambulatory Follow Up after hospitalization
   - Admissions/readmissions
   - Projected claim costs

3. **Seasoned team**
   - Comfortable working with complex, challenging populations
   - UM/CM/DM experience
   - Integrated physical/behavioral health orientation
   - Extensive training program
Service Coordinators

- Deployed in Teams
  - Staffing ratio - 1:35
  - Backup support
  - Double-teaming

- Supervised by clinical Team Leader

- Profile
  - Enthusiastic, passionate
  - Intrinsic motivation, gratification
  - Technology-savvy
  - Innovative, creative, problem-solving ("street smart")
  - College Interns, BA-level with diversity of experience
  - Dedicated, caring - seeking “helping profession”
  - Effective communication skills
ServiceConnect Training Program

• Best Practices
• Motivational Interviewing
• Wellness & Recovery Model
• Identifying & Utilizing Community Resources
• Assessment & Service Plan Development
• MH Diagnoses
• Substance Abuse Issues
• Medication Training
ServiceConnect℠ Training Program

- 40 Hour Orientation Program
- On-going training
- Field Based Training/Shadowing
- Assessment of training effectiveness
- Utilization of most current resources and materials
- Neumann University Training Certificate
Technology
"IntegraConnect"

Web-Based Electronic Health Record
Powered by TAI Software Technology

Industry leading information technology tools provides staff with full functionality in the field, supporting real-time reporting, resource consultation, and event tracking through a state-of-the-art, web-based electronic health record.
Tidgewell Associates, Inc. / TAI Software

- **Customized Software Applications**
  - IntegraConnect
  - IhSIS
  - CYBER
  - System of Care Technology
  - Eligibility Explorer
  - HCSIS Robot and Advanced Robotics
  - Customized Data Importers
  - Rare & Expensive Case Management (REM)
  - HealthChoices Suite of Analysis Tools (PA)
TECHNOLOGY: IntegraConnect

- Secure access to electronic case records
- Resource location (Geo-tagging)
- Event tracking
- Information sharing
- Real-time reports
- Secure client access to information
- Billing automatically queued for electronic submission
Technology

Intake to Outcomes

- User defined role/hierarchy-based security (HIPAA Compliant)
- Secured internal messaging supported by customized workflow management logic
- Customized Client Registration / Intake
- Scheduling module to support assessment appointments
- Comprehensive client record Face Page, including demographic with TAI Timeline graphic Technology, “watch list” service tracking, progress notes, medications, authorizations, claims, incidentals, tracking elements, providers, supports, TAI Way Back© historical record logging, and graphical service diagramming.
Technology
*Intake to Outcomes*

- Diagnosis tracking, showing historical changes
- Scanned documents attached as an integral component of the record
- Capability to attach video content
- Billing automatically queued with billable units, derived from specified notes or assessments completed.
- Preparation of medical claims
- Outcomes reporting (customized to meet Integra ServiceConnect client specifications)
Program Results

Within 6 months of program implementation:

- Incurred claims - 50% of projected
- Nearly $200K/month ($1,000/PPPM) Net savings
- Admissions halved
- 7-day AFU rate doubled
Program Results

HIGH-COST BH UTILIZERS

Annualized $$

$6,000,000
$5,000,000
$4,000,000
$3,000,000
$2,000,000
$1,000,000
$0

Top 100 Prior to Pgm
186 Pgm Cohort
Program Results

HEDIS 7-DAY AMBULATORY FOLLOW UP **

** IHM verification of AFU
Program Results

PROGRAM COHORT: IP ADMISSIONS

- 1st Half 09: 179
- 2nd Half 09: 241
- 1st Half 10: 258
- 1st 6 Mos in PGM: 121
Member & Family Survey

- 94 Participants in Survey - 56 Males, 38 Females
- 2 Surveys, Members and Collateral Connections

Comments:
- She takes me to the library, helped me find a hobby, helping me to cook and eat healthy
- Jessica is a blessing in our lives and we could not ask for better. She is like our angel. We thank her for everything.
- My case manager visits and calls me regularly and I can always call her.
- My case manager took me to an NA meeting and I still go
- She takes me to the doctor so I can keep my appointments.
- My case Manager really cares about me & helps with my problems
## Member Survey

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<th>Prompt Response</th>
<th>0</th>
<th>1</th>
<th>46</th>
<th>100%</th>
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<tr>
<td>Courteous, professional</td>
<td>0</td>
<td>1</td>
<td>46</td>
<td>100%</td>
</tr>
<tr>
<td>Checked via phone, visit</td>
<td>0</td>
<td>1</td>
<td>46</td>
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<tr>
<td>Info accurate, prompt</td>
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<td>Cares and assists</td>
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<tr>
<td>Concerned and assists</td>
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<tr>
<td>Understands needs, provides resources</td>
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<tr>
<td>Involved with discharge planning</td>
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<tr>
<td>Involvement reduces hospitalization</td>
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## Collateral Survey

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<th>Description</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>% Agree + Strongly Agree</th>
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<tbody>
<tr>
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<td>Checked via phone, visit</td>
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<td>42</td>
<td>100%</td>
</tr>
<tr>
<td>Info accurate, prompt</td>
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<td>Understands needs, provides resources</td>
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<td>Involved with discharge planning</td>
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<td>Involvement reduces hospitalization</td>
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<td>Involvement adds value and recovery</td>
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<td>Satisfaction high, recommended</td>
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<td>47</td>
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Survey Results

• Member survey resulted in close to 100% satisfaction.
  • 100% on 10 questions
  • 98% on 1 question

• Collateral connections survey revealed:
  • 100% on 10 questions
  • 98% on 1 question

• Members and Collateral Connections Were Very Satisfied with Integra Health Management Services.
Best Practices

• Preventing Hospital Readmissions
• Developing effective aftercare plans
• Increasing HEIDIS 7 Day Follow-up Scores
• Establishing effective collaboration
• Improving the quality of life
• Empowering Members & Offering Hope
Improving The Quality of Life for Members
Integra Health Management

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