AHI PPS

Planned Parenthood Mohawk Hudson & North Country

DSRIP in Process: Clinical Integration of PAM and Behavioral Health

May 19, 2016

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Agenda

- Overview of Planned Parenthood Mohawk Hudson and North Country
- Benefits of PAM for our Patient Population
- Implementation of PAM
- Expansion of Primary Care
- Integration of Behavioral Health: MAX Project

Planned Parenthood

An Article 28 provider of primary & preventive health care in 10 health centers.

While known for our quality reproductive and sexual health services, Planned Parenthood also provides **preventive and general primary care services** to ensure each patient receives the care they need.

As part of our standard of care, we routinely provide basic preventive screening services, including:

- body mass index (BMI) assessments and nutrition counseling,
- blood pressure screenings,
- screening & low level treatment for depression and anxiety
- tobacco cessation screening & counseling.

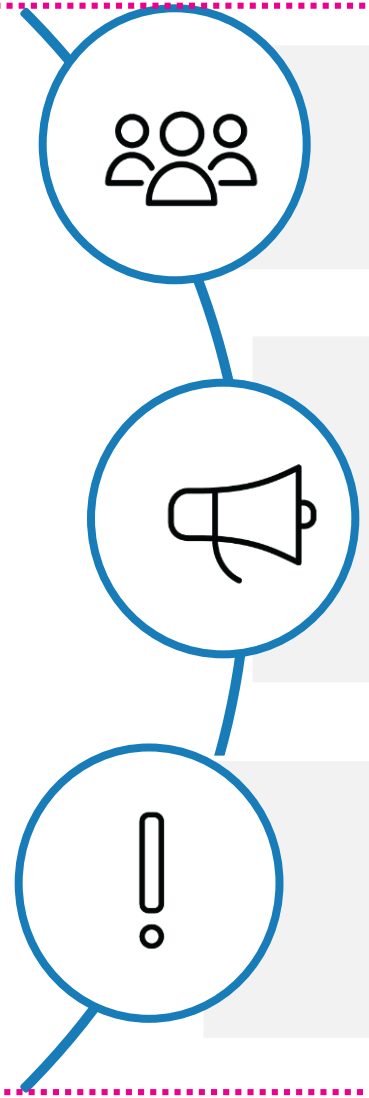
20,000 women, men and teens turned to us for primary and preventive reproductive health care services annually.

47% of our patients consider us their primary health care provider

90% of the services we deliver are preventive including well women exams, contraceptive services and cancer screenings

37% patients had incomes at or below 138% FPL

We Are Uniquely Positioned to Support Project 2di



We see a high volume of uninsured, low-utilizing, and non-utilizing individuals (target population) walking through the front door.

- 21% of our patients presented at PPMH health centers without a form of health care insurance coverage.

We have a strong history of community outreach and enrollment into health insurance programs, which can be leveraged to engage the target population for Project 2di.

- Our affiliate has educational staff and Certified Application Counselors (CACs) who will be trained to administer PAM.
- Last year, we enrolled 2,500 patients into either public or commercial coverage.

For many patients, we are the sole provider and their first adult experience, or only connection with the health care delivery system.

- 40% of our patients are between 18-24, so we are uniquely situated to support and shape their engagement in the health care system.
- 47% of our patients rely exclusively on our health centers for their annual exams and/or preventive health care services.

PAM Implementation: Phase 1

- Our education and outreach staff and our clinic Patient Care Associates have been trained to administer PAM; have a trained trainer (different guidelines across 5 PPS)
- Staff offer PAM when patient goes to exam room and completes on paper; in another site testing use in waiting area
- Staff enter data into Flourish within 24 hours
- PAM is being implemented in all our health centers as of May
- We are developing a plan for coaching and qualified staff will be trained to conduct follow up and coaching by the third Quarter of 2016

PP PAM Project Update 4/1-5/15/16: 2 Clinics/AHI

PAM Assessments	Total Offered	Ineligible	Declined	Accepted
YTD Subtotal	685	328	68	289
		48%	10%	42%
PAM Scoring	Level 1	Level 2	Level 3	Level 4
	8	23	124	134
	3%	8%	43%	46%

Enhancing PAM through Clinical Integration: Phase 2

- We have integrated documentation of PAM results into our EHR (Athena) for clinical staff to assess
- We are looking to incorporate discussion of PAM into our clinical processes for each patient encounter and clinical decision making
- Our goal is to transform the survey from an initial assessment and connector-to-care tool to an integrated mechanism to continually advance behavior modification through clinical interactions.
  - Informing and improving care
  - Strengthening engagement
  - Improving long term outcomes

Expanding Primary Care for Women

A model of primary care delivery that is centered on the unique health care needs of women

Women have unique health care needs that often drive how they access care.

- In the absence of a chronic or episodic health care needs, reproductive health services can be both entry point and primary source of care

Women are also often the primary decision makers for their families when it comes to health care – influencing how families are connected to the health care delivery system

As any entry point to care we have the unique opportunity first to identify risk factors that lead to costly chronic conditions and shape engagement with the health care system.

Our Goal

Create a holistic model of primary care rooted in the reproductive needs of women but responsive to their broad primary care needs.

We leverage our trusting relationships with patients to help them embark on a positive course for care aiming to effectively confronting cost drivers in care before they take root.

Transformation Timeline for Primary Care

2016: Initiate expansion of primary care services and integration of behavioral health services. Connect to HIXNY.

Strengthen clinical capacity to respond holistically to women's needs keeping reproductive health an important focus

- ✓ Annual physicals
- ✓ Sick visits
- ✓ Diagnosis, treatment and management of chronic illness
- ✓ Immunizations

Achieve PCMH level 3/APC status by 3/31/18

- Preliminary scoring demonstrates strong organizational readiness; need to strengthen capacity in care team management and care coordination

Planned Parenthood Mohawk Hudson

Rapid Integration of Behavioral Health

MAX Project through Central NY Care Collaborative PPS
Utica, NY Region 2016

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Overview of the MAX Series Program

As part of the DSRIP program, the Department of Health is offering the **Medicaid Accelerated eXchange (MAX) Series Program**.

MAX Series Program PPS participants will join a learning collaborative incorporating evidence-based methodologies to maximize efficiency in clinical processes and implement sustainable change.

PPS Action Teams include 8-10 inter-disciplinary providers and a patient representative who participate in a 5-month intensive learning experience including 3 full-day workshops.

PPSs will work closely to collaborate, share leading practices, and leverage tools under the guidance of recognized subject matter experts in focused topic areas. The program builds skills and capacity for process improvement at a local level that can be scaled and shared across the broader PPS.

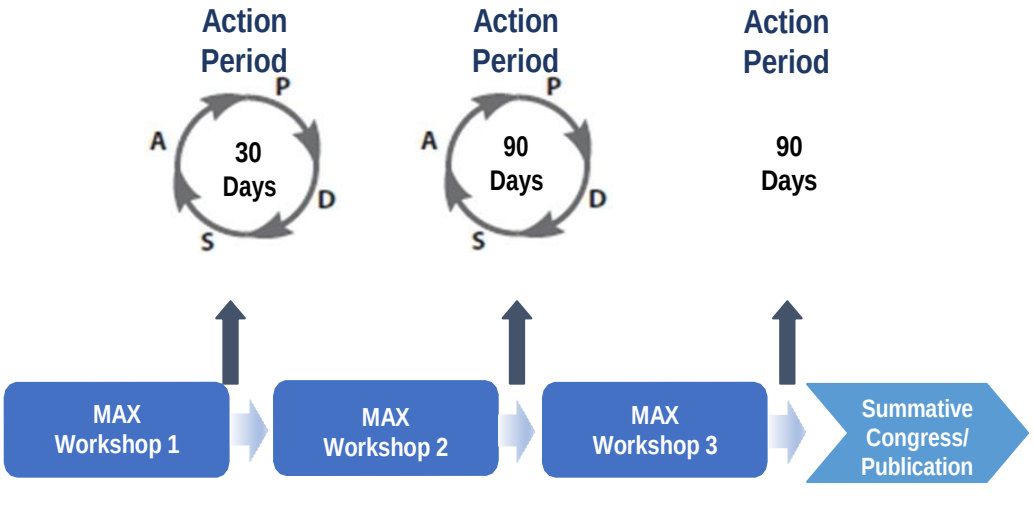
NEW YORK STATE OF OPPORTUNITY. Department of Health

For each Topic, the MAX Series Program is delivered in three phases

Phase 1: Assessment and Preparation

- Introductory Call with PPS
- Follow-up Call with Clinical Leadership
- In-person meeting with Leadership and potential Action Team

Phase 2: Clinics and Improvement Cycles



Phase 3: Reporting

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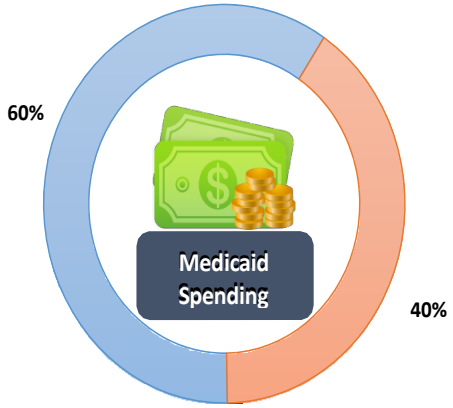
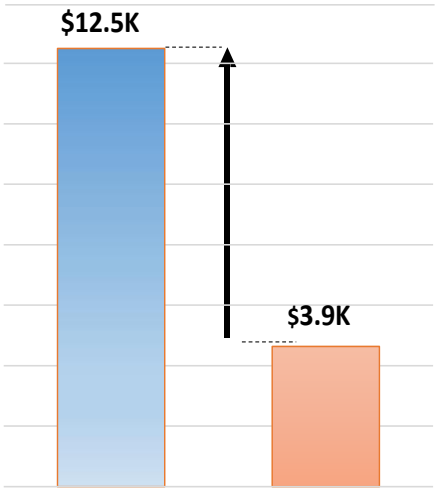
Behavioral health members cost, on average, **3.20 times** more per recipient and represent **60%** of total Medicaid spending

60% **of total Medicaid spending is contributed to behavioral health recipients**

Medicaid Total Spend	BH Total Spend	Non-BH Total Spend
$ 1,173,881,033.33	$ 699,372,103.74	$ 474,508,929.59



The average spending on behavioral health recipients is ***3.2X*** **greater than for non-behavioral health recipients**



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Unique Behavioral Health Recipients by Zip Code

Zip Code	Spending
13501	$69,094,615.40
13205	$47,076,624.70
13021	$36,386,274.96
13440	$34,449,760.64
13502	$32,265,103.53
13203	$30,944,275.79
13204	$27,910,891.80
13126	$25,511,460.20
13208	$22,398,400.68
13069	$19,050,252.63
Total	**$345,087,660.33**

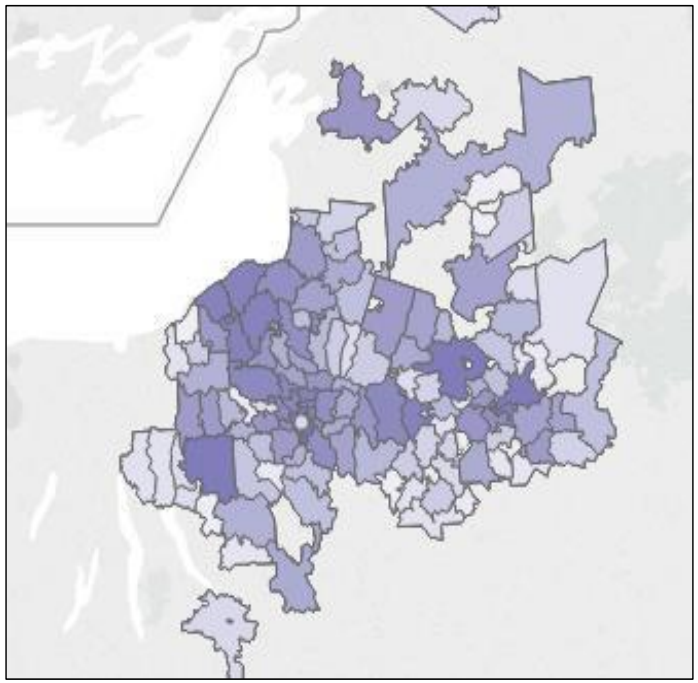
Total of top *10* Zip Codes = $345,087,660.33

Therefore, *.006%* of zip codes account for *49.3%* of total Behavioral Health Medicaid spending

Or…

***29.4%* of total Medicaid spending**

***Reference: BH Recipients represent 1650 Zip Codes ***



Behavioral Health Recipients by Zip Code

40 Recipients — *5,076 Recipients*

*A recipient is considered to have a behavioral health condition if they have 1+ claims with a behavioral health diagnosis on it (as defined by the Office of Mental Health) in the given time frame

NEW YORK STATE OF OPPORTUNITY. Department of Health

Depression is the number one reason for admission to the ER in the Utica area.

Women are 2.5 times more likely to be depressed than men.

PPMH started depression screening in July 2015 and created an internal system of referral to PPMH providers willing and able to manage low level treatment for those screening positive.

PPMH is currently referring patients to other providers for counseling but programs are difficult to access. Women want to stay in care at the clinic.

PPMH is currently partnering with Psychological Healthcare, PLLC to integrate counseling services on-site. Through PH we will be bringing Lesley T, PhD on-site at our Utica center to begin providing these services.

Dr. T specializes in working with individuals with depression, anxiety, post-traumatic stress disorder, anger management problems, or a history of physical, emotional, and sexual abuse, to help them cope with their unique challenges, improve their relationships and enjoy an expanded sense of well-being. She also works with clients to assist them in coping with chronic medical conditions.

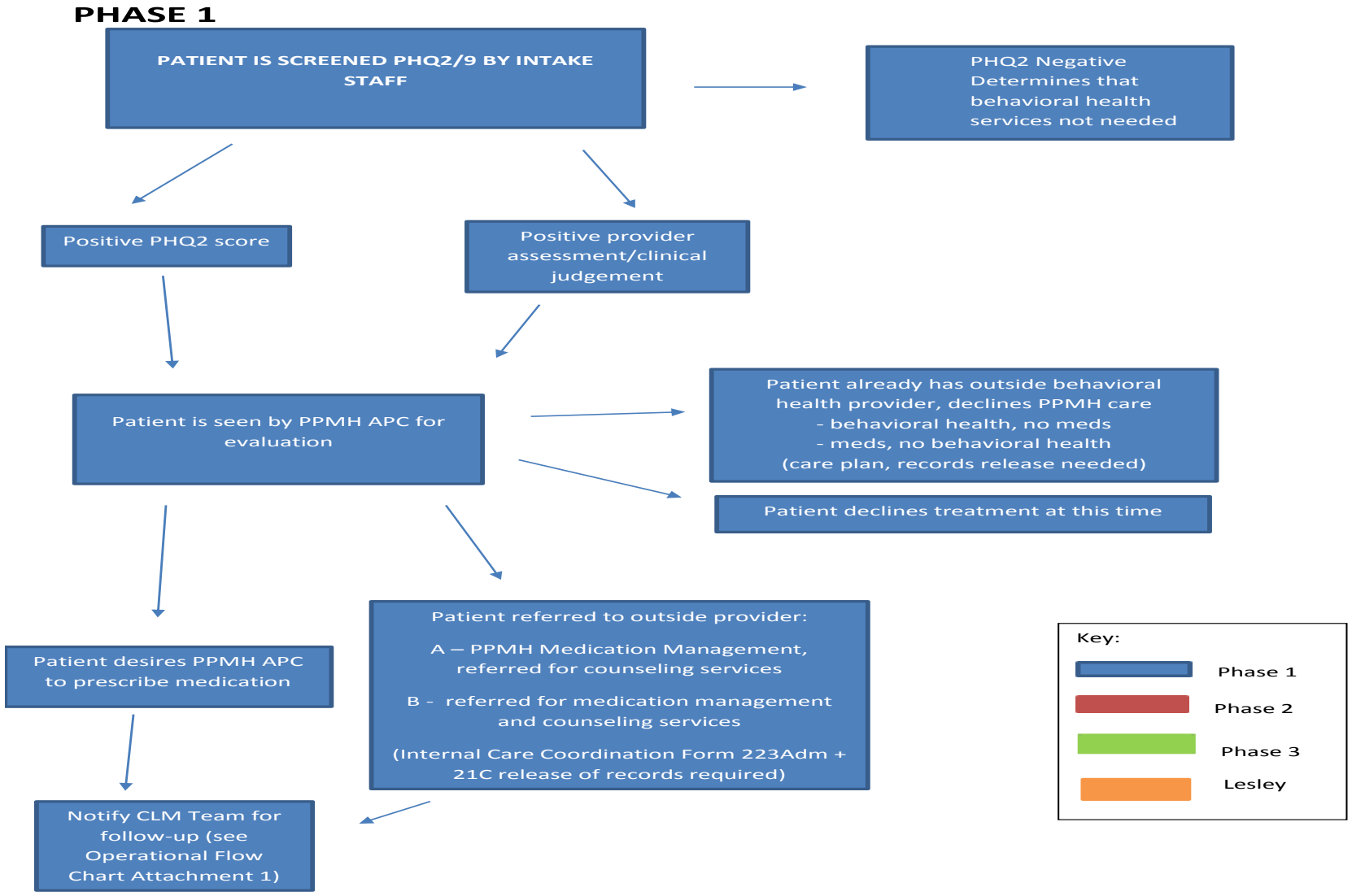
Action Plans – Phase 1

1. **De-duplicate Clinical Work Flow**
   - Identify areas where work is being duplicated during patient visit
   - Streamline the visit process to allow providers more time to screen and address PHQ2/9
2. **Set up a weekly touch base meeting**
   - Opportunity for Action Team to meet and discuss Action Plans
   - Will eventually evolve into a more clinical meeting for Lesley and PPMH medical staff to discuss mutual patients, provide updates/feedback, etc.
3. **Expand the PHQ2/9 Screening**
   - Currently screening patients at annual well person visit or as needed
   - Want to screen all patients 18+ at any visit type or as needed to capture patients who have a need but may only see us episodically.

Action Plan – Phase 2

1. **Clinical Management Algorithm**
   - More organized flow, ability to manage and track behavioral health clients
   - Increase our ability to identify patients with +PHQ score and thus improve the number of patients referred for care and improve patient outcomes.
2. **Identify, Track, and Share Patient Goals**
   - Improve our understanding of patients
   - Greater involvement of patients in their own healthcare
   - Improved compliance rates, satisfaction, and outcomes for patients
3. **Build Partnerships with other Behavioral Health Providers in Community**
   - Improved care coordination in our community
   - Improved perception of PPMH in our community

Behavioral Health Integration



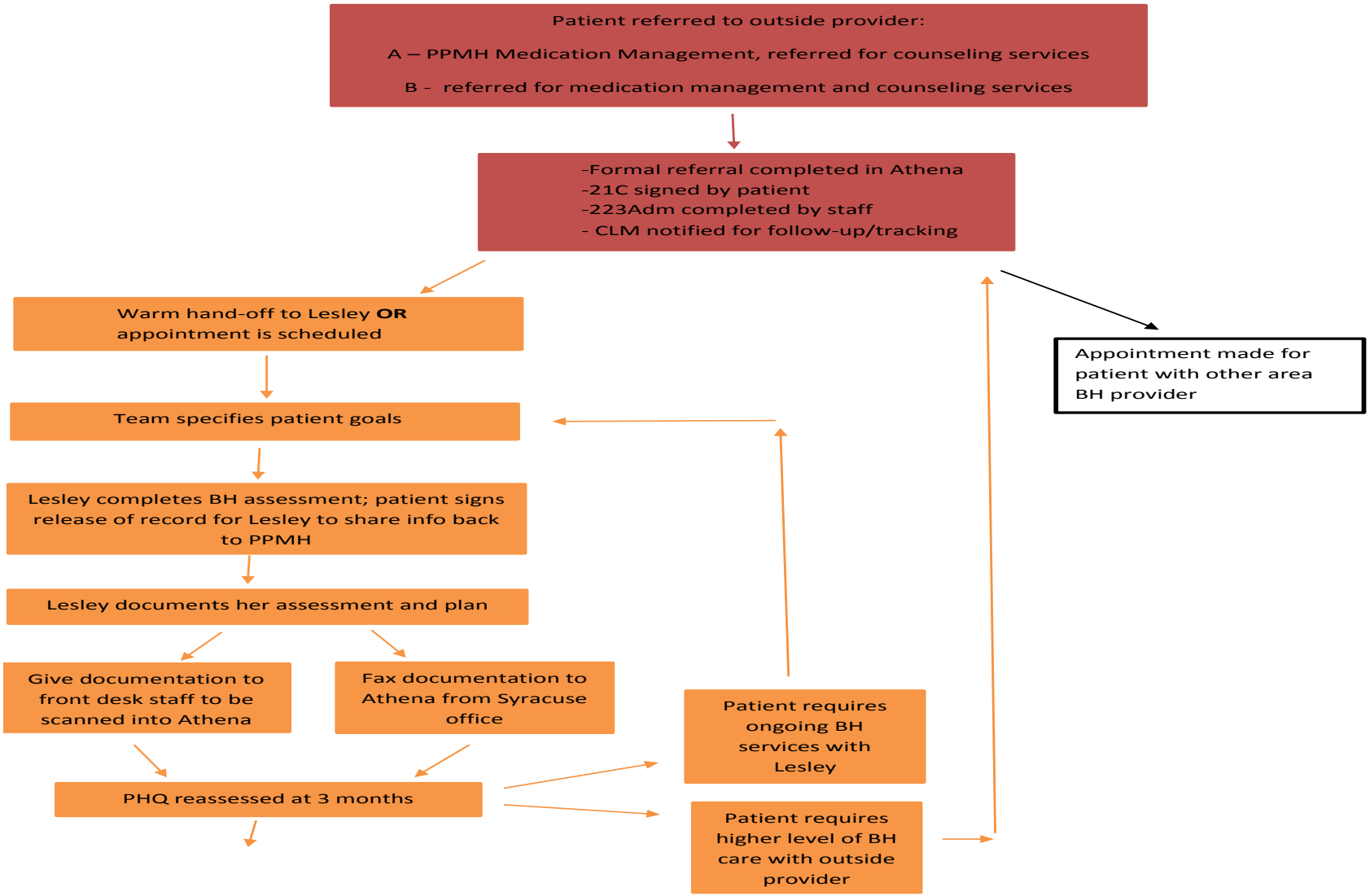
Behavioral Health Integration: Initial PPMH Data

- For date range 7/1/15-2/29/16:
  - 466 patients were screened for PHQ2/9. Average number of patients screened was 14 per week.

- For date range 3/21/16-5/4/16 (implementation of MAX Phase 1):
  - 745 patients have been screened for PHQ2/9. Average number of patients screened was 106 per week.
  - 38 of these patients moved to PHQ9 and required follow-up care. (~5%)

Behavioral Health Integration

PHASE 2



Behavioral Health Integration

PHASE 3

FUTURE INTEGRATION (i.e. group therapy)

FUTURE INTEGRATION (i.e. telemedicine)