# 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

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# SETTING THE STAGE: TODAY'S FACILITATORS

**Brie Reimann, MPA**

**Deputy Director**

**SAMHSA-HRSA Center for Integrated Health Solutions**

# SETTING THE STAGE: TODAY'S PRESENTERS

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**Dr. Todd Wahrenberger, MD, MPH**

**Medical Director & Family Medicine Physician**

**Pittsburgh Mercy Family Health Center**

**Alicia Kirby, MBA**

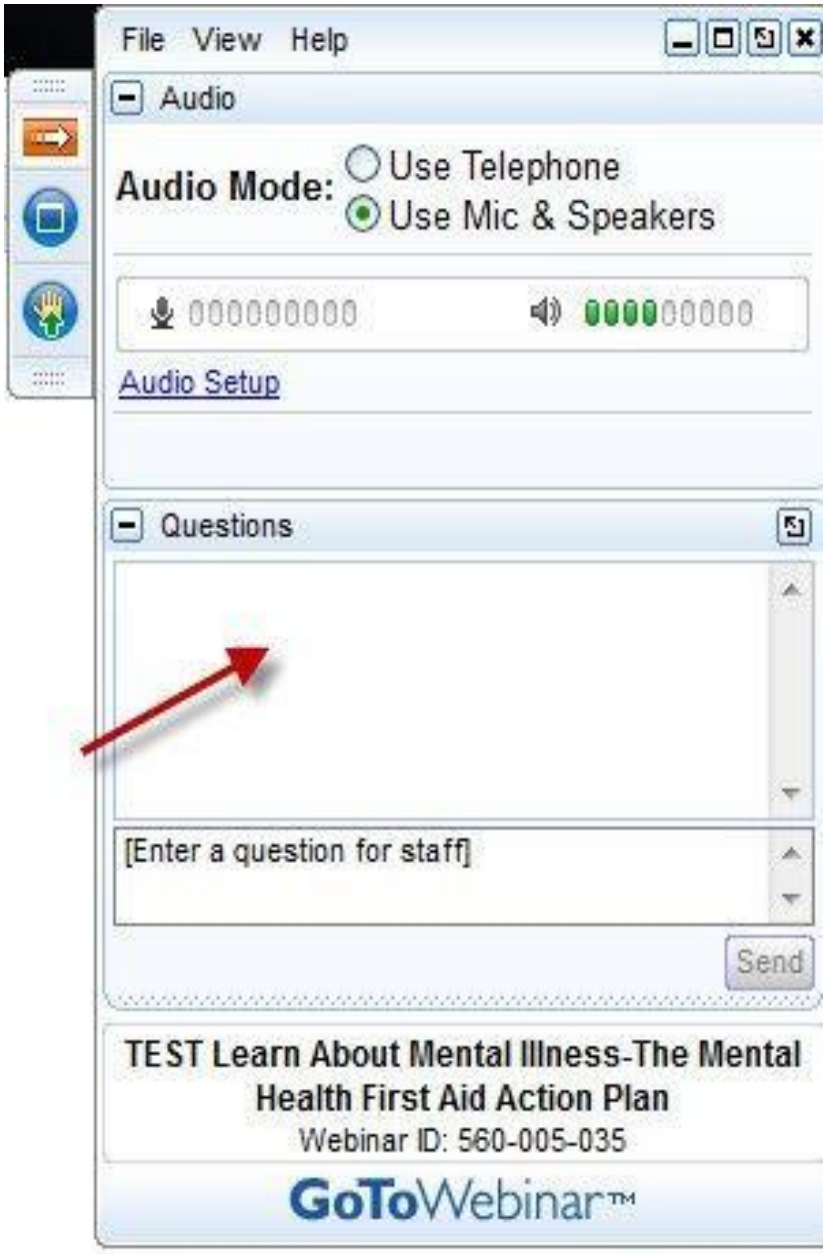
**Director of Integrated Services**

**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*

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

# INTEGRATED PRIMARY CARE:
# PITTSBURGH MERCY HEALTH CENTER

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## 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

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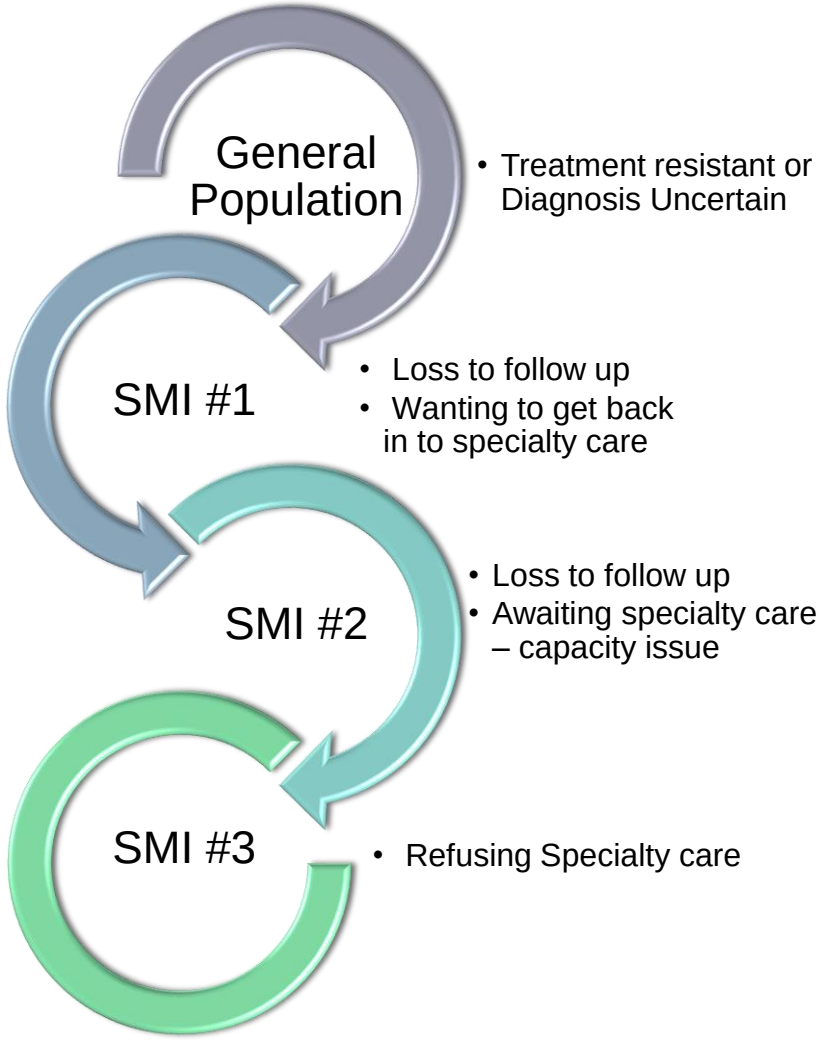
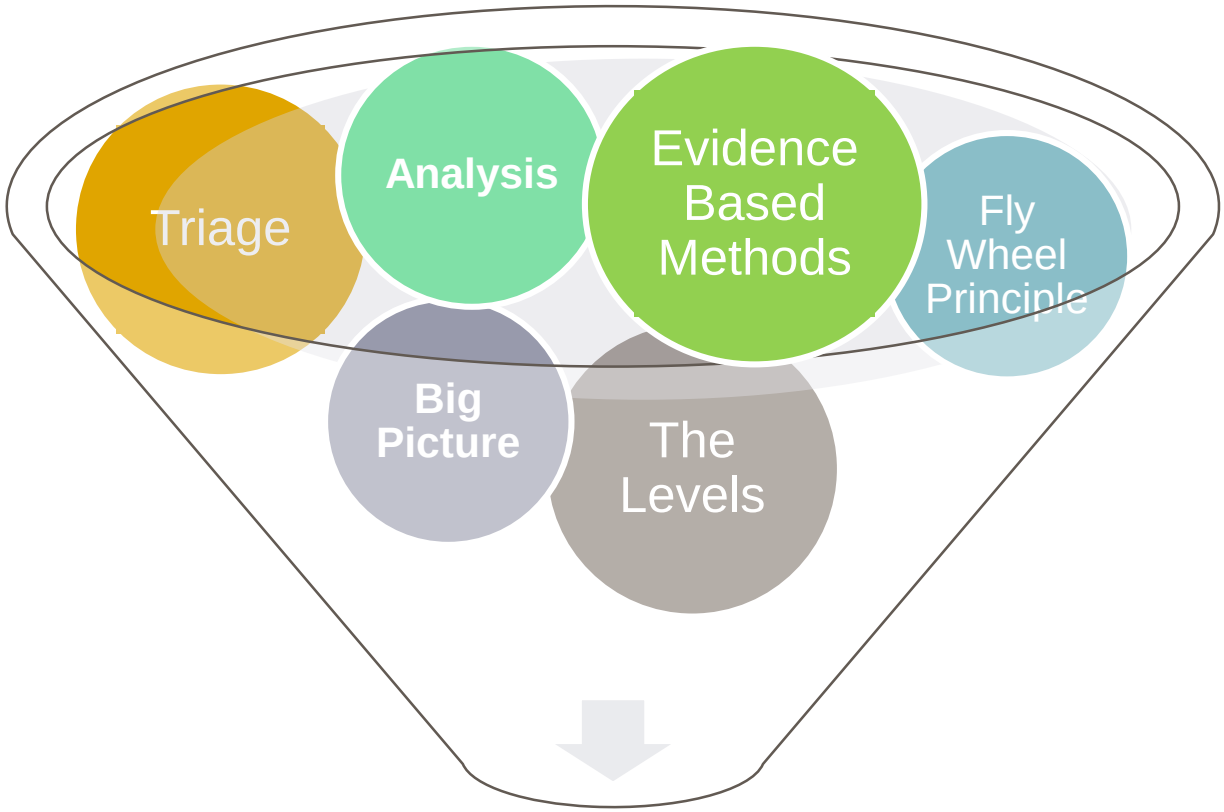
## Our Team

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

Drives our team



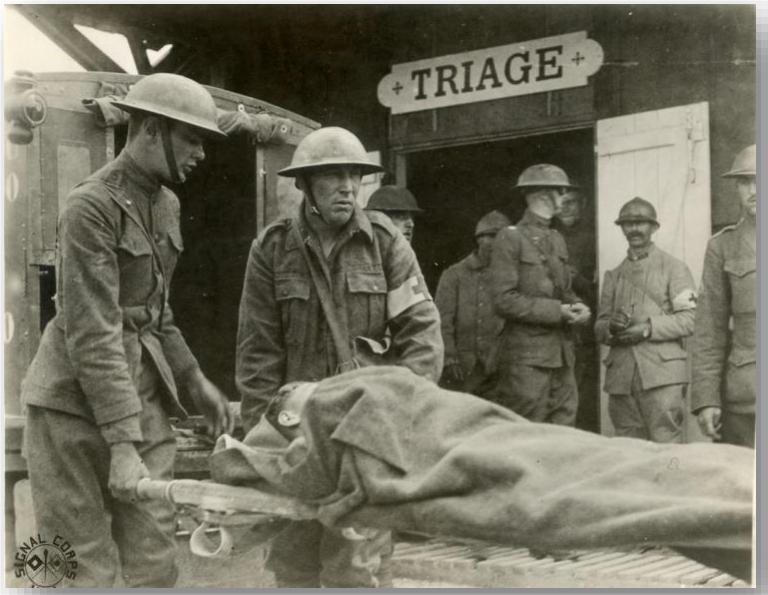
# GENERAL CONCEPTS FOR RISK STRATIFICATION




**The Secret Sauce**

# TRIAGE

Triage (/ˈtriːɑːʒ/ 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

# THE LEVELS

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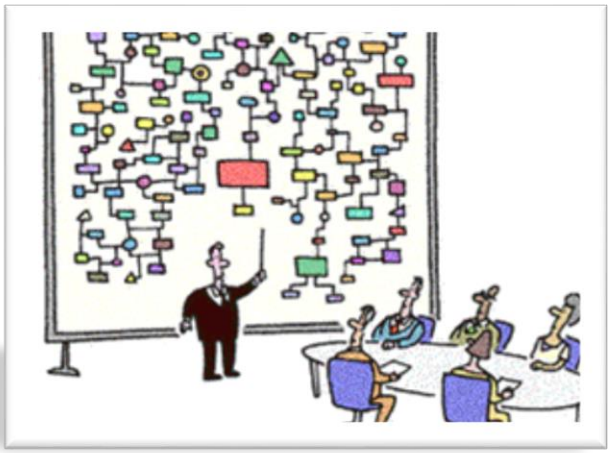
## PMFHC Risk Stratified Patient Care

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

# 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

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## 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

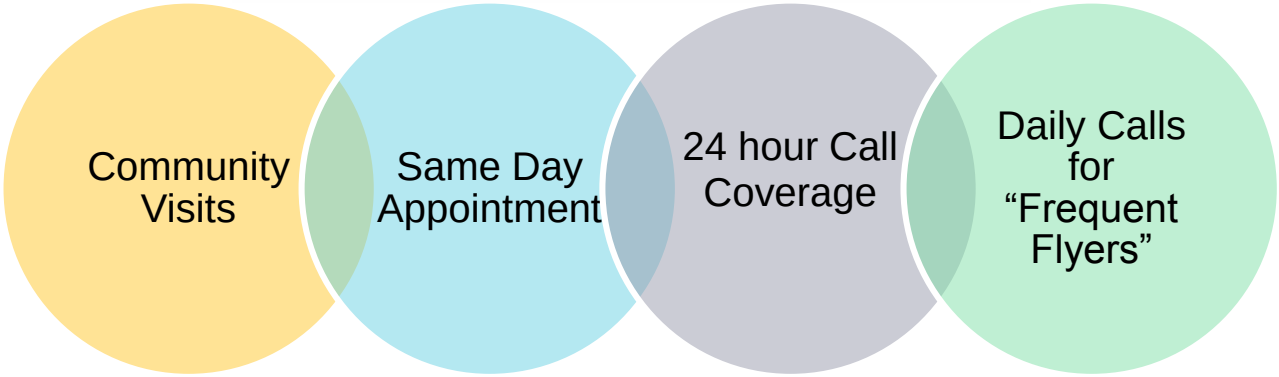
### Peer Support Coach

- Empathy – shared experiences
- Social Supports
- Building Independence
- Engagement

# THE FLYWHEEL PRINCIPLE – JIM COLLINS

- http://jimmyzimmerman.com/wp-content/uploads/flywheel.swf
- Be persistent
- Be persistent
- Be persistent

# ACCESS TO PRIMARY CARE

# MEASURING OUTCOMES

PMFHC participants experienced 67% fewer psychiatric hospitalizations

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

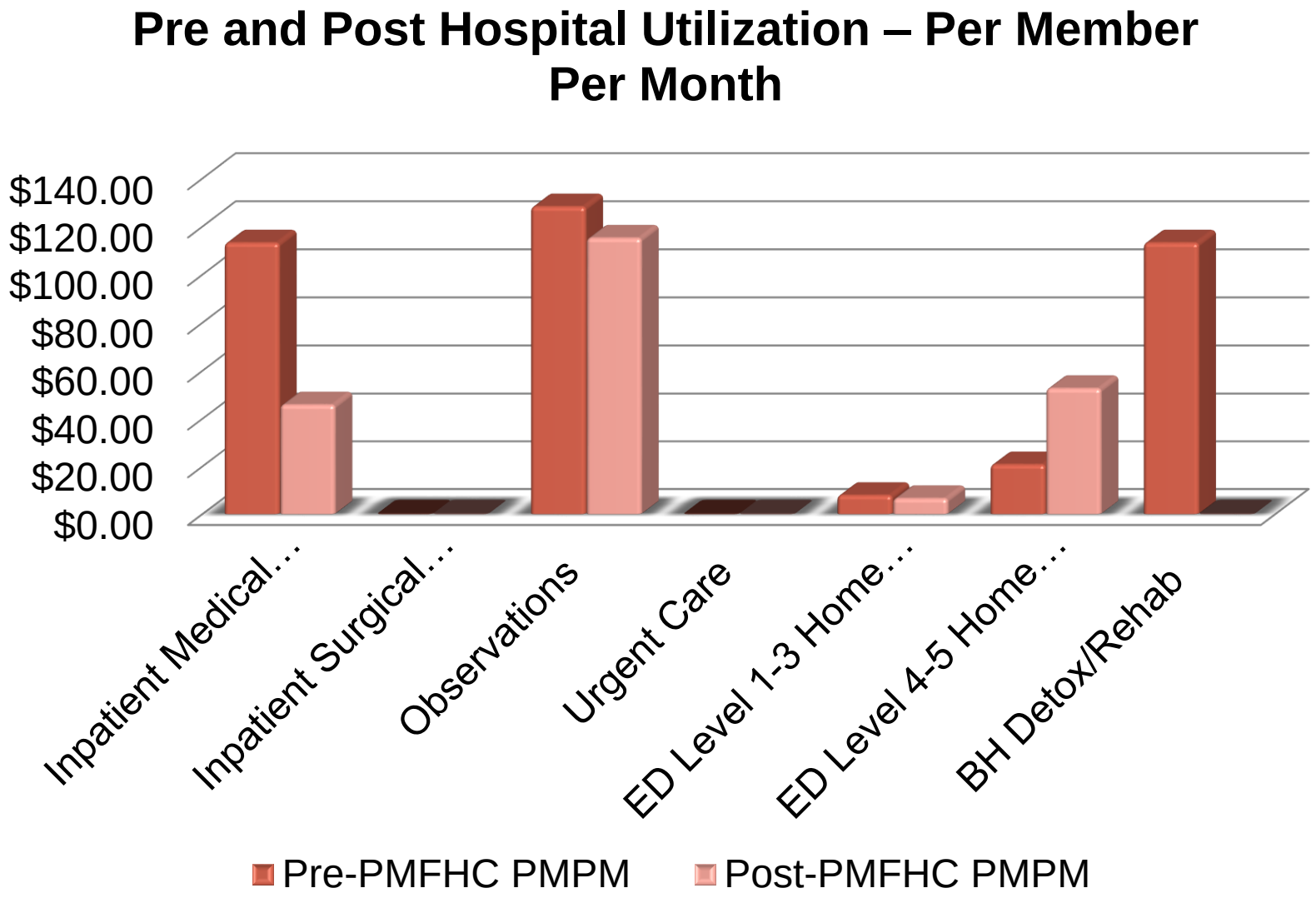
| # of stays | PMFHC participants (n= 84) | non-PMFHC participants (n=73) |
|---|---|---|
| 0 | 76 | 38 |
| 1 | 6 | 25 |
| 2 | 1 | 4 |
| 3 | 0 | 3 |
| 4 | 1 | 3 |
| *Average* | 0.143 | 0.782 |
| *Range* | 0 - 4 | 0 - 4 |

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

| Measures (days) | PMFHC participants n=8 | non-PMFHC participants n=37 |
|---|---|---|
| *Average* | 15.6 | 39.4 |
| *Median* | 10.5 | 30.5 |
| *Range* | 1 - 47 | 3 - 113 |

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

# MEASURING MEDICAL COSTS



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# QUESTIONS, COMMENTS?