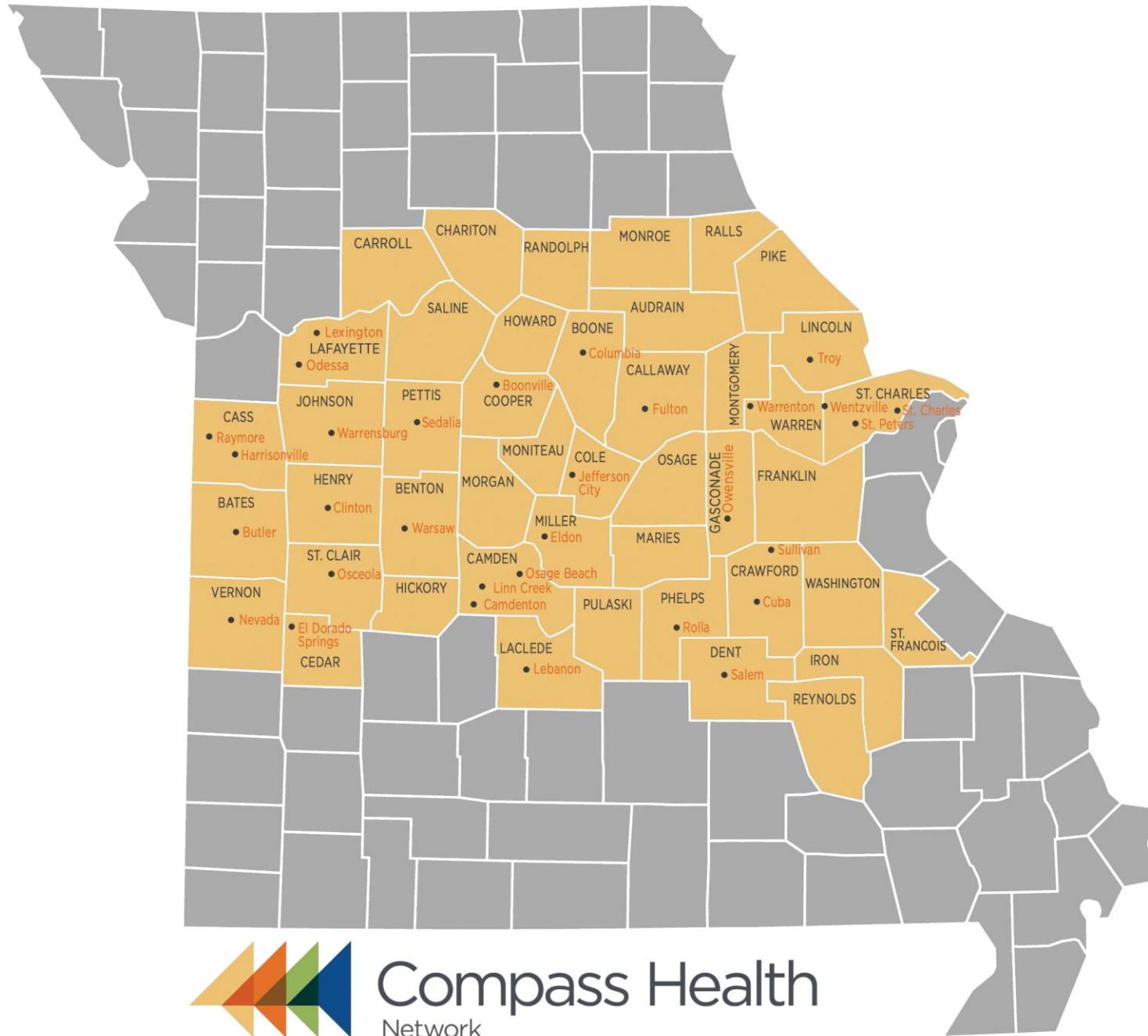


# **CCBHC –Compass Health Network**

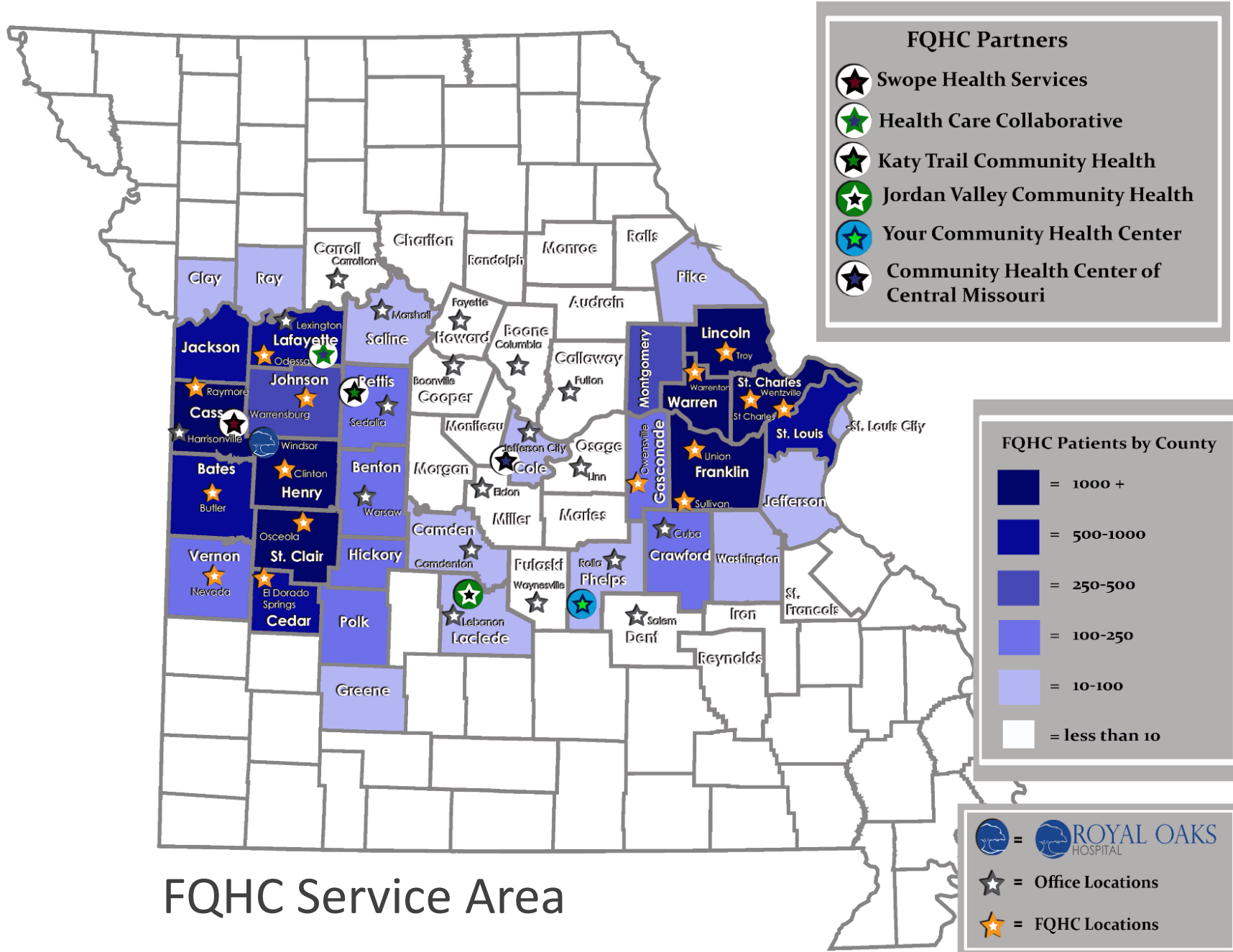


Compass Health  
Network

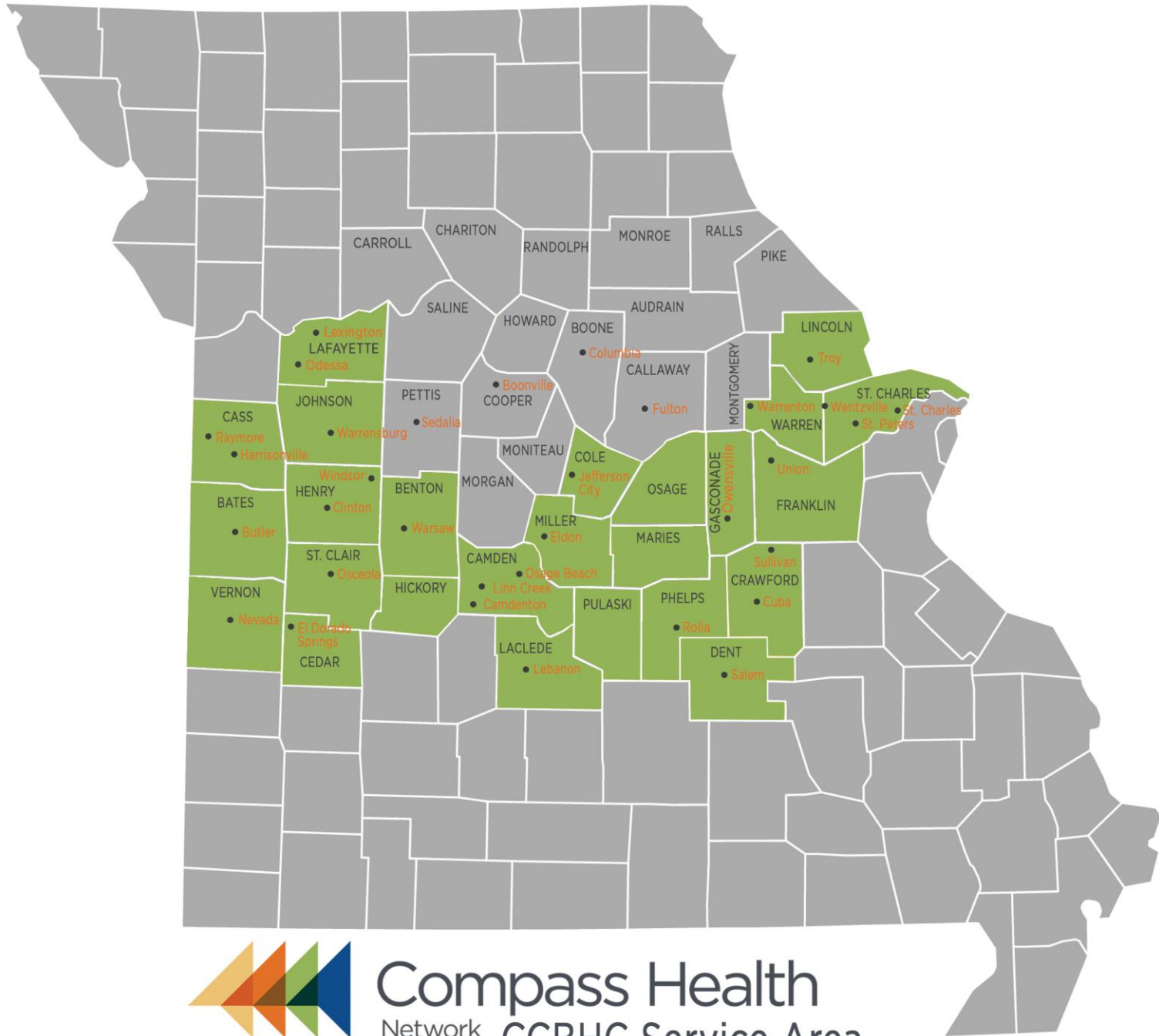
# Organization Overview

- \$232M Annual Revenue
- 2,700 Employees
- 70 Psychiatrists/PA/APRNs
- 18 Primary Care Physicians/APRNs
- 24 Dentists





FQHC Service Area



Compass Health  
 Network CCBHC Service Area





Compass Health  
Network

616 BURKARTH



Compass Health  
Network

# Organization Overview

- 5,535 Health Home Enrollees
- 37,808 FQHC Patients
- 15 FQHC Sites
- 6 FQHC Partnerships

# Behavioral Health Center of Excellence Framework –Dale Jarvis 2014

## BHCOE

- Easy Access
- Comprehensive Care
- Excellent Outcomes
- World Class Customer Service

## CCBHC

- Availability and Accessibility
- Broad Scope of Services
- Quality and Outcomes Reporting
- Coordinate Care Across Settings



# Center of Excellence Adopted



- Collaborative with Community
- World Class Customer Service
- Integration of Health, Behavioral, Oral
- Clinical Evidence Based Medicine
- Great Place to Work
- Wellness & Recovery Culture
- Efficient, Ethical, and Effective



# Now you're a CCBHC so how does that change services?

- Program Budgets just changed substantially
- Services Rates versus Cost
- Value based Events
- Quality Outcomes



# Services Rates Versus Cost

- 1988 Counseling Rate= \$48
- 1988 Psychiatry Rate= \$8 per changed once to \$12.50
- 1999 Psychiatric Rehab= \$96
- 2010 Health Home Rate= PMPM
- Evidence Based Practice= No rate differential

Can you hire a Psychiatrist for \$60,000 per year?



# Services Rates Versus Cost

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# Patient Centered- Value Based Events

- What will have biggest impact on increased access to care
- What will have biggest impact on consumer outcomes
- What services are consumers demanding when they seek access to care?
- Will improved use of technology to support evidence based practice & care management tools?





# Enhanced Access

- Quicker Access means more value to the consumer in distress and increases probability of visit
- YEAR 1 -Offer same day if they cannot schedule within 7 days
- MID COURSE CORRECTION--YEAR 2- SAME DAY ACCESS
- For hospital discharges utilized assertive outreach and engagement
- Time versus Value
- Functional Assessment & Screens enhanced for clinical care paths



# Consumer Outcomes

- Evidence Based Practices – IDDT, DBT, PCIT - use the alphabet soup
- Children & Youth- Improve Assessment Technology
- Addictions- Chronic repeat need to changed the paradigm from Acute care to Chronic Care
- Serious Mental Illness- Reduce reduction in hospital visits and improve or prevent chronic health conditions, medication adherence **MOVING TOWARDS** versus **MOVING AGAINST**



# Technology

- Continued work in progress
- Need to move towards mobile technology
- GPS Tracking is a compliance and safety tool
- Self Help applications are good for general population more difficult for the chronic populations
  - Our highest cost just like the health insurance market is the 5 percent are the 50 percent cost (patient engagement)



# CCBHC Overview Key Issues

- Meaningful Consumer Input
- Sliding Fee for Target Populations
- Evidence Based Practices Cost
- Improved Access
- Data Management/ EHR conversion
- MAT for SUD to over 2,000 consumers
- Consumer Loss of Medicaid coverage





# CCBHC Overview Who

- Generalized Anxiety Disorder
- PTSD
- Major Depression
- Bipolar
- Marijuana Dependence
- Alcohol Dependence
- Opioid Use Disorder
- Schizophrenia

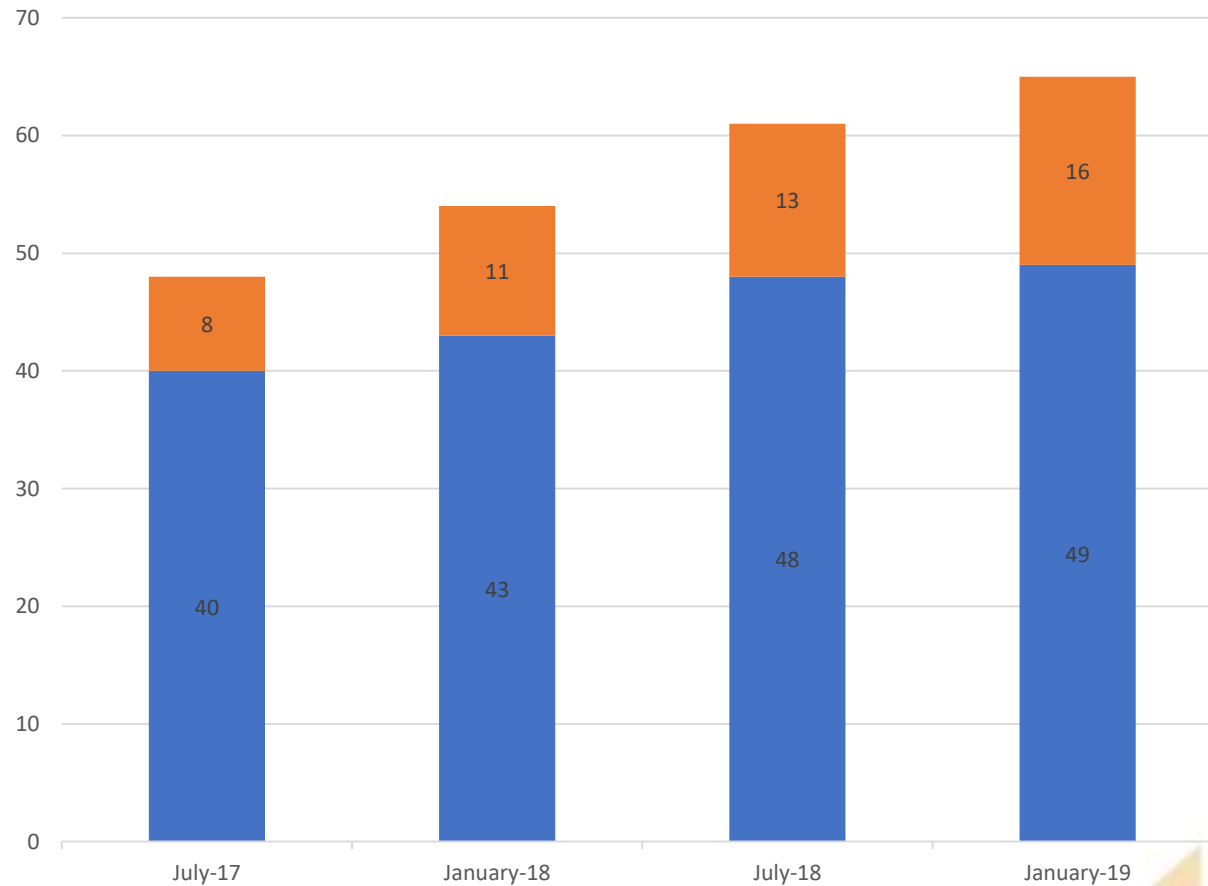


# CCBHC Overview Who

- Medicaid= 18,000+
- Medicare= 1,400+
- Dual Eligible=3,600+
- Tricare/VHA= 500+
- Commercial=6,000 +
- Uninsured= 10,000+
  
- OVER 40,000 Consumers

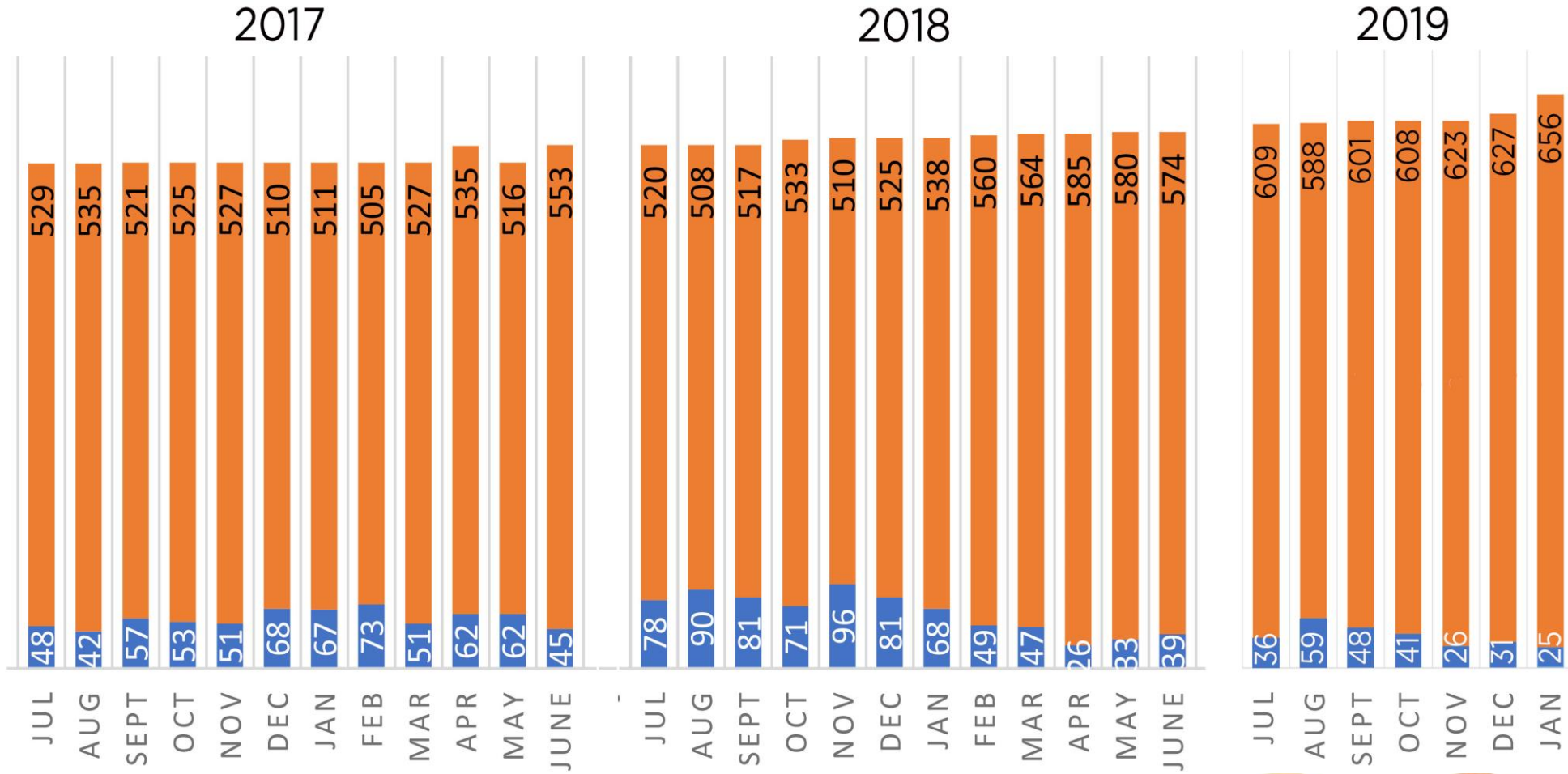


# PSYCHIATRISTS AND APRNS



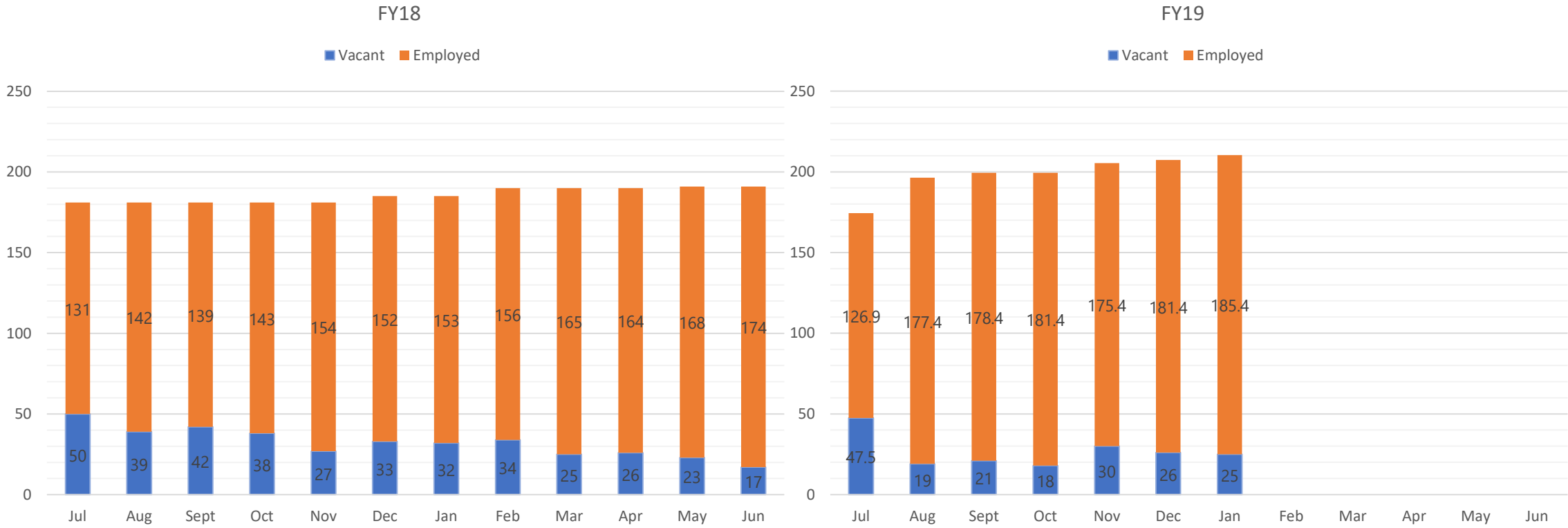
# IHS POSITIONS

■ Vacant ■ Employed





# PSYCHOLOGIST, THERAPIST, BH CONSULT



# Innovations in Crisis Access Services

## CMHLs

- Building strong community relationships with Law Enforcement and Court system to assist in identifying those in crisis who have not formally connected for services.
- YBHL/UCM Liaison positions created
  - Helping schools and colleges with early identification and support for youth with current or developing psychiatric conditions.



- 2679 referrals to CMHLs in 2019



# Innovations in Open Access

- **Old way:** Clients call central operators to set up an initial appointment during prescribed times
  - Led to seeing fewer people (as many did not follow up with appointment)
- **New way:** Come in any time during business hours—and receive a full assessment
  - Sept '18- Current : 1,500 clients seen for same day access per month

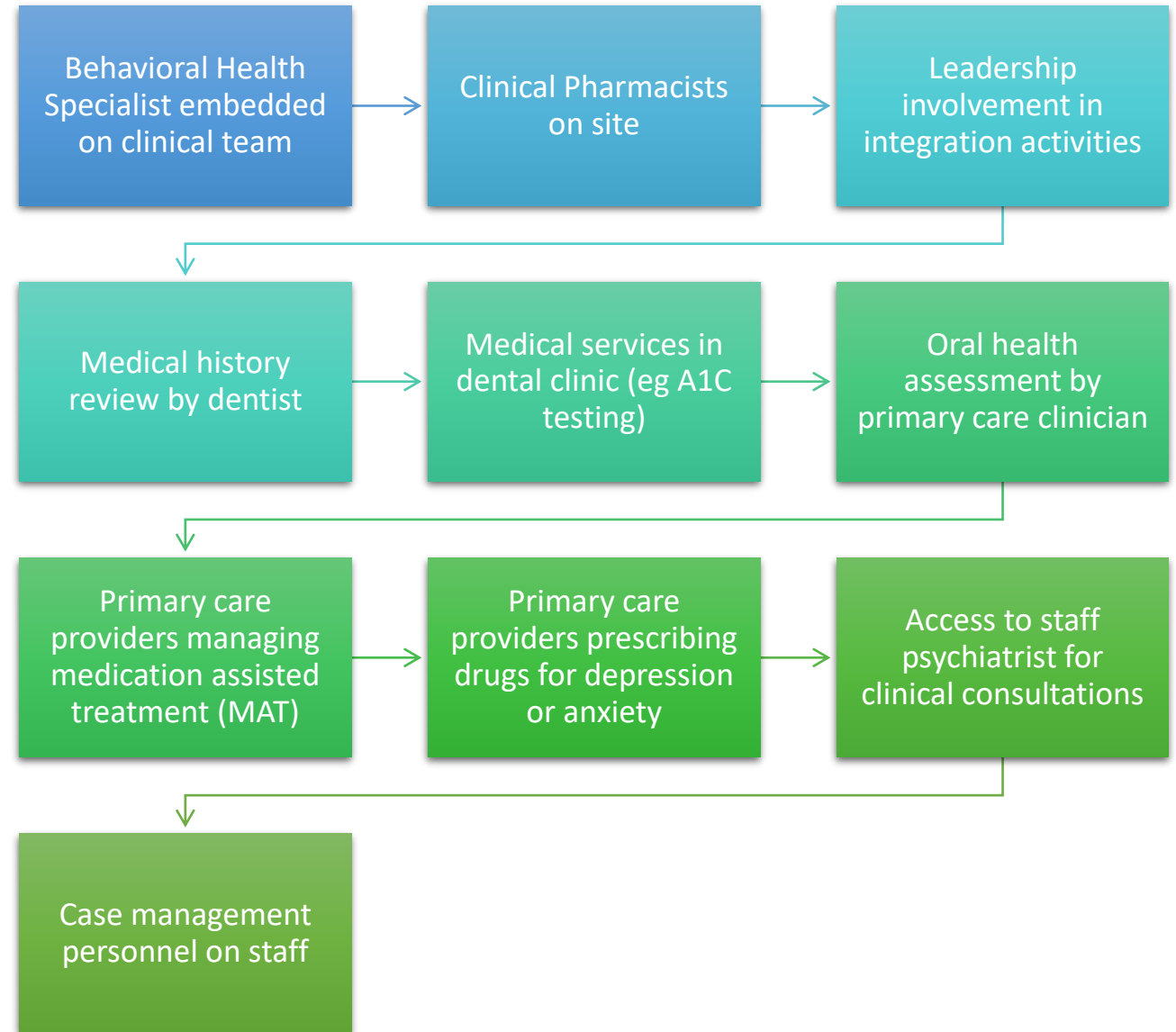


# Open Access and Assessment

- Follow-up visit for Psychiatric Rehabilitation –same day
- Follow-up Urgent Addiction Services- 1-3 days
- Follow-up visit for Routine Psychiatry 5-7 days
- Follow-up Counseling & Psychology 5-10 days
- Provide screenings for Anxiety, Depression, and Substance Use, as well as medical and dental needs
  - This helps guide treatment from their first interaction with staff:
    - Better delineation of urgent vs. routine care needs
    - Rapid turnaround and responsive answers to consumer questions/concerns



# Clinical Providers Fostering Integration at Compass





# Structures Fostering Integration at Compass



Co-location of primary medical, behavioral health, and dental clinical services in a health center



Designation as a Behavioral Health Home



Integrated clinical pods (services in same clinical area)



Multiple clinic locations



Common and service specific waiting areas



Engagement with external community based organizations with mutual interests in patients

# Macro Processes Fostering Integration at Compass

**Patient  
Engagement**

**Staff Engagement  
with Organizational  
Mission and  
Training**

**Formal and  
Informal  
Communication  
Processes**

**Electronic Health  
Record**

**Engagement with  
the Larger  
Community**

**Organizational  
Assessment of  
Integration Level  
(OATI)**

# Specific Processes Fostering Integration at Compass

Common medication list

Clinical activities linked to integration efforts

Depression screening

Smoking/alcohol screening

Patient history form includes question(s) about behavioral health

Regular review of patient medical, dental, social history by all clinical providers

Collection and use of outcomes measures in clinical protocols

Participation in ER diversion programs

Engagement with hospitals in providing post discharge treatment

Encourages providers to engage in informal communication and warm hand-offs of patients

Established internal referral mechanisms

Resources to address social determinants of health

Regular staff and/or committee meetings that include clinicians from a variety of disciplines

Staff training in trauma informed care

Staff training in topics related to other health disciplines

# So What? Data Tell The Story...

- We have convincing evidence that our efforts lead to excellence and effectiveness in whole-person care.
- Only **12%** of enrollees completed metabolic screening at the inception of HCH, which is essential to identifying health risks that contribute to decades of lost life and poor QOL among our population—now **94%** of HCH enrollees do.
- Following efforts to better identify and treat depression in primary care, the percentage of patients screened with evidence-based tools and referred for care has risen from **38%** in 2014 to **84%** now, substantially exceeding both state (75%) and national (66%) averages.



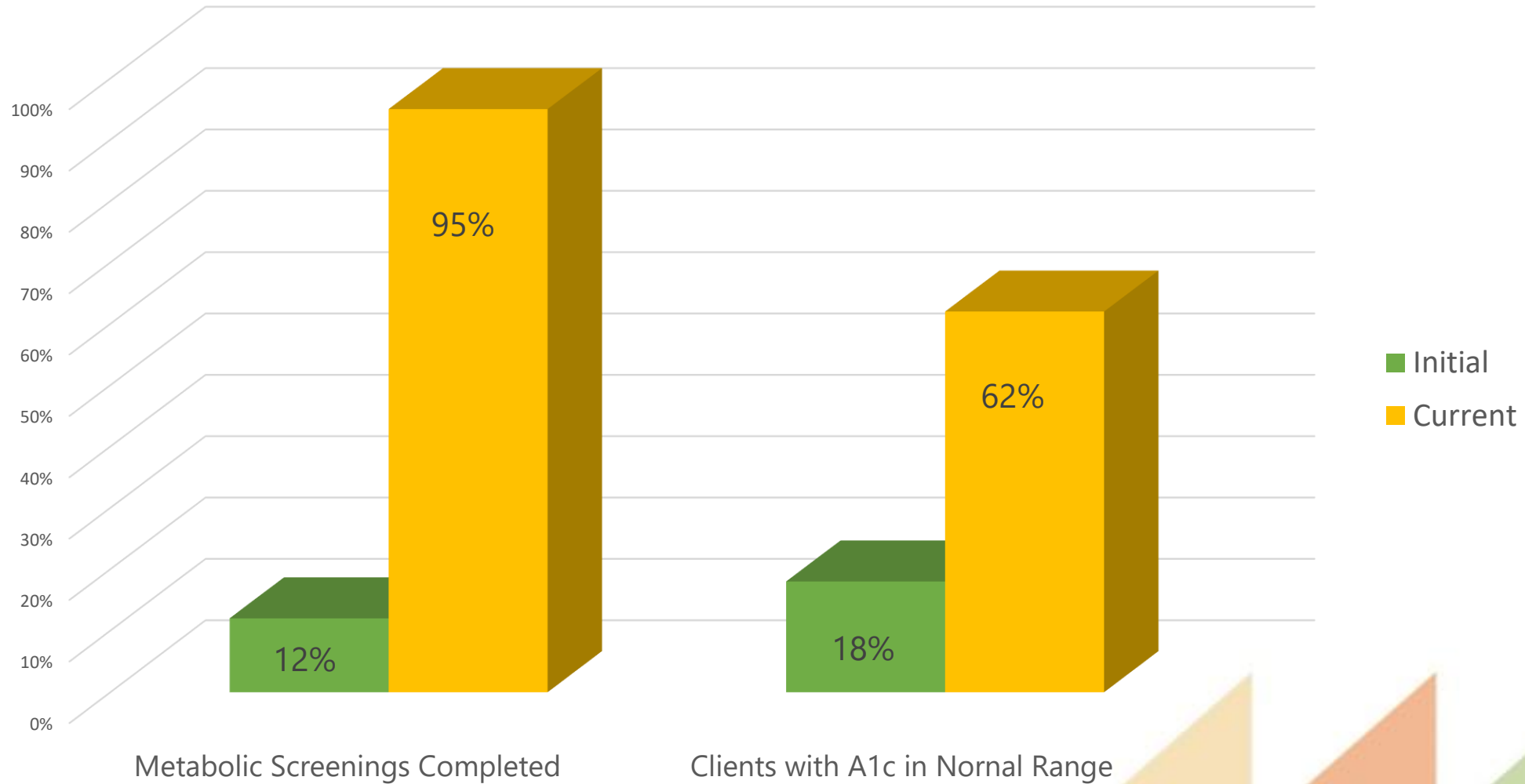
# Patient-Centered Integrated Care

- CCBHC: an opportunity to expand on the Healthcare Home model
- Added staff to Healthcare Home to expand focus on:
  - Metabolic Screenings
  - Medication Adherence
  - Tobacco Cessation
  - Hospital Follow Up
  - Primary Care Physician Status
  - Risk Stratification
  - Education





# Examples of Health Outcomes



# Opioid Response

- Increased number of MAT prescribers to 13
- Added peer specialist
- Added outreach and engagement teams
- Patient Adherence 77% at 3 months and 68% at 6 months
- Medication prescribed for 37%
- Medical Director for all ADA programs
- DEA registered for controlled substances

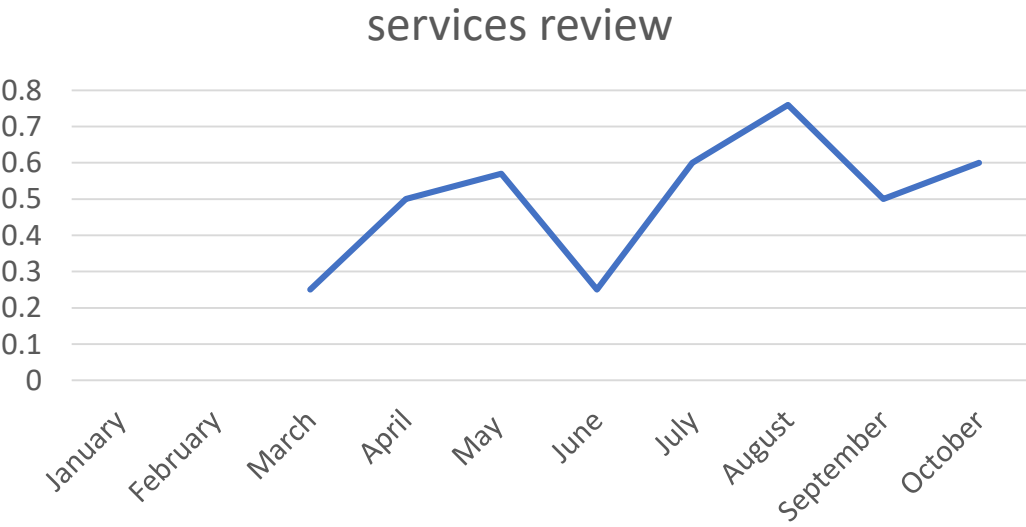
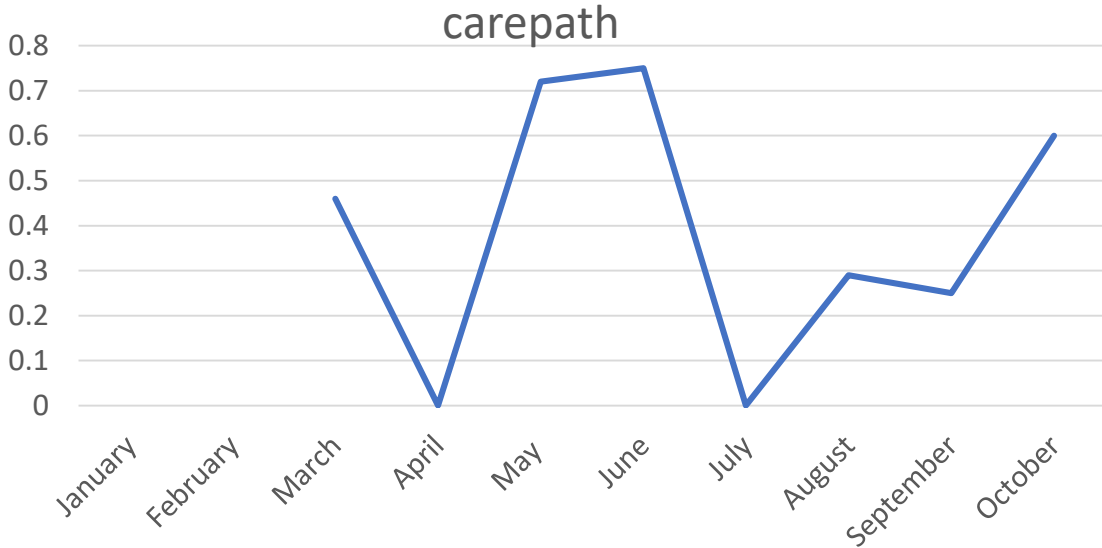
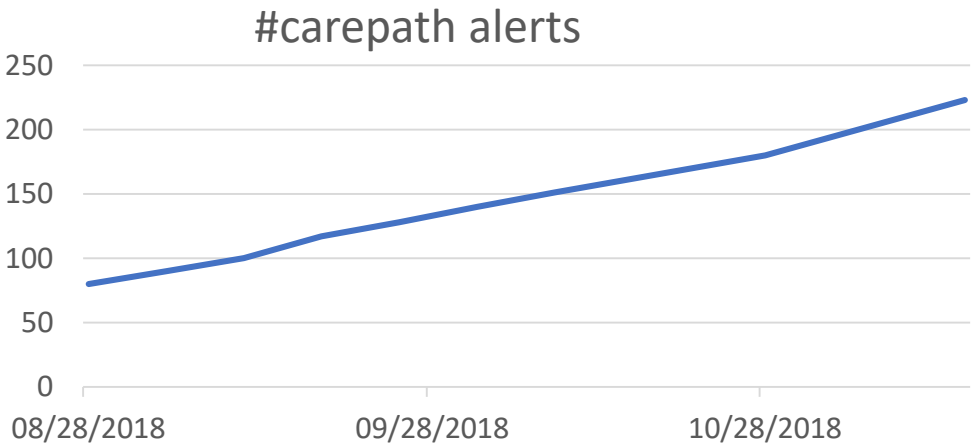


# Innovations in Suicide Prevention

- Zero Suicide Model
  - What is Zero Suicide?
    - Evidence Based
    - Commitment to patient safety
    - System wide approach
    - Relentless screening and assessment of individual risk
    - Safety planning
    - Quality Improvement



# Suicide Care Enhancements at Compass Health



# Maybe we can get to Zero?

- The Quality Department will continue to monitor for impact of our services on suicide rates for those we serve.
- Point in time observation:
  - Fiscal Year 2018 saw 16 confirmed deaths by suicide. That's a rate of approximately 1.33 per month.
  - As of February 20, 2019, 6 months into Fiscal Year 2019, we've had 2 confirmed deaths by suicide.





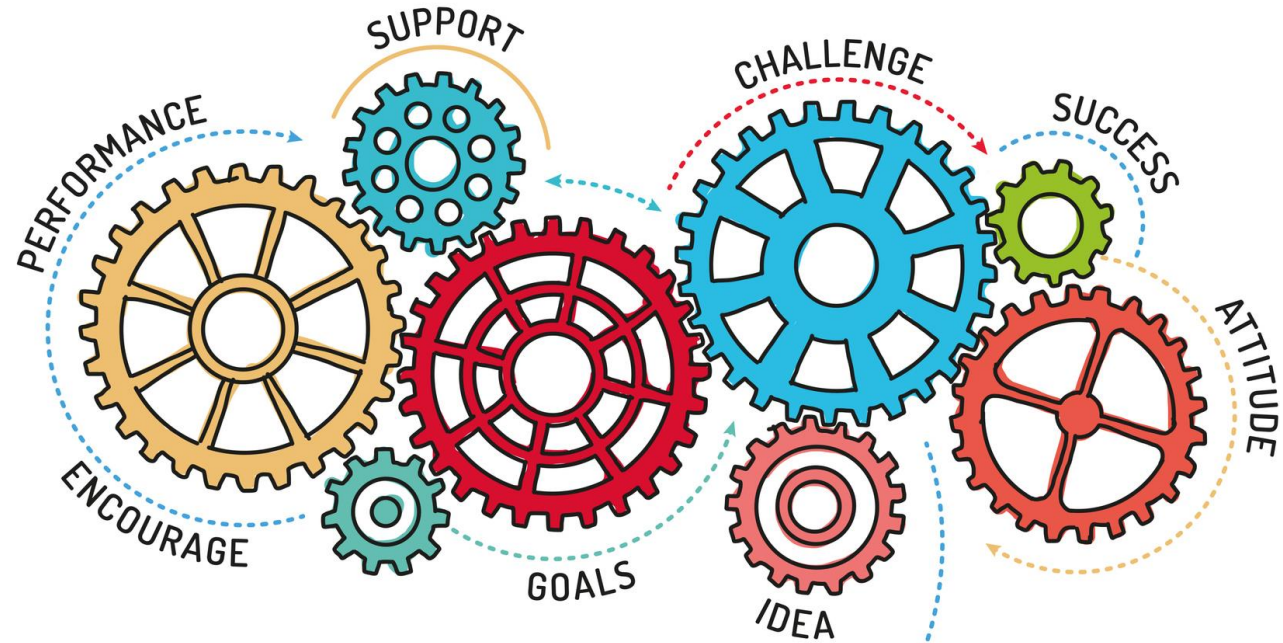
# Evidence Based Practices

- Youth-ACT
- Integrated Co-Occuring
- PCIT
- DBT Teams



# QUALITY BONUS INCENTIVE

Open Access  
7 Day Hospital Follow-ups  
Suicide Prevention  
Medication Adherence  
Addiction Follow-ups



Motivation

# STATE WIDE DATA

- Annual clients served by CCBHCs increased by 24,109 (20%)
- MAT clients served increased by 73%
- VA/Military clients increased by 25%
- Services to Schools increased by over 100% in visits statewide
- Same Day Access adopted by most CCBHC resulting in wait time drops= 14 days-0, 22 days-0 days, psychiatry 3 months to 1 week

