CENTER *for* INTEGRATIVE HEALTH

insight to innovation

Convene.
Strategize.
Activate.

# Networking for Success: LINC and the Connected Community

VISIONARY VOICES

WakeMed
Behavioral Health Network

NETWORK FOR ADVANCING
BEHAVIORAL HEALTH

CONNECTED
COMMUNITY

BlazeAdvisors



WakeMed

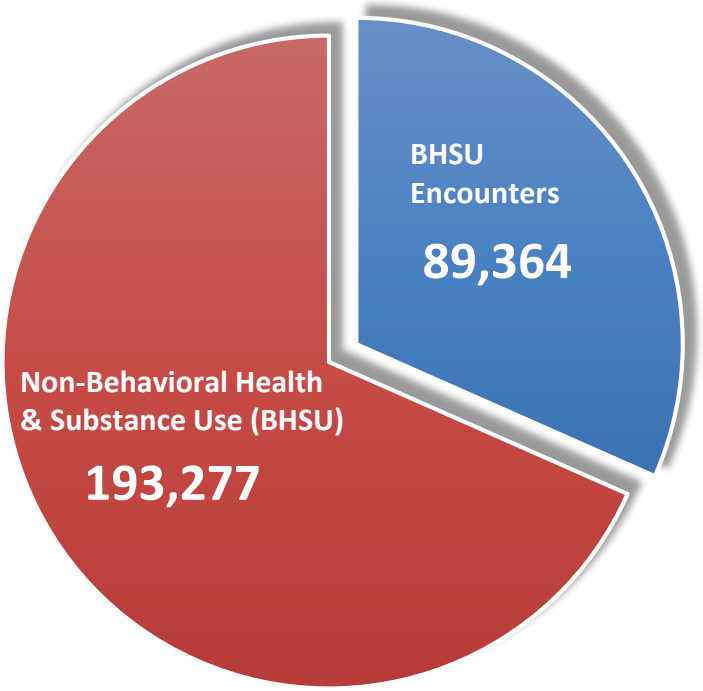
Exceptional People. Exceptional Care.

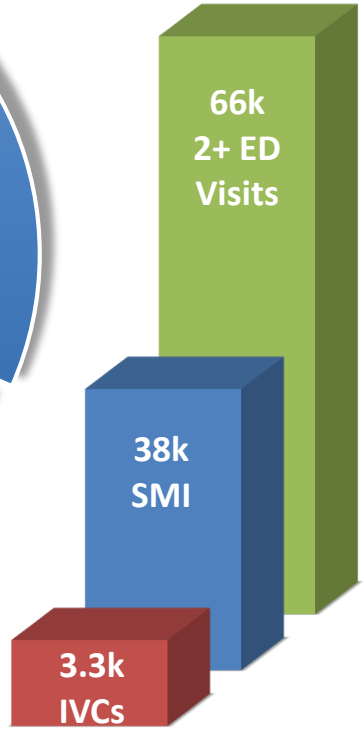
# Strategic Plan


Illustration by Chris Wren/Kenn Brown @ mondoart.net
WakeMed
Social determinants of health
Mental Health
Fear Is Contagious

# The Challenge In Our Community Today

**2017 Emergency Department (ED) Presentations**




**2017 ED Patient Milieu**

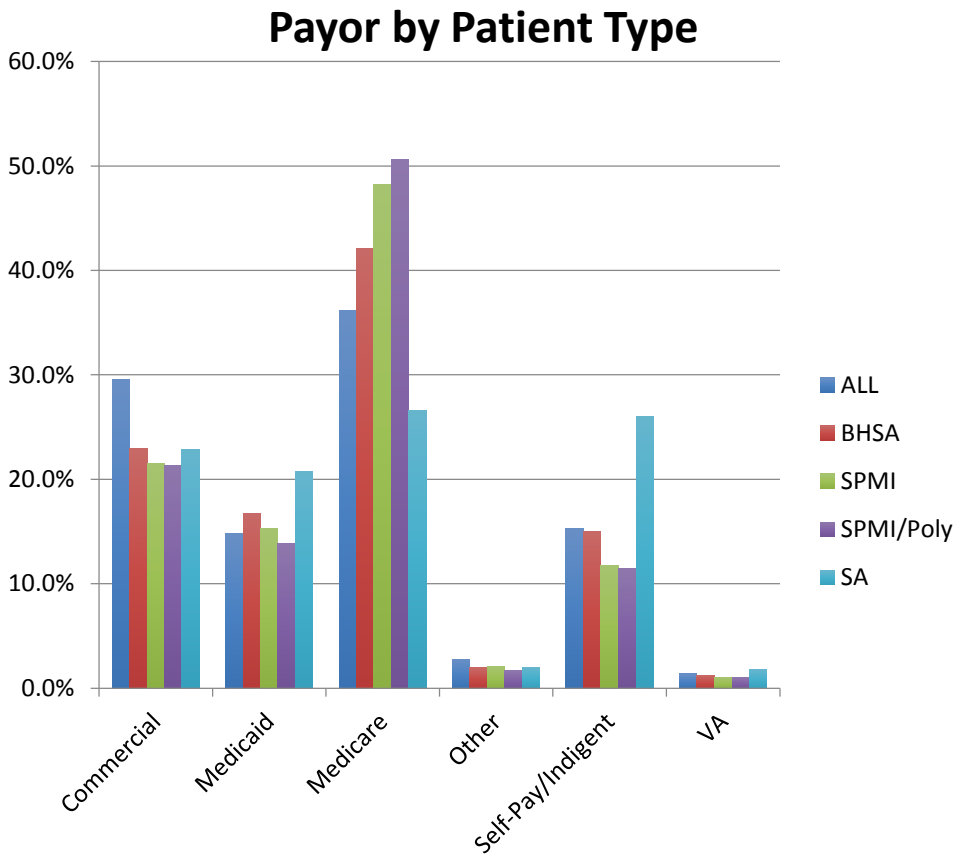
**Average Daily Inpatient Census (ADC)**

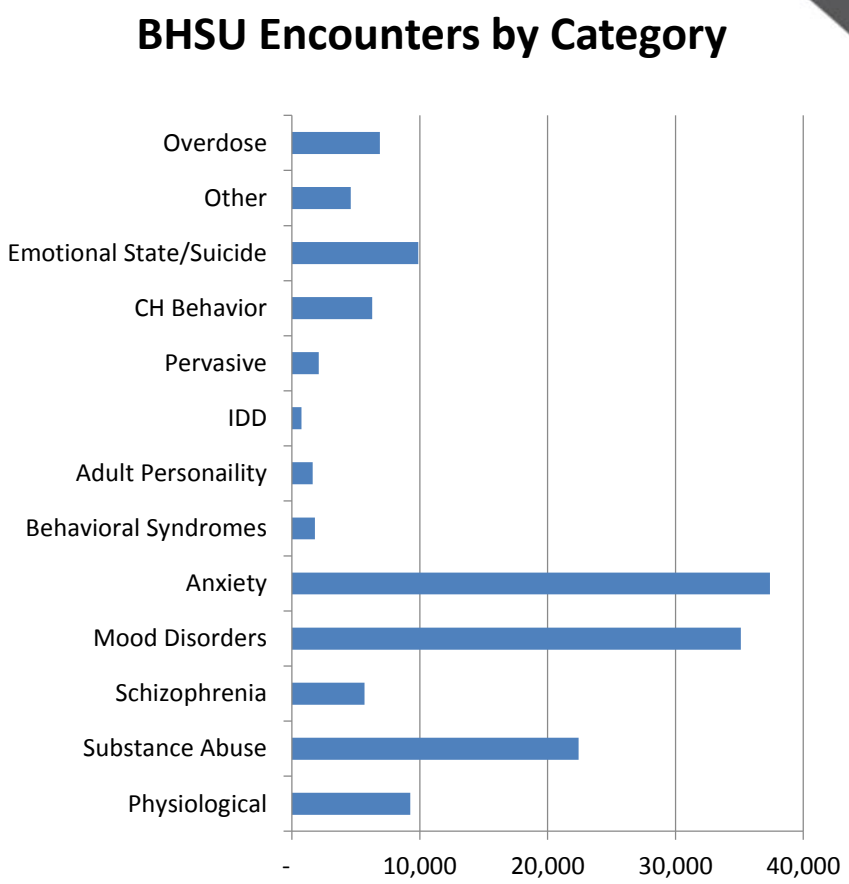
**Baseline ADC = 140 – 160**

**Current ADC = 100 – 120**

**% ADC Decrease = 25 – 30 % ↓**
**(7,200 ABD Saved)**

# Target Population Demographics



## Community Population Health

### An Innovative Approach to Community Health of Vulnerable Populations

INDIVIDUALIZED CARE • COLLABORATION • EDUCATION • ACCESS • STABILITY

### Purpose

Activate and sustain a community-wide effort to improve the quality of life and health for underserved members of our community who have chronic medical and behavioral health conditions.

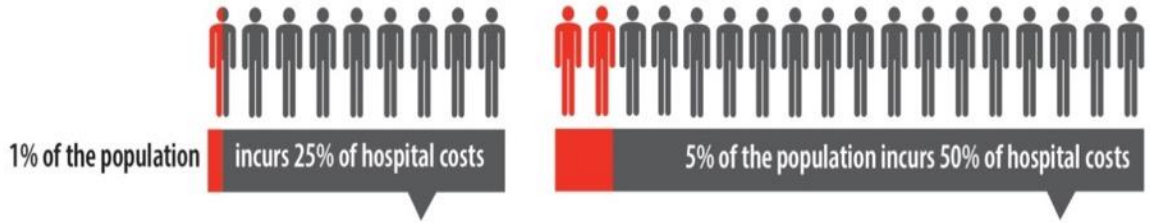
### Goal

Improve access to care and to improve health outcomes and avoid unnecessary costs.

### Results

- 523 high-risk patients enrolled
- 145 of those patients have had zero return visits to WakeMed post enrollment
- Estimated cost savings (those enrolled thru June 2017) - $6.07 million
- Actual Emergency Department visits pre-enrollment and post-savings: 327 visits
- Actual inpatient visits pre and post enrollment savings: 176 admissions

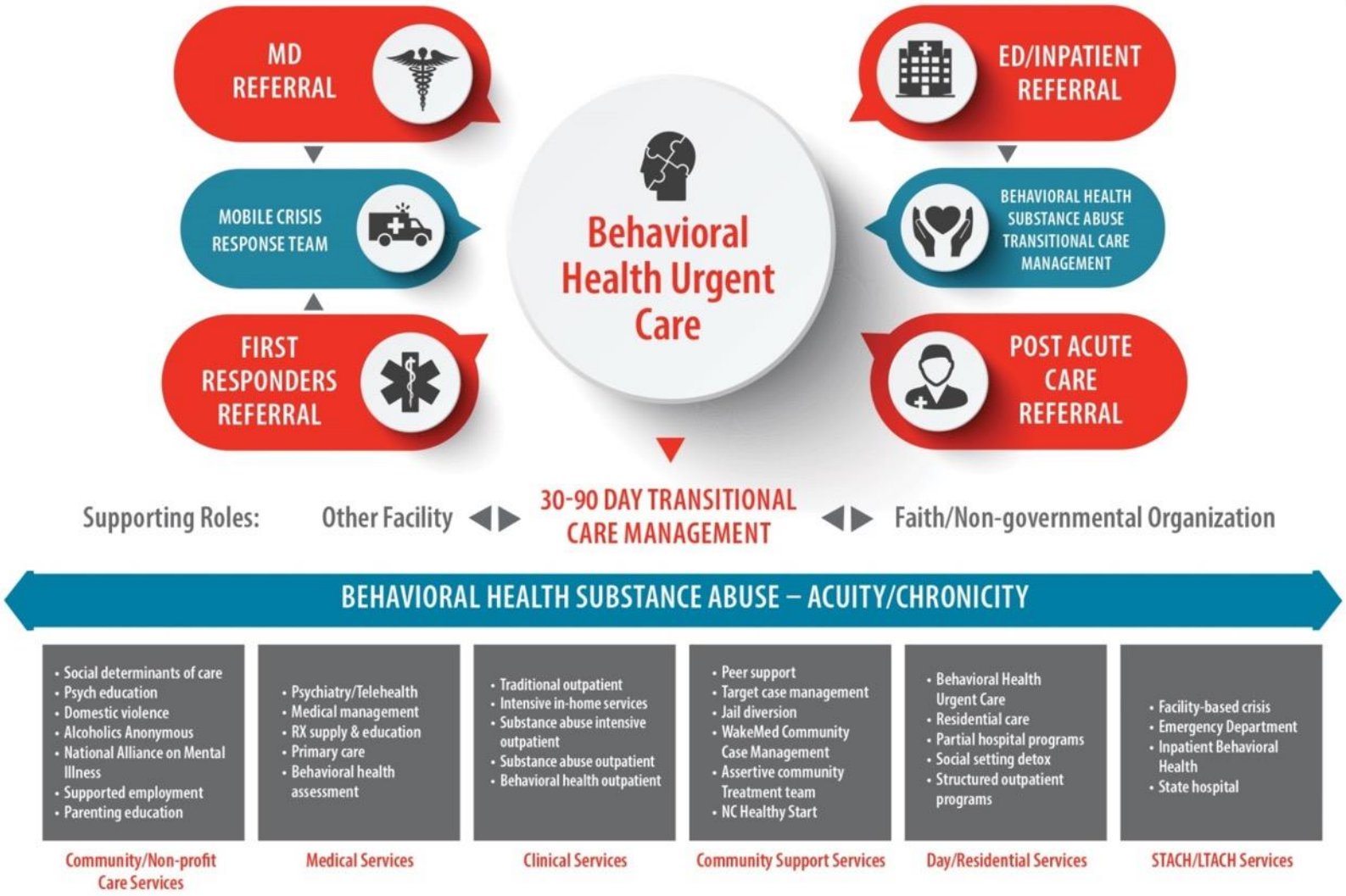
### Current Rates of Hospital Use




**7,000** uninsured patients are seen every year at WakeMed, costing the health system **$7.9M** per year

# So, what did we do?

# We've dug into our data and…




**WakeMed Services**
Crisis & Assessment
ED Psychology Program
WPP Providers
Transitional Care Management
Community Case Management

**Inpatient BHSU Network**

**BHSU Outpatient Network**
Traditional Outpatient Services
Group Therapy Services
Behavioral Health Urgent Care (BHUC)
Medication Assisted Therapy (MAT)

**Community Based Organization (CBO) Network**
CBO's focused on insecurities related to food, transportation & housing

NETWORK FOR ADVANCING BEHAVIORAL HEALTH

CONNECTED COMMUNITY

## POTENTIALLY FUNDED BY PHILANTHROPIC PARTNERS SUCH AS:

- **WakeMed / WakeMed Foundation**
- **Inpatient Network Partners**
- **Outpatient Network Partners**
- **Duke / Duke Foundation**
- **UNC Healthcare**
- **Wake County**
- **Other community care organizations**
- **Other behavioral health providers**
- **Other NC health systems**
- **Health Plans**
- **Philanthropic partners**

# NETWORK FOR ADVANCING BEHAVIORAL HEALTH

WakeMed

Monarch

Yes Yelverton's Enrichment Services
Quality & Professional Support Services

Carolina Outreach
Promoting Individual and Family Strengths

It Takes a Village

CareNet Counseling

TelePsych SUPPORTS

TPEC
Turning Point Family CARE
An ncgCARE Partner

RHA HEALTH SERVICES

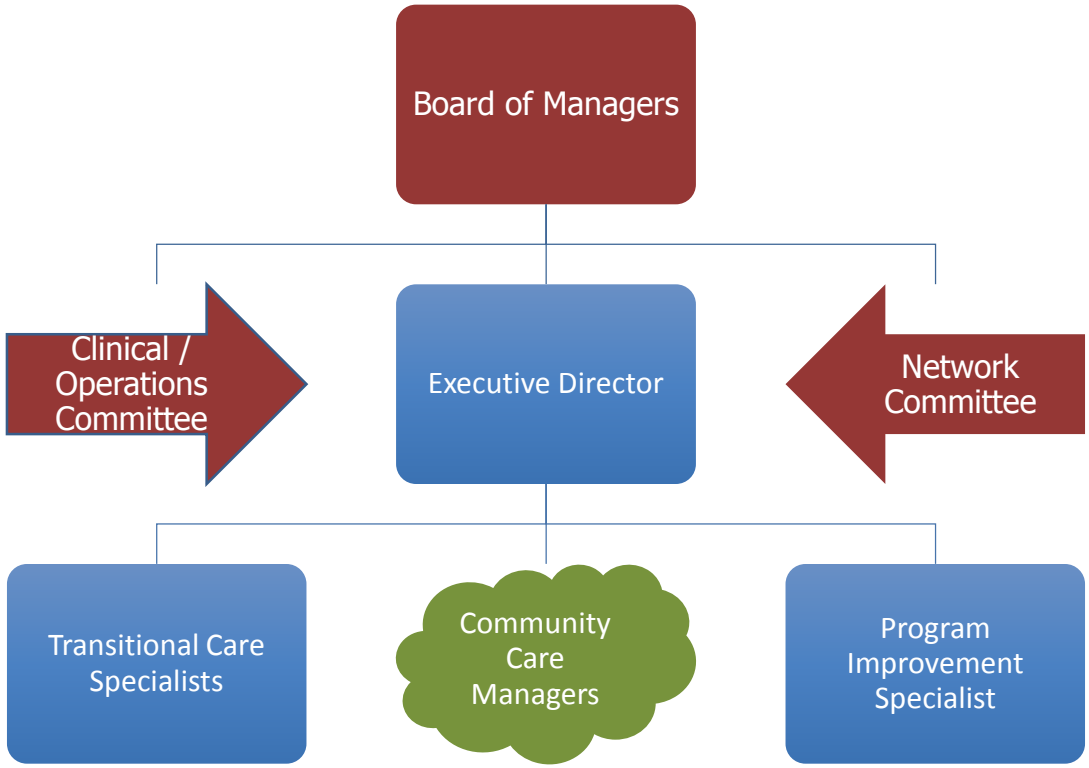
SOUTHLIGHT HEALTHCARE

*** All members have signed agreements committing to both quality and operational KPI's.**

# How do some of the key components operate?

NETWORK FOR ADVANCING
BEHAVIORAL HEALTH

# Governance/Ops Structure



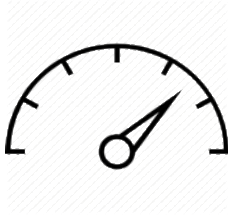

- 2 Year Terms
- Oversight/Strategic Direction
- Professionally Managed
- Balance of Provider and WakeMed Representation

NETWORK FOR ADVANCING
BEHAVIORAL HEALTH

# The Chassis

Network alignment, goals, and governance. Working committees with concrete **charters** and roadmaps. Linked to **shared services** and **sister networks**.

Standardized triage, screening, and referral **protocols**. Common assessment **tools** to front-load care transitions. Socialized clinical care pathways.



Provider-level process and outcome **KPI's** leveraging **accessible** data. Impact data shows **OpEx** and **community** savings as well as network **performance** and **adequacy**.

Shared **e-referral** and **care coordination** platforms for clinical and social services. Embedded **decision support**, compliance **monitoring**, and bi-lateral **communications**.

# Patient Acuity Drives Timely Access to Care

| | Tier 1 | Tier 2 | Tier 3 | Tier 4 |
|---|---|---|---|---|
| | Self-Managed Routine OP F/U | Advance Access to OP Services | Advance Access & TCM | Maintain IP Plan. Not Yet Ready for OP plan |
| **ED/Admitted** | Either | Either | Either | Either |
| **IVC** | No | May meet criteria but due to protective factors, motivation, etc. voluntary, can be considered | Terminated/ending soon; no active SI/HI | Not stable |
| **Medical** | Stable. Not in need of medical detox | Stable. No need of medical detox | Stable / on track for clearance. No need of medical detox | Not stable or needs medical detox |
| **Mental Health Status, (If app.)** | May have active psychosis but otherwise functional in community | May have active psychosis but functional in community | Active psychosis but not impaired/or psychosis has continued to improved | Psychosis causing functional impairments in the community |
| **Substance Use Status (if app.)** | Actively attempting recovery with concrete support system and plan | Actively attempting recovery with concrete support system | Interested in recovery but lacks support system and plan | Needs medical detox or use behavior is immediate danger to self/others |
| **Discharge Status** | Ready. Can self-manage care. Concrete support system and plan. | Ready. May need help managing care transition or relapse risk while awaiting OP appointment | Ready or ready in 1-2 days with solid outpatient plan and TCM F/U | Continues to have significant barriers to be addressed |
| **Social Determinant of Health (SDOH) Barriers to Care** | None significant. Has access to social and support resources. | Known SDOH barriers that impede outpatient follow up that require mitigation at discharge | Needs plan and TCM support to mitigate significant SDOH barriers | Significant SDOH obstacles which can be addressed by TCM as patient progresses |
| **Referral to NABH partners** | **7 Business Days** | **2 Business Days** | **1 Business Days** | **Direct Transfer** |

- **71% adherence to advanced access metrics/goals to date!!**
  – and 4% adherence by non-NABH members…

# Shared Resource: Transitional Care Management


**(5) to +45 Days**

NETWORK FOR ADVANCING BEHAVIORAL HEALTH

CONNECTED COMMUNITY

CONNECTED COMMUNITY


# Addressing SDOH

- Connecting Hospital, Providers, & **Community Based Organizations**
- Transitional Care Management to "Fill the Gap" before services start
- Link person to resources to improve health/**community outcomes**. Advanced access to services.
- Shared **Care/Crisis Plans** to minimize unnecessary 911
- Care compliance **alerts** identify at-risk behaviors early
- Use accountable partnerships to **steer referrals and funding**

CONNECTED COMMUNITY

# "Medical Meets Mission"


**Care Management:**

- Links to Medical, Clinical, and Social Services
- Shares documents/Referrals
- Patient Surveillance/Alarms
- Community Resource Directory
- Referral Decision Support

**Hospital/Network:**

- CBO/Provider encounters visible
- Assess Need
- Initiate Transitional Care
- Convene Accountable Networks

**Community Based Org:**

- Track incoming referrals
- Communicate with care team
- Engage patient in self-care
- Target resources and measure impact.

**Housing support and shelters**

**Food security programs**

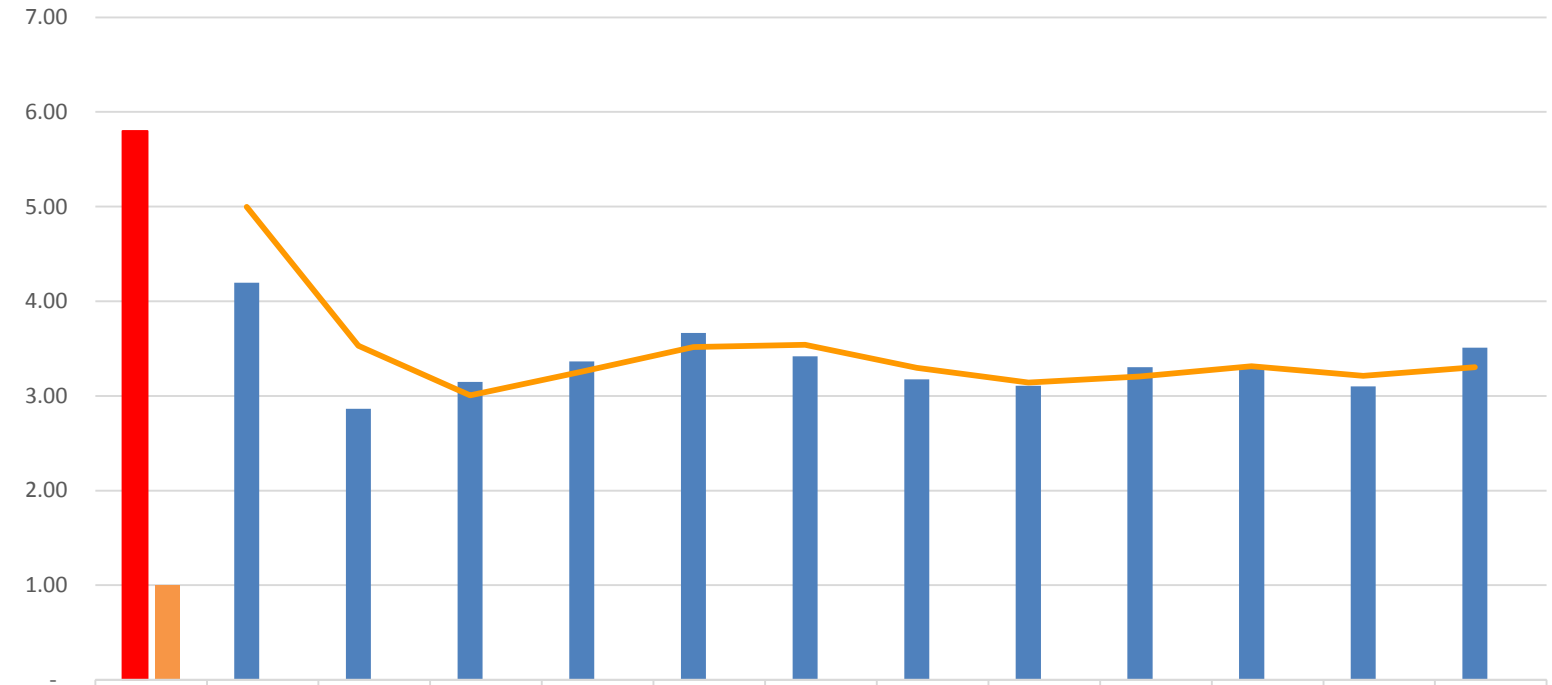
**Faith Based Community Care**

**PAP and mobile pharmacy programs**

**NAMI/AA/NA, etc.**

# Early Results

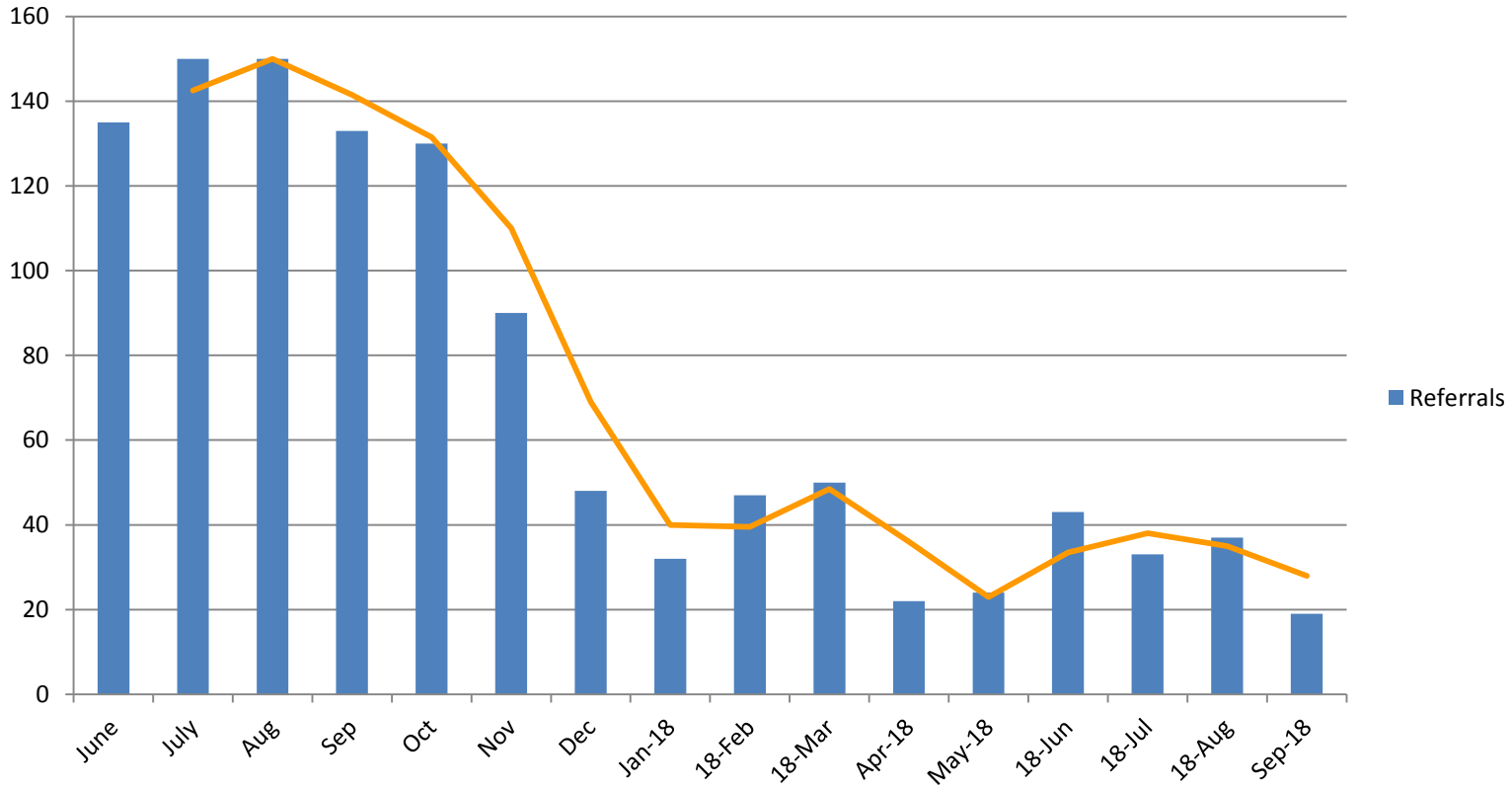
# Average Length of Stay (ALOS)




| | 5 Month Average | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ALOS | 5.80 | 4.20 | 2.86 | 3.15 | 3.37 | 3.67 | 3.42 | 3.17 | 3.11 | 3.30 | 3.32 | 3.10 | 3.51 |
| #REF! | 1 | | | | | | | | | | | | |

* 42 % decrease in ALOS

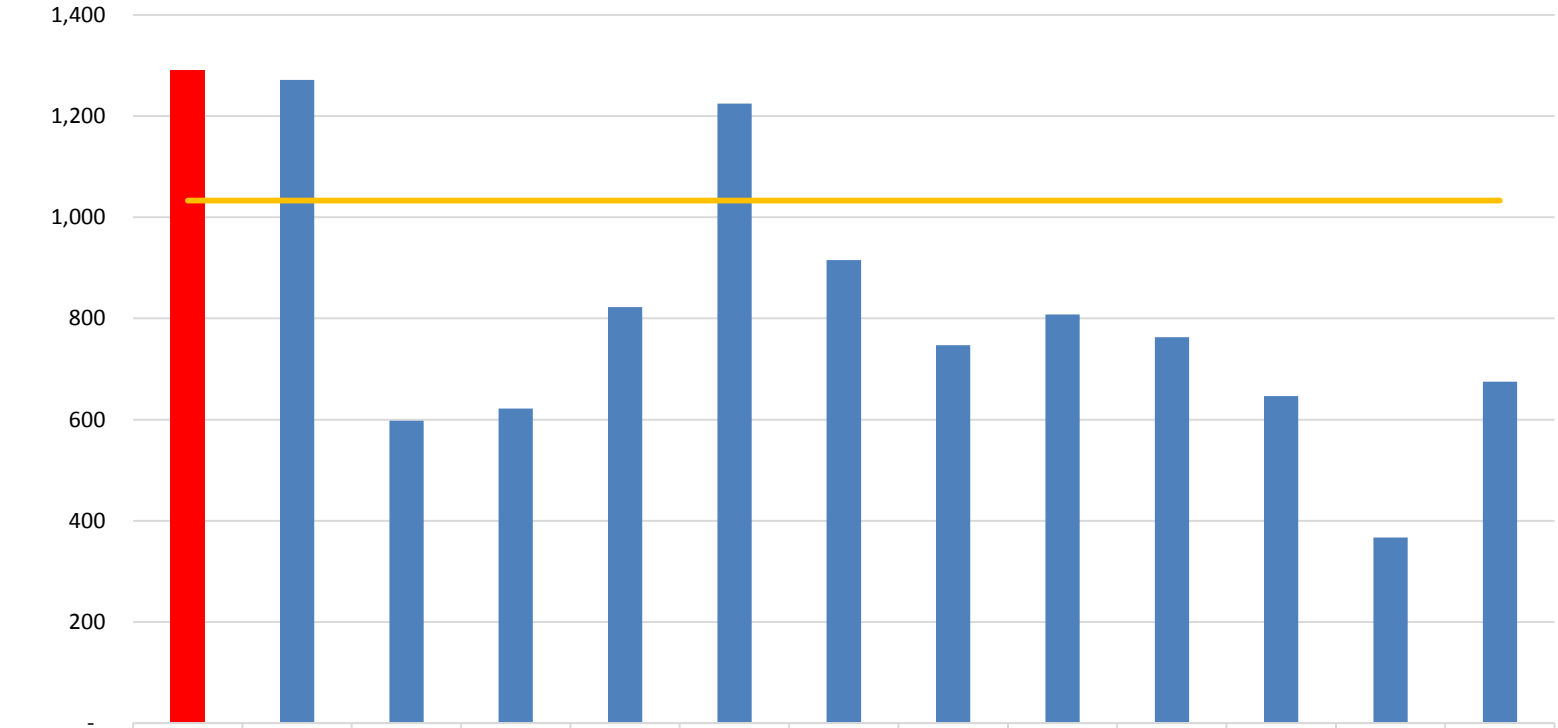
# WakeMed Referral to Central Regional Hospital (CRH)




* 71.4 % decrease in state hospital referrals

**Data Provided by:**
**Jody Webster, RN-BC**
Associate Chief Nursing Officer
Division Of State Operated Healthcare Facilities,
Central Regional Hospital
N.C. Department of Health and Human Services

# Avoidable Bed Days (ABD)




| | 5 Month Average | Nov-17 | Dec-17 | Jan-18 | Feb-18 | Mar-18 | Apr-18 | May-18 | Jun-18 | Jul-18 | Aug-18 | Sep-18 | Oct-18 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ABD's | 1,291 | 1,272 | 598 | 622 | 822 | 1,225 | 916 | 747 | 808 | 763 | 646 | 367 | 675 |
| Goal | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 | 1,033 |

* 39% increase in getting patients to the treatment they need and deserve!

# Next Step Ideas…

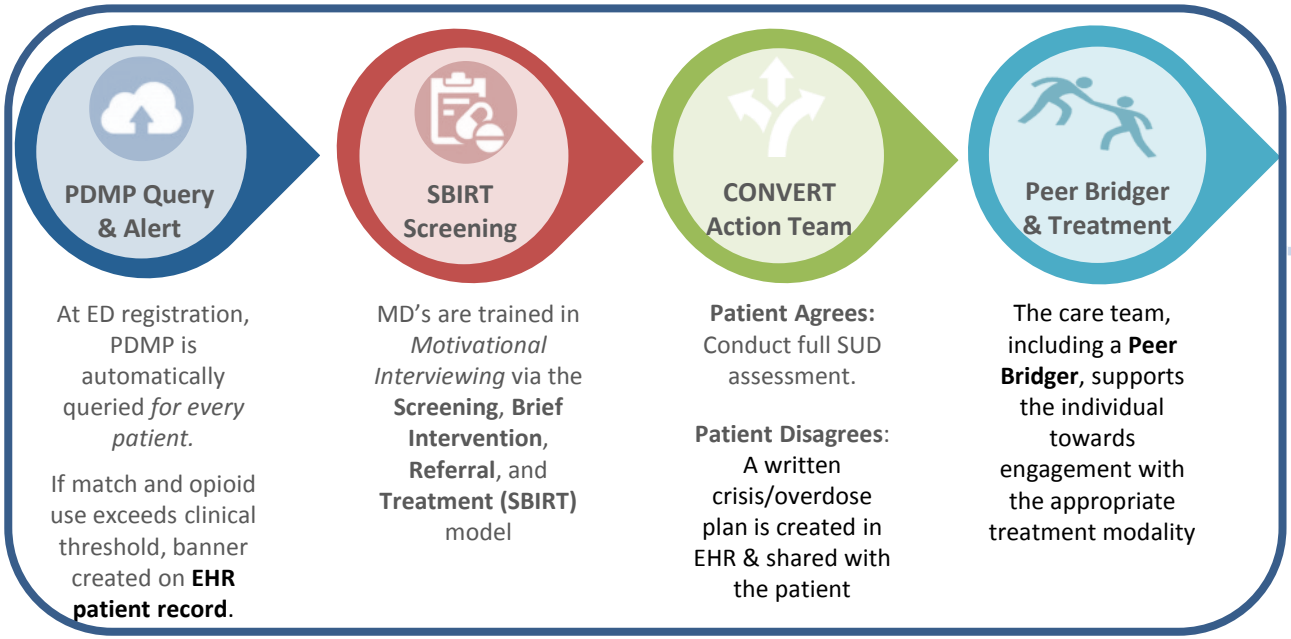
# Our Vision: Working Together to Make a Difference

*A comprehensive, connected, community-based solution to the behavioral health crisis*


GRAPHIC CREDIT: PCCI

NETWORK FOR ADVANCING
BEHAVIORAL HEALTH

# *CONVERT*: OUD Detection, Intervention, *CONVER*sion and Transition




OBOT NORTH CAROLINA

North Carolina Medical Society FOUNDATION

# aLARM

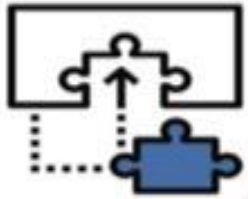
## AGGREGATED LAB ANALYTICS RISK MODELER

Analyzes discrete lab data results against claims data to identify risk segmentation markers

Predictive model that helps NCHA members to anticipate and proactively meet patient needs

Identifies rising risk and intervention timing in target populations

Allows members to use pre-existing data. No need to clinically integrate



All payer solution

# Some Key Next Steps…

1. **Fully Implement WakeMed's Behavioral Health Network**

   Working with the Department of Health and Human Services (DHHS), Wake County, ACO's, and Payers on sustainable funding models for our Network.

2. **Short and Long Term Funding for Connected Community**

   Continue to work with the Philanthropic Partners, DHHS, Payers, and Wake County for funding options for our Connected partners.

3. **Technology, Automation, and Artificial Intelligence (AI)**

   Act as an innovation incubator for emerging technology and analytics. Engage support for using Artificial Intelligence (AI) technology for advancing care (suicidal ideation detection, depression, anxiety, etc).

4. **Behavioral Health Network "Engine"– get the Network fully engaged and running efficiently**
   - Recruit Network leadership team (Tom Klatt, Executive Director)
   - Deeper Clinical Integration and Transparency
   - Decrease "Time to Treatment" and increase Patient Engagement
   - Primary Care Integration
   - Begin Connected Community Network operations


If Fear is contagious…

then so is Hope!!

# Questions?

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