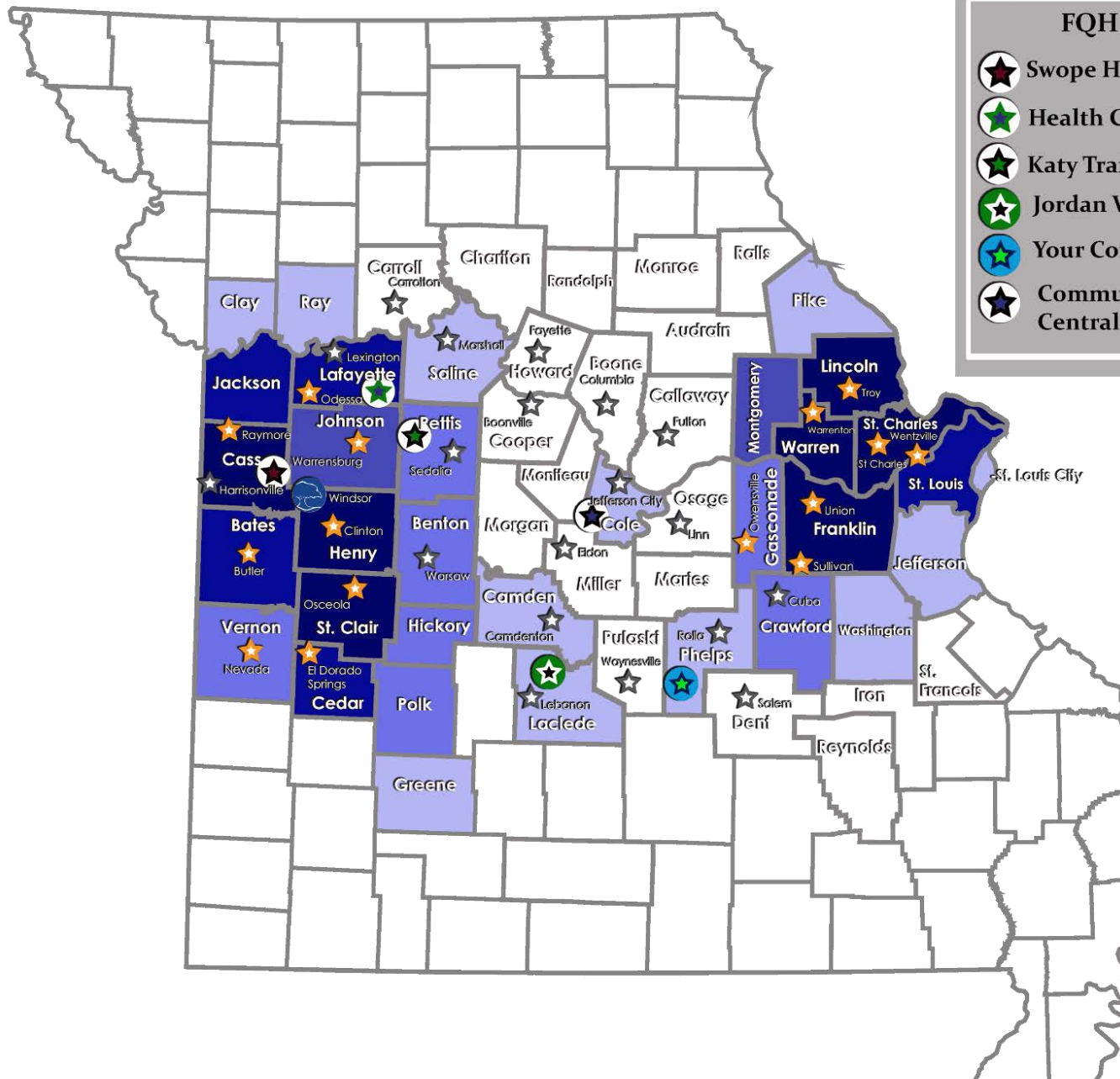




Tim Swinfard, CEO
Compass Health Network



Compass Health
Network



FQHC Partners

- Swope Health Services
- Health Care Collaborative
- Katy Trail Community Health
- Jordan Valley Community Health
- Your Community Health Center
- Community Health Center of Central Missouri

FQHC Patients by County

- = 1000 +
- = 500-1000
- = 250-500
- = 100-250
- = 10-100
- = less than 10

- = ROYAL OAKS HOSPITAL
- = Office Locations
- = FQHC Locations

Organization Overview

- \$205M Revenue
- 2,700 Employees
- 70 Psychiatrists/PA/APRNs
- 18 Primary Care Physicians/APRNs
- 24 Dentists





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?



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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?



What Does A New Customer Want?

- Access & Answers
- They don't want long psychosocial history
- They do want to see a mental health professional aka a Psychiatrist
- A place to call after hours when they are in distress



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**

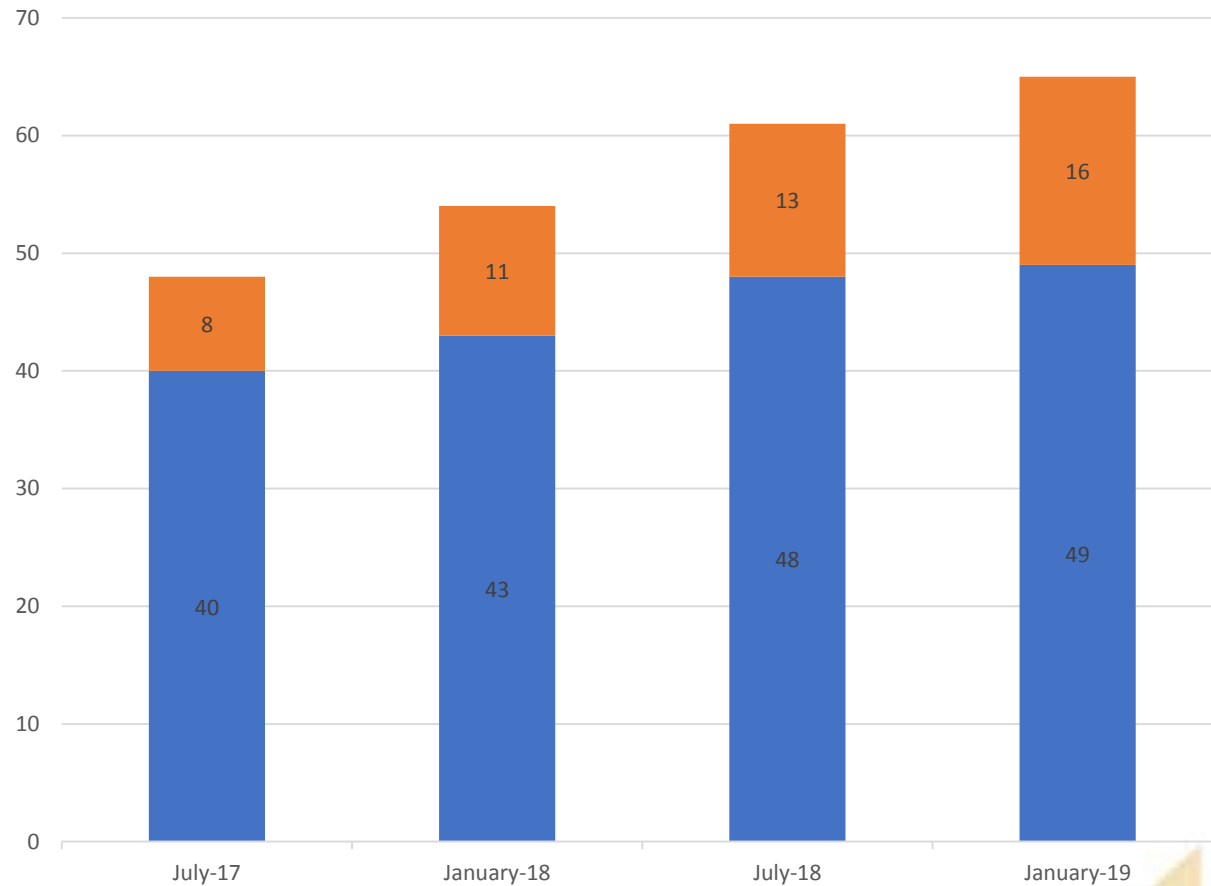


Technology

- 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)



PSYCHIATRISTS AND APRNS



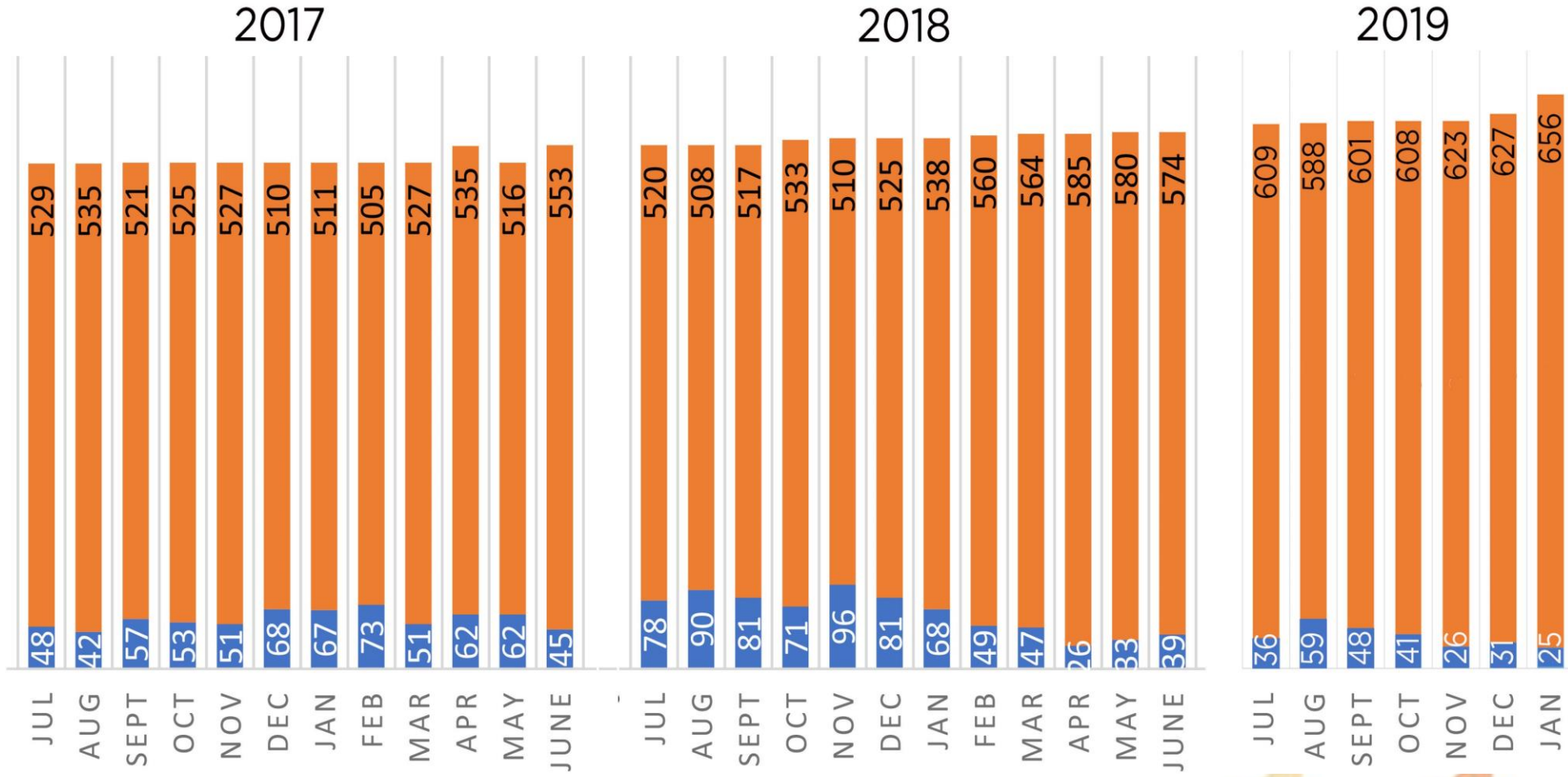
Employee Satisfaction

- Overall Job Satisfaction
 - Above Average 2017-39.5% 2018-52.8%
 - Average 2017-47.8% 2018-43.1%
 - Dissatisfied 2017-12.7% 2018- 4.1%
- Good Place to Work
 - 2017 84.1%
 - 2018 93.1%



IHS POSITIONS

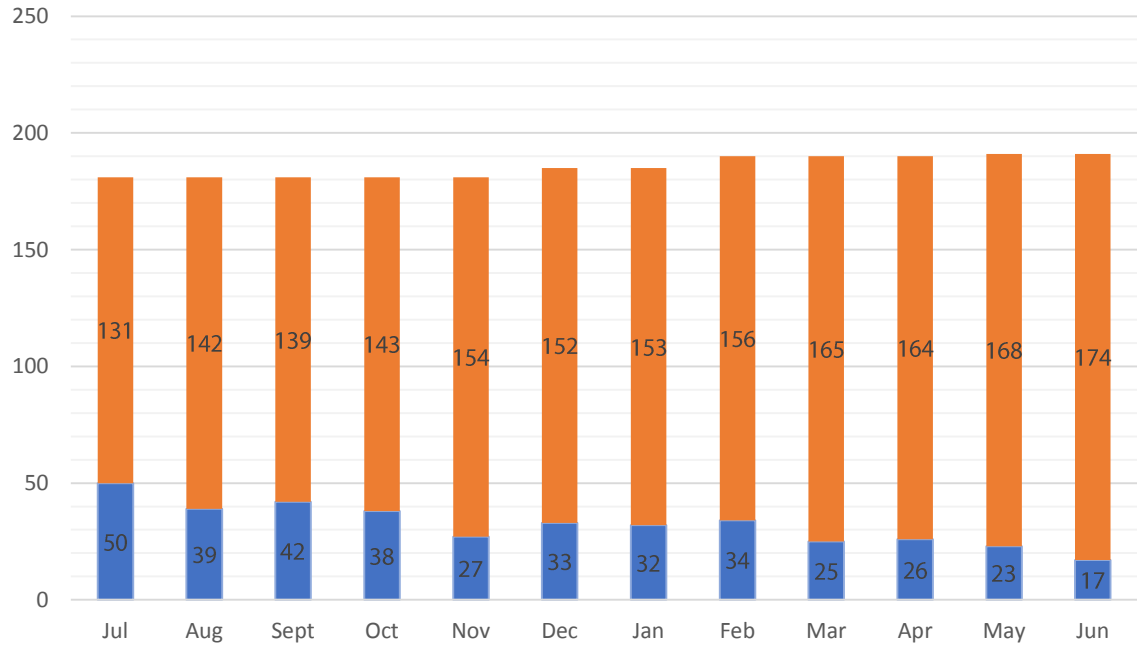
■ Vacant ■ Employed



PSYCHOLOGIST, THERAPIST, BH CONSULT

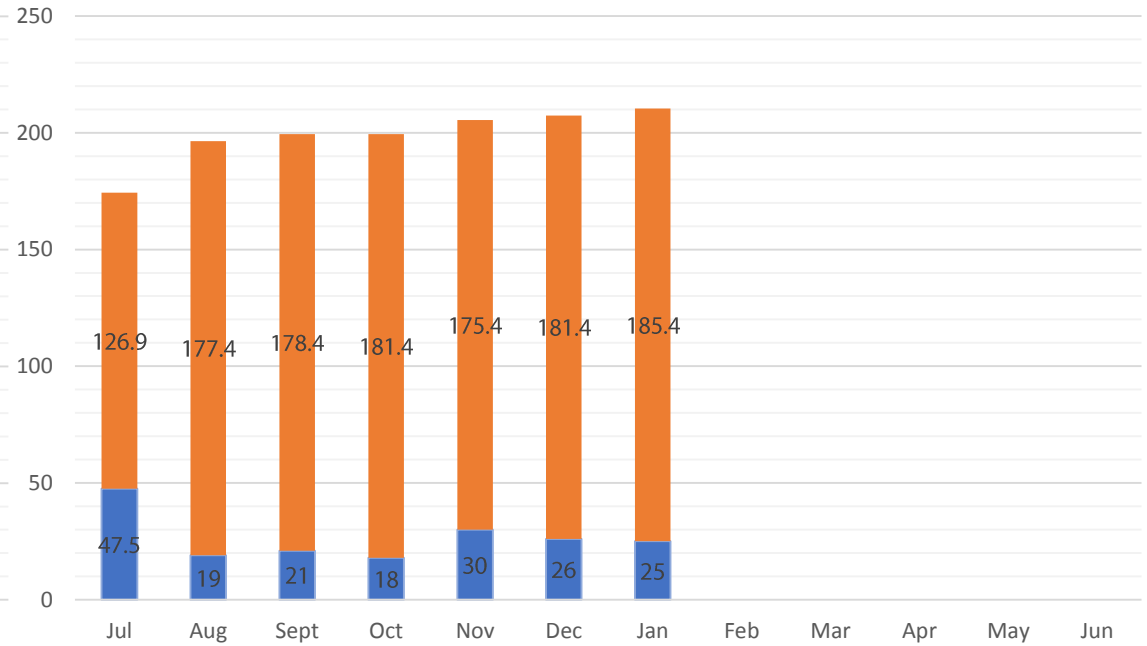
FY18

■ Vacant ■ Employed



FY19

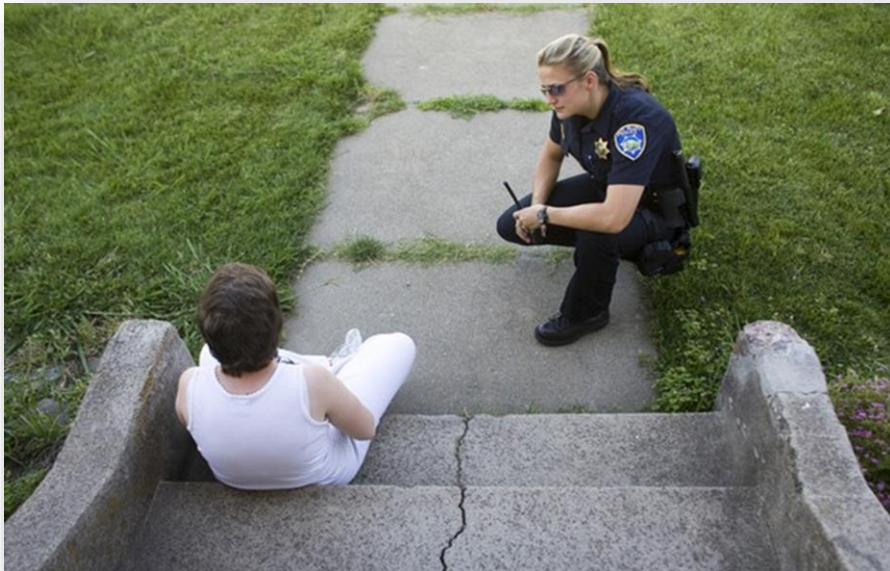
■ Vacant ■ Employed



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
- Accounts for 20-25% of Missouri's CMHL referrals



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

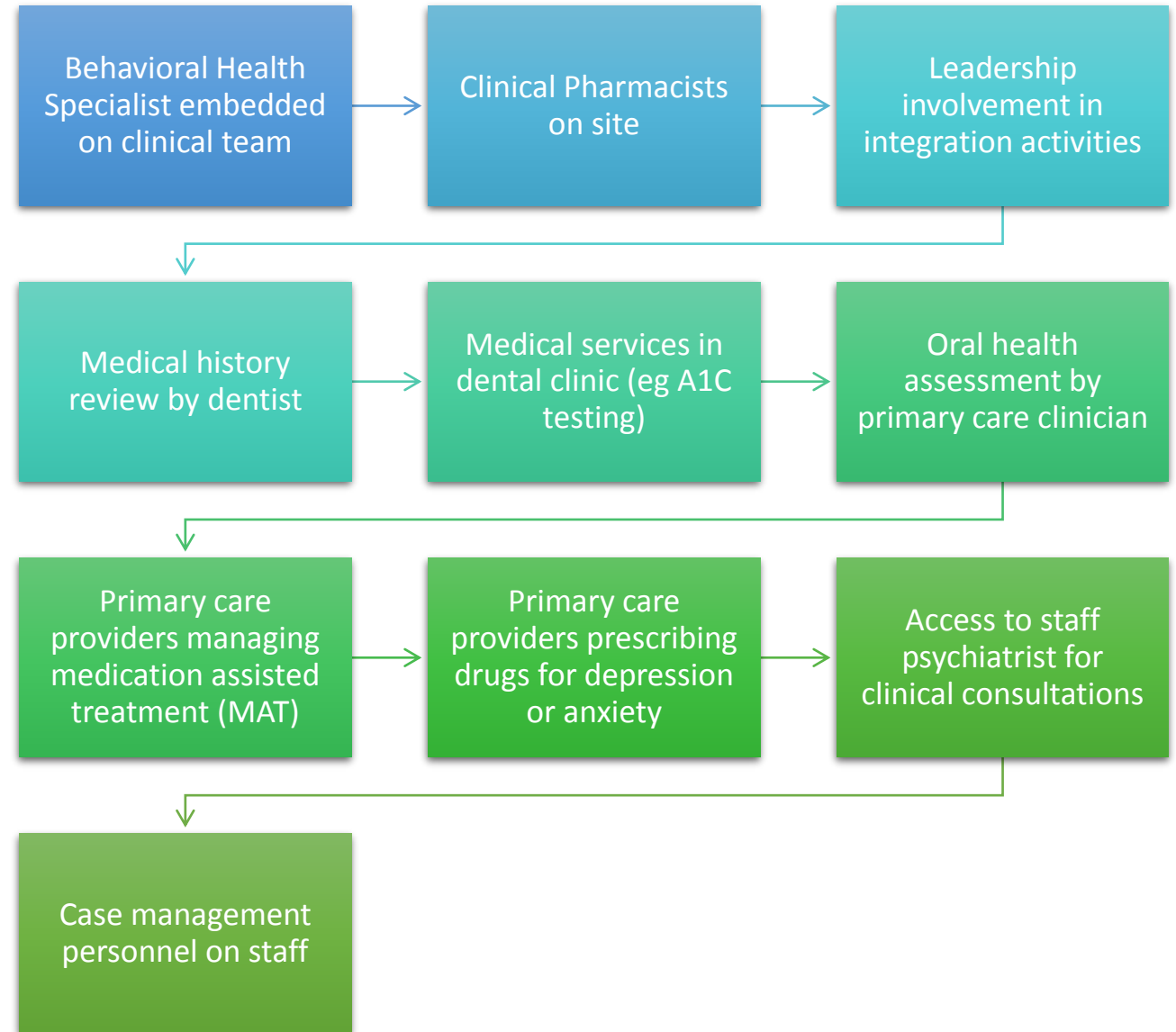


Open Access and Assessment

- 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.

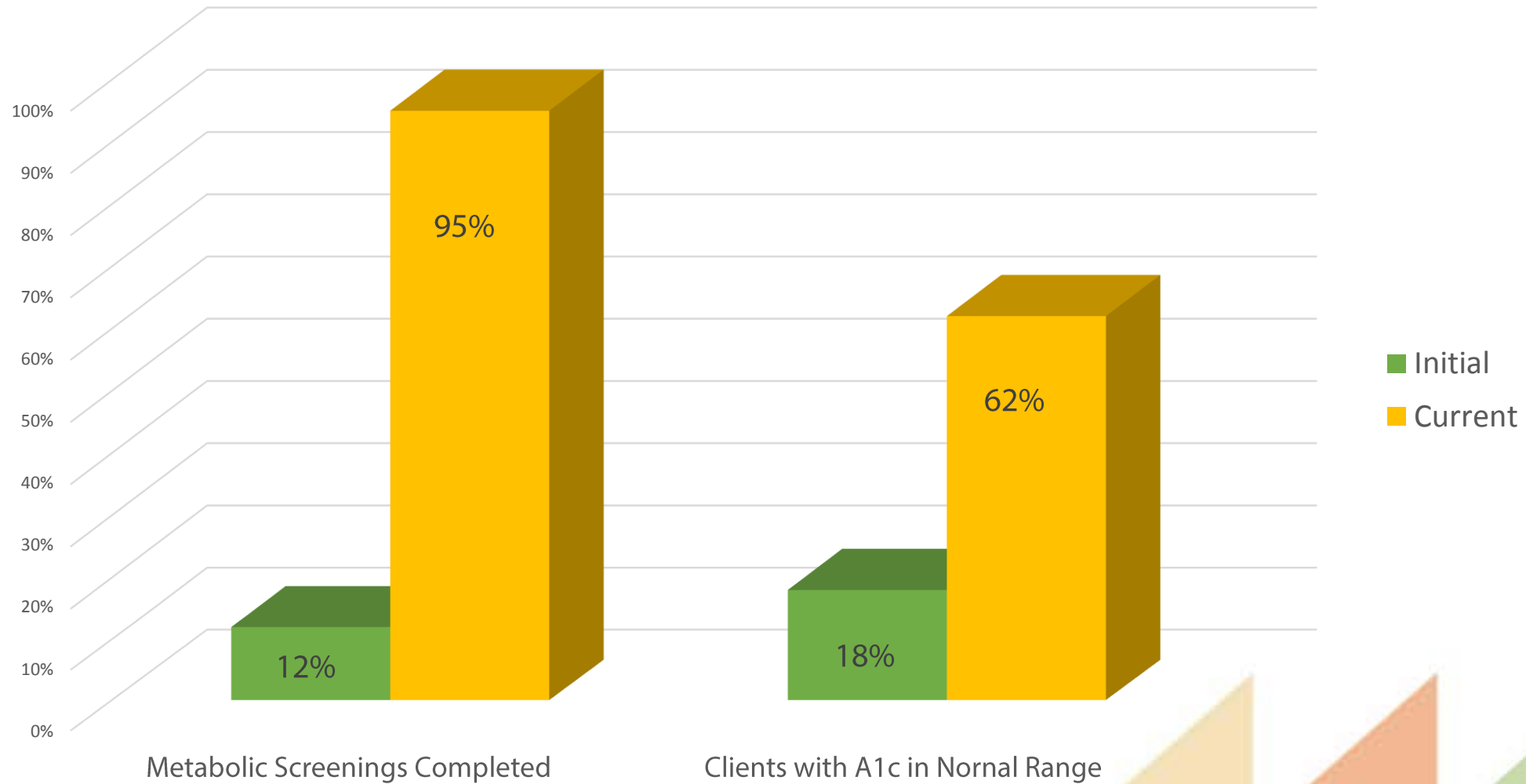


Patient-Centered Integrated Care

- 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
- Increase in Medication Assisted Treatment by 100%
- Added peer specialist
- Added outreach and engagement teams

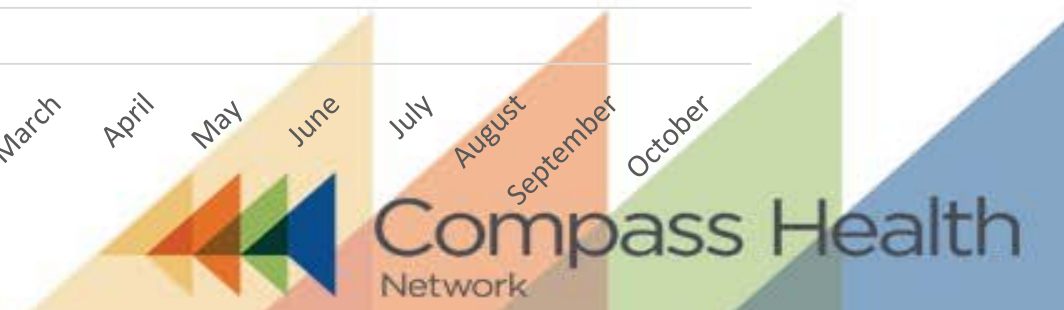
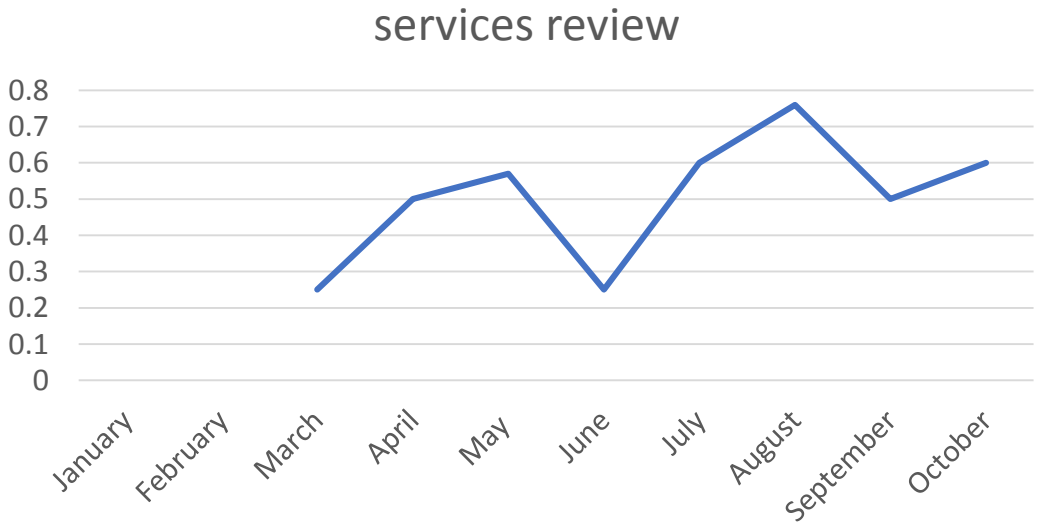
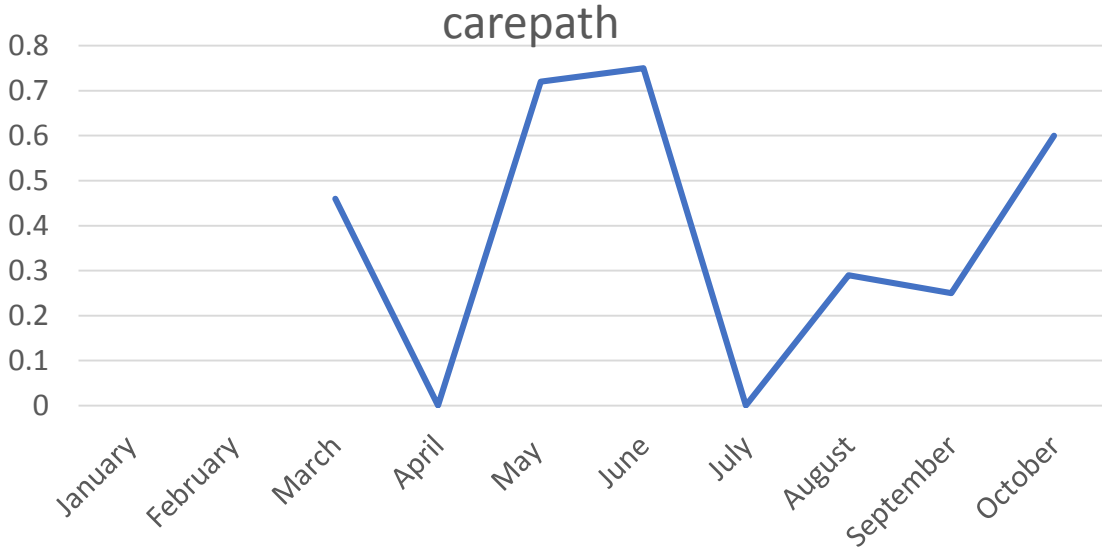
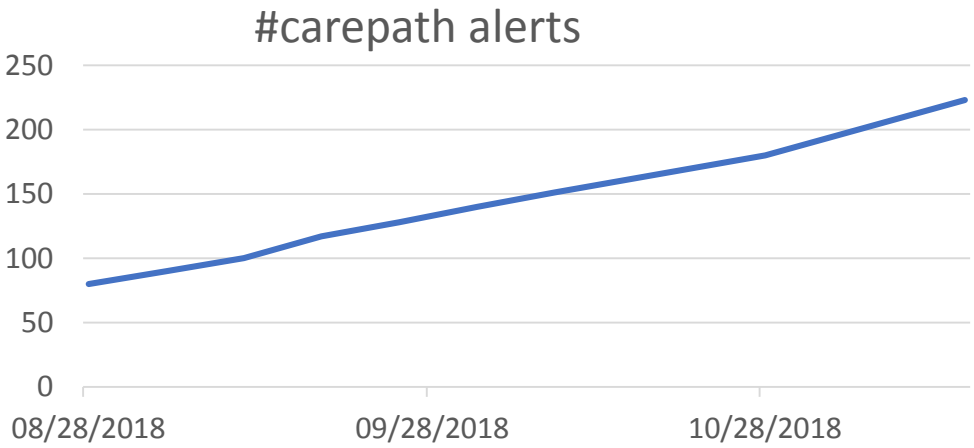


Innovations in Suicide Prevention

- 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



Evidence Based Practices

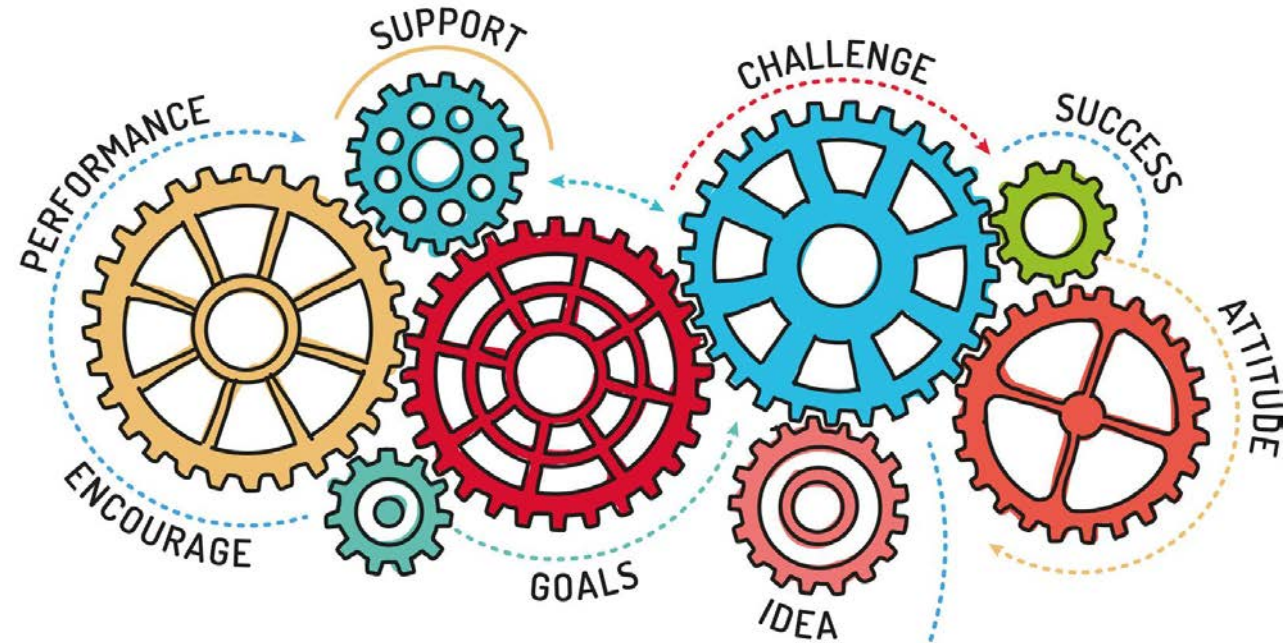


COMPASS
TRAINING
INSTITUTE



COMPASS QUALITY BONUS INCENTIVE

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



Motivation

Cost Saving\$

Year 1

4,815 persons

Cost Decreased by \$395 PMPM

Total Cost Savings **\$22.8M**

Year 2

2,896 persons

Cost Decreased by \$751 PMPM

Total Cost Savings **\$26.1M**

Year 3

1,678 persons

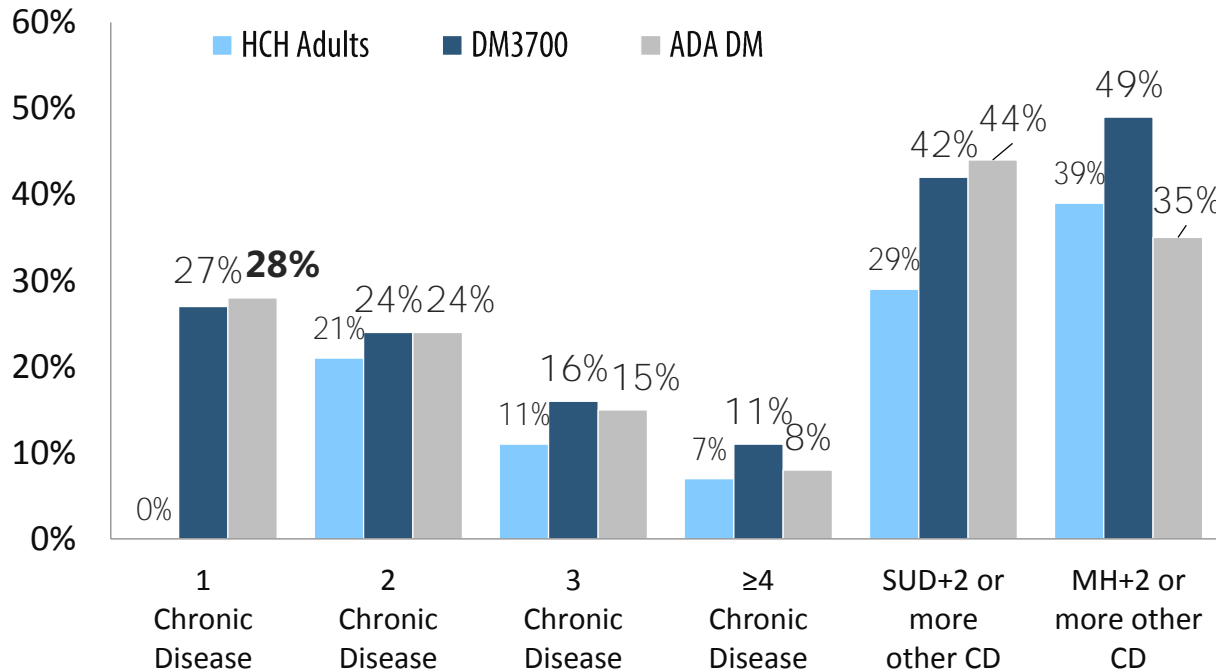
Cost Decreased by \$904 PMPM

Total Cost Savings **\$18.2M**



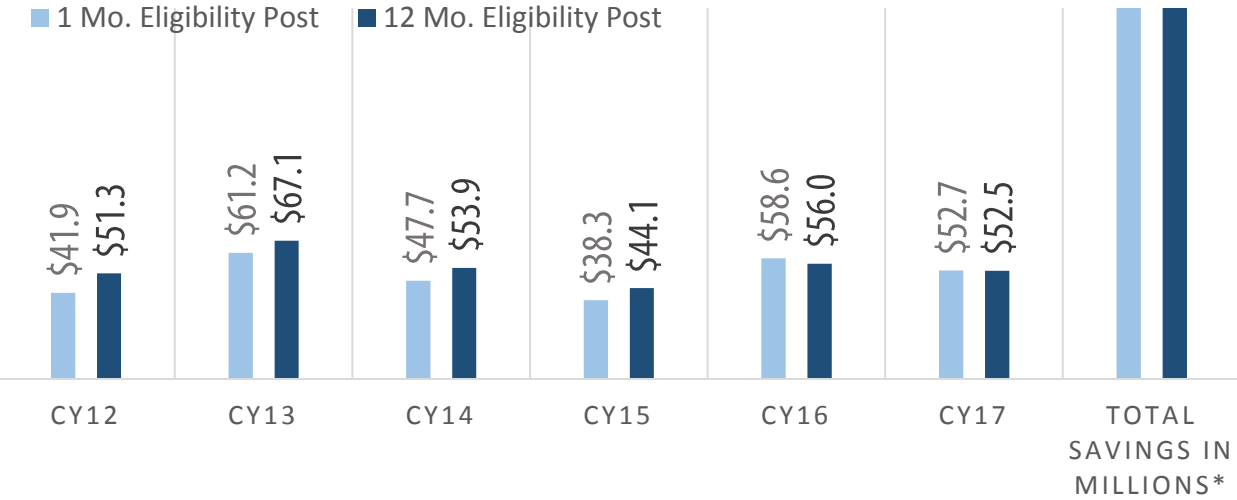
Disease Management Outreach

This project is a coordinated effort between Dept of Social Services, Dept of Mental Health, and behavioral health providers to identify and engage Medicaid participants with high medical costs and a serious mental illness or substance use disorder who are not receiving behavioral health services. Outreach teams are deployed into the community to locate and introduce individuals to their services and supports for better health and recovery.



healthcare home net cost saving\$

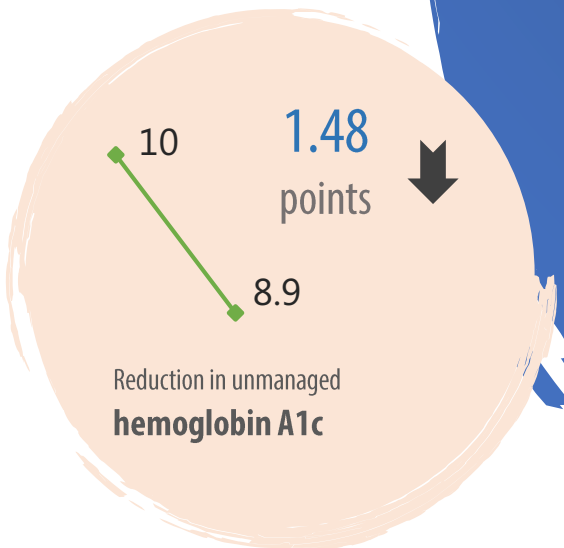
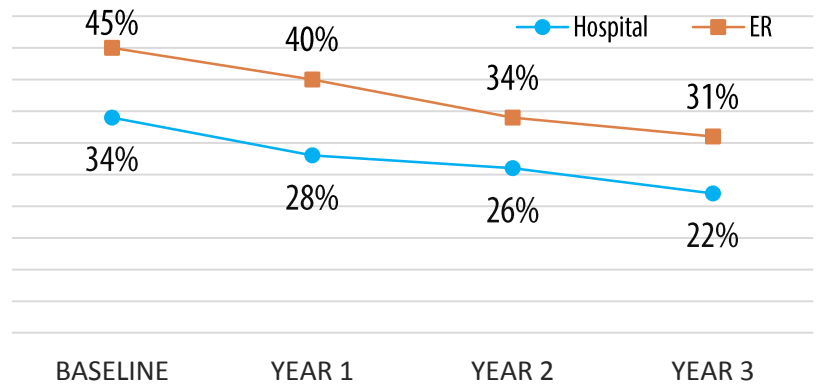
Cost savings reported includes all individuals with at least 1mo. and 12mo. Medicaid eligibility post enrollment with a CMHC healthcare home and 3SD removed.



Behavioral Healthcare Home

26 Behavioral Healthcare Homes cover every county in the state and assist individuals in accessing needed health services and supports, and learning to manage their chronic conditions. The health home care teams apply a population health approach to alert and manage gaps in care and improve overall health and wellness for individuals served.

% of clients with 1+ hospitalization / ER



small changes make a **BIG DIFFERENCE**



Community Mental Health Liaisons



31 Community Mental Health Liaisons are employed by CCBHCs and actively engage and collaborate with law enforcement agencies across the state to:

- > Facilitate access to behavioral health services for persons referred by law enforcement
- > Provide certified training to law enforcement officers at no cost
- > Assist with crisis situations and home wellness checks



over **13,000**

Referrals to CMHLs from law enforcement and courts calendar year 2018

78%
primary mental health history / dx



43%
primary SUD dx / history



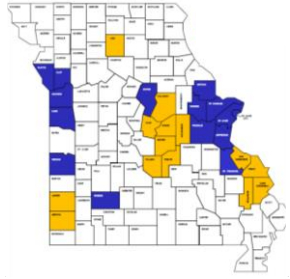
13%
homeless



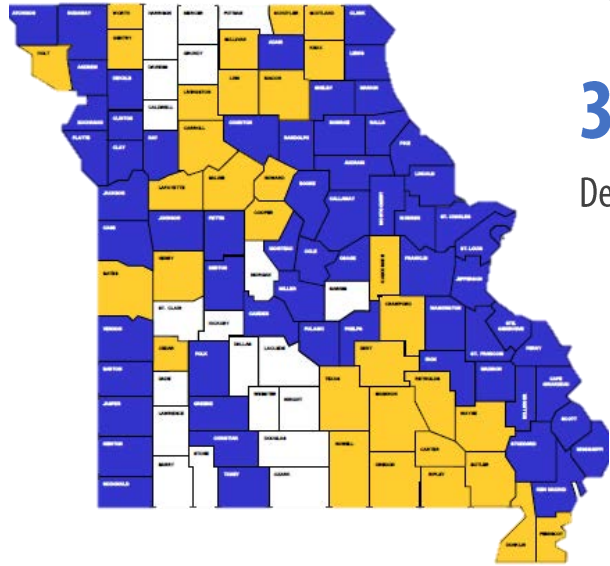
82%
unemployed



11%
probation/parole



CIT Councils
April 2014



31 CIT Councils
December 2018

9,600



law enforcement officers trained
in CIT



Crisis Intervention Teams

Crisis Intervention Teams (CIT) provide a model of specialized law enforcement expertise. CIT focuses on de-escalation strategies and redirecting the individual from the criminal justice system to the mental health care system – avoiding the placement of individuals in emergency rooms.



EMERGENCY ROOM

ENHANCEMENT

Improving Access to Behavioral Health Care



83%



hospitalizations after engaging in behavioral health services

75%



ER visits after engaging in behavioral health services

69%



Reduction in homelessness



32%



Reduction in unemployment



55%



Reduction in criminal justice involvement

Emergency Room Enhancement

The Emergency Room Enhancement Project establishes a collaboration between hospitals and behavioral health providers to improve care coordination and increase access to behavioral healthcare. CCBHCs have provided teams to coordinate and respond to individuals frequenting the ER and have been referred for behavioral healthcare.





CCBHC Provider Outcomes
Improving Access to Care



20%

increase in the # of clients served each month



25%

decrease in wait times to see clinicians



30%

increase in # of appointments



3%

increase in client satisfaction (from 91% to **94%**)

Annualized Increases of Individuals Served
Improving Access to Care

CCBHC Provider Outcomes *Building A Workforce*

After one year, CCBHCs increased their workforce, including these competitive positions:



15%

ADULT PSYCHIATRISTS

67%

CHILD PSYCHIATRISTS

13,629

more individuals receiving services from a CCBHC



12%

QUALIFIED ADDICTION PROFESSIONALS

34%

LICENSED CLINICAL SOCIAL WORKERS

32%

LICENSED PROFESSIONAL COUNSELORS

