How Can Integrated Healthcare Help You and Your Residents?

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INDIVIDUALLY WE ARE A DROP BUT TOGETHER, WE ARE AN OCEAN.

RYUNOSUKE SATORO

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True Integration

Within the healthcare team itself

- Better outcomes for the patients
- Better experience for the patients and families

Within the healthcare team & the LTC Communities

- Decreased regulatory concerns
- Decreases burden of transportation
- Improved census and retention
- Improved experiences for your staff

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A Patient-Centered Whole Health Model

Patients are at the center of our healthcare team

We will build our integrated team around what is the best care for the patient

Patient

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Primary Care Foundations

- Primary care services are the first members of the patient's healthcare team
- Includes an NP or PA + a physician
  - The APP takes the primary role as the patient's PCP and attends to both chronic & acute medical needs
  - The Physician is an important member of the team who performs less often, but medically necessary visits to oversee the totality of the patient's care

PCP Phys

PCP APP

Patient

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Primary Care Model

Robust Primary Care Services

Preventative services
- Annual H&P
- Annual wellness visit
- Healthcare screenings
- Advanced care planning

Management of chronic conditions

Management of acute issues
24/7 triage services

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Primary Care Model

Core Differentiator: Proactive Management of Chronic Conditions

- See patients not just when they are acutely ill
- Provides opportunity for reducing medications, polypharmacy, prescription cascades, GDR, etc
- Review multiple chronic issues on a regular monthly cadence
- Proactively managing chronic condition → better outcomes
  - Reduced medications
  - Reduced ER visits & hospitalizations
  - Reduced cost

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Primary Care Model

Special Attention to Chronic Pain

- Chronic pain (no matter the etiology) is a specific chronic condition that warrants specialized attention based on best practices and regulatory requirements surrounding controlled substances.
- This is often overlooked in many primary care settings, resulting in overuse or of pain medications long term and deterioration in function
- Palliative care team available to be sure pain is properly addressed and overarching goals of care are discussed and followed

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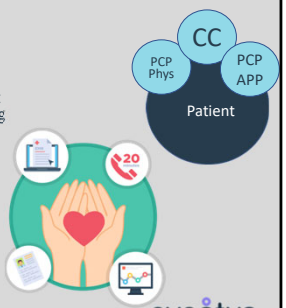
Primary Care Model

Care Coordination

Care coordination programs serve patients' needs between in person visits and ensure that all the patients care team members are working together

- Medication reconciliation
- Assurance that orders, labs, and referrals, are followed
- 24/7 triage with telehealth capability
- Care coordination with time spent with other members of the team (staff, family, and other clinicians)
- Coordination with other levels of care (hospitals)



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"The greatest mistake in the treatment of diseases is there are physicians for the body and physicians for the soul, although the two cannot be separated"

-- Plato

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Integrated Behavioral Health Model

Behavioral Health Team

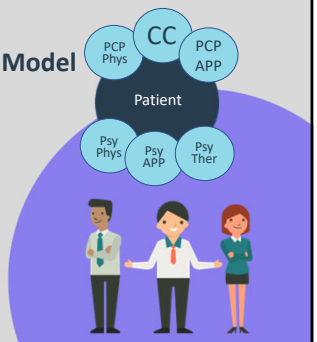
Making integrated behavioral health services available to all your residents who need it is in the patient's best interest

Best outcomes are when primarily delivered in person with telehealth available as needed 24/7

Includes Psychiatry and Psychotherapy services

Psychiatry team is made up of a psychiatric specialty trained NP or PA + board certified psychiatrist to work together like the primary care pair of APP + physician

Psychotherapy includes a psychologist or LCSW to perform clinically validated non-pharmacologic interventions for the patient



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Behavioral Health Model

Specialized Treatment

- Psychiatry APPs visit the patient regularly (monthly) to attend to all the behavioral health needs of that patient
  - Mood, anxiety, psychotic, sleep, and cognitive disorders are best treated by those with expertise in these conditions
  - Related medications are managed by the psychiatry team with focus on optimizing medication regimen
  - Related triage mood or behavioral needs and psychiatric refills are the responsibility of the psychiatry team
- Psychotherapy providers evaluate the referred patient, perform measures-based assessments, discuss the patient with the care team, and determine if ongoing psychotherapy services are needed
- Provides equally effective treatments for psychiatric conditions such as depression, anxiety, and insomnia
- Ability to assist with behavioral interventions in cognitive disorders (ie not your cinematic version of psychotherapy)
- REDUCES the need for psychiatric medications

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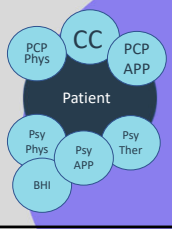
Behavioral Health Model

Collaborative Coordinate Care = BHI (Behavioral Health Integration)

Truly integrated care goes beyond direct care

- Collaborative care plans
- Coordination between providers
- Coordination with families
- Coordination with facility staff

When Primary care and Behavioral health are truly integrated together, outcomes for BOTH improve



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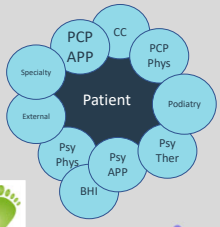
Additional Specialties

Primary Care + Behavioral Health + Specialty Services

Primary Care + Behavioral Health = core services of integrated health model

Specialty services are also available when necessary (but minimized when PCP and BH are integrated)

- Podiatry
- Wound Care
- Dermatology
- Palliative Care
- Cardiology



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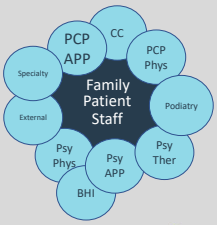
Integrated Health Model

Primary Care + Behavioral Health + Specialty Services, In A Systems Based Practice

Patients exist in a system that adds other members to the team

- Families
- Facility staff

Only when we embrace the whole health model and incorporate the system the patients live in, do we achieve the best outcomes for our patients



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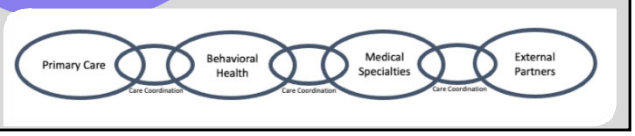
Integrating with Families

- Placing loved ones in LTC settings is often one of the largest life stressors.
- Families WANT to be involved with their loved one's care
- Significantly accelerated during the pandemic
- Families are more and more tech savvy – email, portals, text messaging



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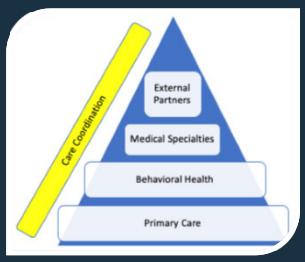
Integrating with Facilities



Care provided onsite creates co-location but integration takes conscious effort

= Care Coordination

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Don't tell people about your plans.

Show them your results.

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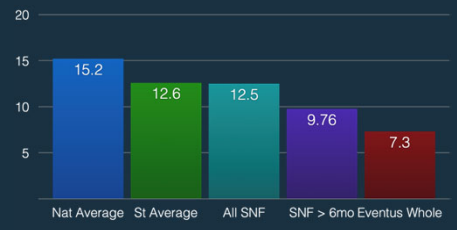
Integrated Health Outcomes Reduced Antipsychotic Use



Integrating behavioral health reduces AP rates 22%

Integrating PCP and behavioral health reduces AP rates 42%

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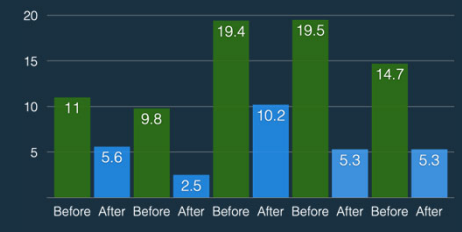
Integrated Health Outcomes Reduced Antipsychotic Use



Individual facility performance in AP reduction

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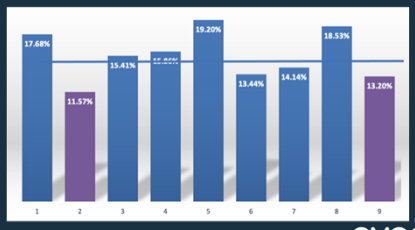
Integrated Health Outcomes Reduced Antipsychotic Use

Reductions based on adding integrated BHI services in 6 months:

- Region 2 reduced from 14.36% to 11.57%
- Region 9 reduced from 16.0% to 13.2%



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Integrated Health Outcomes
Reduced PRN Psychotropic Rates

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I	48(	3(
I5	5;(	9(
K	49(	6(
R	49(	7(
S	43(	5(
W	55(	5(
Z	4;(	;(

Reductions in PRN psychotropic need in buildings with BOTH PCP and BH services in 6 months

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Integrated Health Outcomes
Reduced Antipsychotic Use

Integrating Psychiatry MD further improves outcomes

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Integrated Health Outcomes

Why does reducing medications help my residents?

- Fewer falls
- Fewer ED visits
- Less burden on staff
- Less chance for medication errors and less violations
- Lower cost of care

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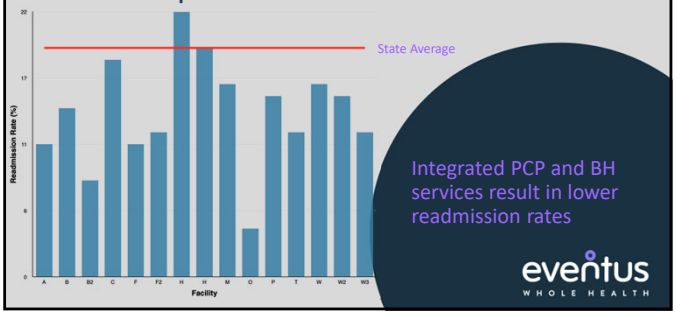
Integrated Health Outcomes
Reduction in Hospital Admissions



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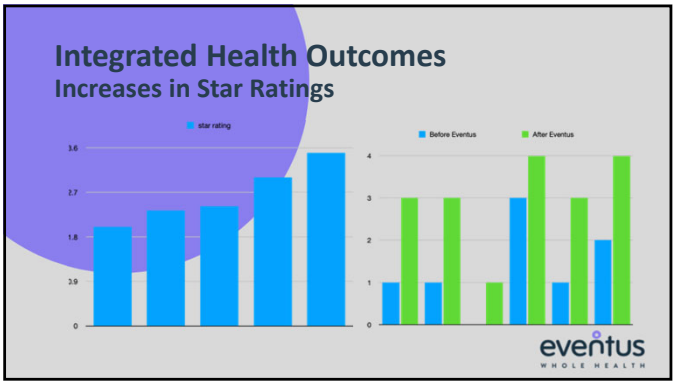
Integrated Health Outcomes
Increases in Star Ratings



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Integrated Health Outcomes

LTC ACO performance 2021:

- Blood Pressure: 100%
- Depression Screening: 98.48%
- Diabetes Management: 92%
- Cost savings: 23%
- 32% less hospitalizations than benchmark
- 39% less inpatient cost

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Integrated Health Outcomes

Why do these other outcomes help me as a facility?

- Improved quality ratings
- Reduced regulatory concerns
- More resident stability in census
- Less transportation and medication administrative costs
- Happier residents and more satisfied families
- All of this comes together to improve financial performance

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The Model of the Future

Partnering together integrated healthcare models WITH LTC groups is the model of the future

Results in improved outcomes at a reduced cost

THIS is how you change the future of healthcare for large populations

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Resources on Proactive Chronic Care

- JAMA 2002 Oct 9;288(14):1775-9. doi: 10.1001/jama.288.14.1775.Improving primary care for patients with chronic illness
- J Cardiovasc Med (Hagerstown) 2007 May;8(5):324-9. doi: 10.2459/JCM.0b013e32801164cb.Two-year outcome of a prospective, controlled study of a disease management programme for elderly patients with heart failure
- Popul Health Manag. 2013 Apr;16(2):125-31. doi: 10.1089/pop.2012.0027. Epub 2012 Oct 31.Impact of a chronic disease management program on hospital admissions and readmissions in an Australian population with heart disease or diabetes
- https://www.ama-assn.org/practice-management/digital/why-innovation-needed-better-manage-chronic-disease
- https://www.ama-assn.org/education/accelerating-change-medical-education/new-model-managing-chronic-disease-begins-medical

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Resources on Integrated PCP & BH Care

- The Journal of the American Board of Family Medicine March 2017, 30 (2) 130-139; Outcomes of Behavioral Health in Primary Care.
- J Am Board Fam Med. 2017 Mar-Apr;30(2):130-139. doi: 10.3122/jabfm.2017.02.160234. PMID: 28379819. Outcomes of Integrated Behavioral Health with Primary Care.
- https://www.ncmha.org/wp-content/uploads/2019/04/2017-NCMHA-Report-on-Integrating-Older-Adult-Behavioral-Health-into-Long-Term-Care-Rebalancing.pdf
- Front Psychiatry. 2021 Dec 22;12:742169. doi: 10.3389/fpsyt.2021.742169. PMID: 35002793; PMCID: PMC8727450. Applying Care Coordination Principles to Reduce Cardiovascular Disease Risk Factors in People With Serious Mental Illness: A Case Study Approach.
- https://bipartisanpolicy.org/report/behavioral-health-2021/

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