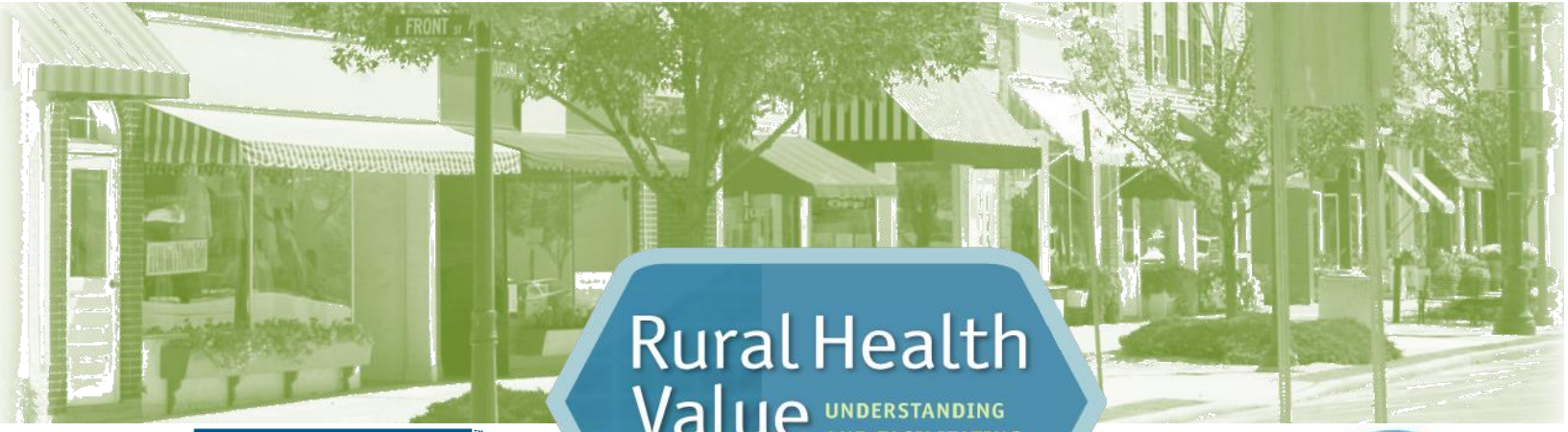

RURAL POLICY RESEARCH INSTITUTE
Center for Rural Health Policy Analysis

Rural Health Value
UNDERSTANDING AND FACILITATING RURAL HEALTH TRANSFORMATION.

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Rural Innovation Profile

Integrated Care in a Frontier Community

What: Care coordination focused on wellness and addressing nonmedical obstacles to overall health.

Why: Medical care addresses only 10-20 percent of what influences the health of people[1] and communities. People with mental health conditions have additional challenges getting their care needs met.

Who: Southeast Health Group, La Junta, Colorado.

How: Providing team-based care guided by a focus on integrated health care delivery and value.

Key Points

- Lead with a clear vision for how the organization delivers care and ensures supportive services are received.
- Establish a culture that supports patients to control their own care. Team-based decision-making groups effectively coordinate patient care.
- Structure services so all staff work at the top of their license.
- Hire only those individuals who share the organization's philosophy of care.
- Establish a strong network of referral relationships that addresses patients' social determinants of health.

1. "Health Policy Brief: The Relative Contribution of Multiple Determinants to Health Outcomes," Health Affairs, August 21, 2014. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_123.pdf

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SOUTHEAST HEALTH GROUP

Southeast Health Group (SHG) is a private, nonprofit corporation providing mental health, substance use disorder, primary care, and wellness services to six rural and frontier counties in southeastern Colorado. The SHG service area covers 9,600 square miles with an aggregate population of 47,420. SHG serves roughly 3,600 patients annually through its 14 locations.

SHG promotes a culture of wellness through its coordinated services, encouraging patients to recover through empowerment and self-directed care.

Founded in 1957 as one of 17 community mental health centers in Colorado, SHG added in-house primary care in 2013 to address unmet physical health needs of their mental health patients, including managing hospitalizations and emergency room visits. When several primary care providers in the area closed their clinics, patients sought out SHG to support their physical health. As a result, SHG now has a patient profile with only about 18 percent of patients who have co-occurring physical and behavioral health issues.

ORGANIZATIONAL STRUCTURE

Addressing patients' mental health needs remains core to the SHG mission. The main office, in La Junta, was designed to support an integrated care model. It uses a single reception area and intake procedure to remove the stigma of receiving mental health or substance use disorder care. All patients are screened for mental health and substance use disorder problems on their first visit and annually. If positive, follow up with psychiatric services, therapists, and addiction counselors is literally a few steps away. Staff assume responsibility for patient follow up, as many people with mental health issues have poor communication skills and have difficulty navigating the care system. Depending on a patient's needs, staff will monitor the patient, schedule follow up with behavioral health services, or provide an immediate warm hand-off.

SHG participates in one of seven Regional Care Collaborative Organizations (RCCOs), part of Colorado Medicaid's Accountable Care Collaborative (ACC). RCCOs develop a network of providers; support providers with coaching and information; manage and coordinate member care; connect members with nonmedical services; and report on costs, utilization, and outcomes for their member population. Medicaid data provided through the ACC showed that the communities served by SHG had the second-highest chronic disease rate in the state. This finding increased SHG's motivation to act as a Patient Centered Medical Home for its Medicaid patients. A robust service plan is provided for patients with complex conditions. SHG receives incentive payments for improving care and containing costs, such as reducing the number of emergency room visits and hospitalizations. The RCCO incentive payments for positive outcomes support four health navigator positions.

TEAM-BASED STAFFING STRATEGY

SHG's team-based integrated care model includes patients in decision making regarding their care. Providers work together closely and meet briefly throughout the day to discuss patient needs and provide a seamless system of care. The integrated care team—which includes primary care clinicians, mental health and substance use disorder treatment professionals, health coaches, case managers, and health navigators—meets weekly for care coordination.

Staffing strategies are key to support the clinic's team-based approach. Clinicians are hired under a modified volume-based process, with an expectation that they will spend more time with each patient. Seeing 13 to 14 patients per day, rather than the typical 23 to 24 patients, allows clinicians to understand and address the complex needs that arise from co-occurring physical and behavioral health conditions. Telepsychiatry implementation eliminated the need for an on-site psychiatrist, which reduced costs enough to support hiring physician assistants and nurse practitioners. All staff work at the top of their license.

"Lack of workforce in rural and frontier communities makes them quick to hire to fill positions. We spend a lot of time making sure we get the right person who fits our philosophy."
JC Carrica, Chief of Operations

Hiring for Organizational Fit

SHG leadership believes that providers who prioritize care integration are key to success. SHG only hires individuals who share its philosophy of care. Each interview step emphasizes SHG's team-based approach with discussions that elicit insights about a potential candidate's organizational fit. The organization's greatest success pursuing this staffing strategy for clinicians has been in hiring physician assistants and nurse practitioners.

Community Resource Support

Patient navigators coordinate comprehensive, community-based care for high-risk, high-cost, and chronically ill residents. Embedded in three of the SHG health clinics, the navigators increase patient access to primary and behavioral care, preventive care, and early intervention services. They offer team-based education and coaching to improve both population health and self-management of disease. This bachelor's-level-trained role assesses a patient's social determinants of health to discover barriers to self-care and access to care. Navigators know the community resources and can broker connections to veteran services, the housing authority, transportation, and other services.

Through a Centers for Medicare & Medicaid Services Health Care Innovation Award, SHG's TIPPING Point Project demonstrated that the more interactions patients had with a health navigator, the better their health outcomes. In Prowers County, Colorado, 61 percent of Medicaid funds were used by 3.7 percent of Medicaid members in 2012. The project focused on all residents of Prowers County who were high

utilizers of Medicaid, made frequent trips to the emergency room, or lacked a primary care provider. SHG health navigators gave special attention to people with co-occurring chronic physical and behavioral health problems. Medicaid spending initially rose as patients accessed care for long-standing problems. Long-term costs were driven down by teaching chronic disease self-management skills and focusing on wellness and prevention.

To address rural Colorado's ongoing need for qualified care coordinators, SHG partnered with Otero Junior College to offer a health navigator training program, under the TIPPING Point Project. In the first three years, 88 students participated in classes, with 13 receiving community health worker certificates and 5 receiving health navigator associate of applied science degrees. A three-year grant award from the Colorado Department of Public Health and Environment will sustain the training program through 2018.

Peer Support Specialists

Peer support specialists promote patient recovery and treatment at SHG by providing nonclinical support such as front desk intake, respite assistance, and transportation. No formal education is required, but the specialists must have their own recovery experience with chemical dependency or mental health conditions. This lived experience prepares them well to relate with and support SHG clients who face similar challenges.

Lack of transportation was a major barrier for patient access to care, as the area has no specialty care. SHG decided to engage its peer support specialists to provide transportation services. During 2015, SHG transported patients 6,000 miles in one month alone, with the longest journey four hours one way to Denver for a surgery.

NEXT STEPS

Southeast Health Group will continue to support person-centered wellness with the addition of a 5,000-square-foot wellness center based on the Healthy Eating Active Living (HEAL) movement and will support patients in making lifestyle changes focused on healthy eating and physical activity.

For more information about the Rural Health Value project, contact:

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