genoa
a QoL healthcare company
**PROGRAM OBJECTIVES**

- This session will take a pragmatic look at how integrated care delivery models designed to serve high risk, complex populations are working to produce real improvements in clinical outcomes for consumers that struggle to engage in the healthcare system.
  - What models and partnerships are managed care plans seeking to implement with the care delivery system to move to value based reimbursement?
  - What are the critical pieces of the care model (and team) that need to be in place?
  - Why is understanding the total cost of care required in the evaluation of integrated care models designed to support value based initiatives?
  - How does tele-psychiatry and pharmacy complement integrated care initiatives for individuals with behavioral health conditions?
TODAY'S SPEAKERS AND PANELISTS

- Managed Care Behavioral Health Viewpoint:
  - Amy Rice; Director of Behavioral Health Services, Optum
- Provider Viewpoint, Huddle Program:
  - Mona Darwich; Program Director, La Frontera Southwest
  - Dr. Shahzad Rashid: Psychiatrist, Genoa Tele-psychiatry
- Provider Viewpoint, Targeted High User Model:
  - Orville Mercer, VP Behavioral Health, Chestnut Health Systems
Alignment of Care Delivery with Performance Based Models: Integrated Care Models to Produce Improved Outcomes within Complex Populations

Deb Adler – SVP, Network Strategy
Our work in the reimbursement continuum

<table>
<thead>
<tr>
<th>Small % of financial risk</th>
<th>Moderate % of financial risk</th>
<th>Large % of financial risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee-for-service</td>
<td>Performance-based Contracting</td>
<td>Shared Savings</td>
</tr>
<tr>
<td></td>
<td>Bundled and Episodic Payments</td>
<td>Shared Risk</td>
</tr>
<tr>
<td></td>
<td>Capitation</td>
<td>Capitation + Performance-based Contracting</td>
</tr>
</tbody>
</table>

Low Accountability | Moderate Accountability | Maximum Accountability

**Examples**

P4P/Shared Savings Contracts with Qualified Facilities and Outpatient Providers (national footprint across all payor types)

**Metrics**

- Outpatient
  - Quality: Case-mix adjusted member reported outcomes (wellness assessment)
  - Cost: Case-mix adjusted average visits per episode and episode cost

- Inpatient
  - Quality: HEDIS 7-day follow-up; CMS readmission rate for 30 and 90 day (case mix adj)
  - Cost: Case-mix adjusted ALOS and episode cost

- 15% to 20% reduction in readmit rates
- Ambulatory follow-up rate improved from 3% to 10%

**Results**

- SUDS Medication Assistance Therapy (MAT) Providers
- DRG
  - Quality: Readmit rate (case-mix adjusted) – 30 and 90 day
  - Cost: Case-mix adjusted average visits per episode and episode cost
  - DRG/Bundled payment methodology

- Reduced readmissions
- Improved community tenure

**ACOs, medical-behavioral integration in health homes**

- 8 metrics across 6 domains
  - Care coordination
  - Care transition
  - Referral management
  - Health promotion
  - Individual support
  - Family/caregiver support

- Improved care coordination
  - 9% increase in adherence to quarterly PCP visits
  - 4% increase in primary caregiver or peer support linkages
**Performance-Based Contracting – At A Glance**

Incentivizing provider performance leads to better outcomes for consumers.

<table>
<thead>
<tr>
<th>Facility Participation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Adheres to our utilization management process, Level of Care Guidelines and Coverage Determination Guidelines, including attending MD visits, pre-authorization requirements, and discharge planning</td>
</tr>
<tr>
<td>• Qualifies as an OptumHealth High-Volume provider</td>
</tr>
<tr>
<td>• Participates in periodic meetings with OptumHealth clinical operations staff to review data</td>
</tr>
<tr>
<td>• Submits claims electronically</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Balance of Cost and Quality Measures</td>
</tr>
<tr>
<td>• Reduced average episode costs</td>
</tr>
<tr>
<td>• Reduction in 30 day Readmission rate to any inpatient LOC</td>
</tr>
<tr>
<td>• Member reported instruments regarding outcomes</td>
</tr>
<tr>
<td>• Improved results on ambulatory follow-up rates (7 days post inpatient discharge)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Performance Incentives</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provider searn escalator based sharing of savings if performance is within targeted range</td>
</tr>
<tr>
<td>• Bonus payment tied to quality metrics</td>
</tr>
<tr>
<td>• Provider earns additional escalator through greater sharing of savings if performance exceeds range (up to a cap)</td>
</tr>
</tbody>
</table>
ACE Metrics Guide Performance-Based Contracting

- In our 3rd year of outpatient for providers achieving two-star rating (effectiveness first and supplemented with efficiency ratings)
- Enhanced facility pay-for performance initiative to tie to enhanced facility metrics under ACE – Achievements in Clinical Excellence

<table>
<thead>
<tr>
<th>Clinician Metrics</th>
<th>Facility Metrics</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>Severity-adjusted effect size from the Wellness Assessments</td>
<td>30-day readmission rate</td>
</tr>
<tr>
<td><strong>Cost</strong></td>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td>Case-mix-adjusted average number of visits</td>
<td>Risk-adjusted 30-day readmission rate</td>
</tr>
<tr>
<td>Average cost per episode</td>
<td>Follow-up after mental health hospitalization (HEDIS)</td>
</tr>
<tr>
<td></td>
<td>Peer review rate</td>
</tr>
<tr>
<td></td>
<td><strong>Cost</strong></td>
</tr>
<tr>
<td></td>
<td>Case-mix-adjusted average length of stay</td>
</tr>
<tr>
<td></td>
<td>Spending per beneficiary</td>
</tr>
</tbody>
</table>
Challenges – Solution Identification in process

- Lack of an industry-standard outcome tool (Optum working with ABHW – Association for Behavioral Health and Wellness to encourage standardization)
- Low number of patients/admits; many low-volume providers
- Lack of assignment of members challenges use of capitation
- Provider readiness to manage risk and challenges to achieve metrics
Facilitating Provider Performance

- Tools to support 7 and 30 day follow up metrics (Express Access and telemental health)
- Appointment Reminders to “no shows” (Appointment Reminders)
- Member Engagement/Community Tenure (Peer Services/Recovery and Resiliency Toolkit)
- Data Review (e.g., provider practice patterns)
- Reducing Administrative Burden (Quick Cert, Rewards for High Performance that reduce burden, Review Online)
Express Access Network – Improving Member Experience and Speed to Appointment Within 5 Business Days

Peer-reviewed research has shown that decreased wait times for treatment are associated with improved outcomes. Express Access Network tops the industry standard of typical two-week wait times. The network’s improved access and availability can, in turn, lead to a significant decrease in missed or “no-show” appointments.*

We’re continuing to improve the member experience, increase access to more providers and empower members to seek the right care on their terms.

### Telemental Health Services: Today and more to come

<table>
<thead>
<tr>
<th>Member experience</th>
<th>Today</th>
<th>2017</th>
<th>Q2+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Members can easily access Telemental Health Services (TMH) through <a href="https://liveandworkwell.com">liveandworkwell.com</a></td>
<td>(New) Optum Behavioral Health telehealth portal with improved visit scheduling capabilities will streamline the member experience through the use of a standard technology platform</td>
<td>(New) Behavioral Health Network integration with new myUHC provider search and transparency experience</td>
</tr>
</tbody>
</table>

| Access            | ~3000 providers currently offering TMH visits, including vendors: • American Well® • Doc-On-Demand™ • 1DocWay | UHC Virtual Visits with behavioral health (BH) providers on American Well and Doc-On-Demand networks will now pay through members’ BH benefits | More access and expertise — Recruiting EAP providers to be TMH providers and contracting with TMH providers to also offer Express Access |

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Telemental Health Broadens the Scope for Delivering Convenience and Increase Member Accessibility

Telemental Health Advantages

- Faster appointment times
- Increased accessibility, especially in under-served areas
- Eliminates inconvenience and expenses of travel
- Promotes a more conducive therapeutic environment
Telemental health: Why is it so important?

It improves **access and capacity** to address the growing **shortage of psychiatrists**.

**Supply of psychiatrists not keeping pace**
(Growth 1995–2013)

- **45%** Physicians
- **37%** U.S. population
- **12%** Psychiatrists

**Severe shortage in communities**
4,000 Areas in the U.S. with one psychiatrist for 30,000 or more people

**Cohort is aging**

- **59%** Percentage of psychiatrists who are aged 55 or better

---

1. Shortage of Psychiatrists Only Getting Worse, Psychiatry Advisor, September 08, 2015.  
New service delivery models using telemental health

- Behavioral provider site to site
- Member/User
- Behavioral provider direct to consumer

- Provider (e.g., primary care)
- Provider Care Coordination
- Behavioral provider
Research on telemental health*

<table>
<thead>
<tr>
<th>Access</th>
<th>Efficiency</th>
<th>Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bridges gaps in shortage areas, especially psychiatrists</td>
<td>• Helps reduce costs both professionally (overhead expenditures) as well as costs to members (largely travel costs)</td>
<td>• Telemental health has shown to be as effective as face-to-face services for depression and anxiety disorders</td>
</tr>
<tr>
<td>• Helps bring coverage to underserved populations and areas</td>
<td>• Increasingly more cost effective with larger volume of patients and more usage</td>
<td>• Improves mental health care in primary care settings</td>
</tr>
<tr>
<td>• Meets specialty population need, e.g., youth, autism, geriatrics</td>
<td>• Allows for more scheduling flexibility from both the member’s and clinician’s perspective</td>
<td>• Improves outcomes where patients have comorbid medical conditions</td>
</tr>
<tr>
<td>• Members’ choice of service locale may prove more conducive to treatment</td>
<td></td>
<td>• Improves medication adherence</td>
</tr>
</tbody>
</table>

Using telemental health to promote whole person care

Bridging access gap for FQHC in rural Kansas

More than 300 consultations in one year
Using telemental health to promote whole-person care

Improving cost and quality for individuals with comorbid conditions

$9,000 savings per case

Lessons learned in member adoption of telemental health

Member adoption is slow

Requires ongoing marketing to members

Educate primary care physicians to help patients get faster access to services

Show primary care value of telemental health for case consultation
Alignment Of Care Delivery & Value Based Programs: Integrated Care Models To Produce Improved Outcomes Within Complex Populations

Dr. Shahzad Rashid, Genoa Telepsychiatrist
Mona Darwich, Program Director at La Frontera Southwest
About the Huddle Program

- A huddle is a team meeting where the care team consisting of the telepsychiatrist, pharmacist, case manager and clinical coordinators meet together to discuss ways to improve patient care management.

- Launched at La Frontera Southwest, Tucson, Arizona in April 2016.

- Daily meetings vs. Monthly meetings.
<table>
<thead>
<tr>
<th>Reasons for the Launch of the Huddle Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrate the telepsychiatrist into the clinic’s care team and culture and clinical workflow</td>
</tr>
<tr>
<td>• Increased care coordination across case management, pharmacy and clinic coordinator teams</td>
</tr>
<tr>
<td>• Help overcome implicit limitations of telepsychiatry</td>
</tr>
<tr>
<td>• Holistic patient care experience</td>
</tr>
</tbody>
</table>
Mechanics of the Huddle Program

The care team will meet to discuss the following items:

- **Clinical Management**: manage care for a defined group of patients (including patient judicial reviews, doc-to-doc requests, hospitalized patients, discharge planning, etc.)

- **Medication Adherence**: track medication compliance for patients and work to improve adherence

- **Operational Management**: discuss program utilization, patient satisfaction with the program and identify ways to improve the program
Preliminary Results

- Prevented Staff Splitting

- Built dialogue, trust and transparency across the care team, especially given that the telepsychiatrist is remote

- Created awareness of implicit limitations of telepsychiatry and how to overcome them as a team

- Improved patient compliance with medications

- Provided constructive feedback on improving patient satisfaction and patient outcomes
ALIGNMENT OF CARE DELIVERY & VALUE BASED PROGRAMS: INTEGRATED CARE MODELS TO PRODUCE IMPROVED OUTCOMES WITHIN COMPLEX POPULATIONS
1. Managed Care company engaged Provider Owned Network in a project to address HIGH USERS throughout Central Illinois.

2. Evaluation of project based on evaluation of total health claims Pre referral and Post referral at 3,6,9 month intervals.

3. Annualized savings of approximately 1 million dollars realized on co-hort of 79 high users. If scaled 25 times (2000), savings of 26 million might be realized.

4. Currently negotiating this scale up

5. What is a “good enough” ROI? 2/1; 3/1; 4/1; ???
What is a high user?

- 2-3 inpatient episodes < 6 months
- 2 or more ED visit < 6 months
- MLR 300% - 2000% based on claims
- Chronic co-morbid conditions (3-5)
- Drug abuse/addiction
The Four Elements of IBHHC Integrated Wellness Clinic

- **Behavioral Health**: Core population/core service – health home for consumers with serious mental illness
- **Primary Care**: Coordination of primary and other specialty services
- **Care Coordination**: The traffic controller and interpreter for the consumer
- **Health Promotion**: Activation of the consumer in own health outcomes
Network Characteristics

1. Integrated Care Activities
   - 5 major geographies with FQHC status or co-located FQHC partners
2. 4 partners with / had SAMHSA funded Primary care behavioral health integration projects
3. Best Practice Pharmacies
   - 4 Genoa pharmacies located in 4 most populated partner sites
4. FY 17 --28 Certified Group Leaders through the Stanford Chronic Disease Management Program
5. Care Management Technologies / Predictive Analytics
6. FY 18 System wide utilization of the Patient Activation Measure
Care Team Activities

1. TCM teams / leadership participate in ongoing Learning Community Activities
2. Fidelity to all training requirements / Baseline testing pre-post
3. Special emphasis on:
   - Motivational Interviewing --BH and Primary Care
   - Recovery Oriented Philosophy
   - Social Determinants of Health
4. Network Wide PAM utilization
5. Care Management Technologies
   - Reviewed by project
   - Reviewed by network partner and region
Care Team Training

- Behavioral Healthcare
- Breast Health and Breast Cancer
- Blood Pressure/Hypertension
- Cardiovascular Health and Heart Disease
- Cervical Health and Cervical Cancer
- Colorectal Health and Colorectal Cancer
- Health Coaching and Motivational Interviewing
- Health Literacy
- Healthy Eating Active Living
- Navigating Health Insurance
- Pre-Diabetes and Diabetes
- Prostate Health and Prostate Cancer
- Social Determinants of Health Disparities
"Local Solutions"
Community Provider Synergies

TCM TEAM
Managed Care Cohort

- IPS Employment program
- All points bulletin on cohort monthly
- Residential chemical dependency
- Flex funds
- Outpatient mental health children and adults
- PCBHIP
- Medical monitoring detox
- 24 hour support and supervised housing
- Outpatient chemical dependency
- 24 hours crisis intervention
- Crisis residential unit
- Specialized programs
- Psychiatric
- FQHC
- Opportunities psycho-social
- Case management Homeless shelters Hospital Liaison
Tipping Point

Problem
Co-morbid & Complex Disease States

Solution
Data Enabled - Targeted Case Management

- More Complete Problem List
- Identification of Providers and Key Stakeholders
- Care decisions made by patient’s in isolation
- Clearer understanding of barriers to remove to meet patient goals
CMT’s Population Health Cycle

Data + Targeted evidence-based interventions for patients and care team = Improved Outcomes

Meeting the Triple Aim of Improved Care, Improved Health and Lowered Costs
IBHHC Cohort Population

- N = 79
- Mood Disorders = 68
- Alcohol and Drug Abuse Disorders = 56
- Psychotic Disorders = 43
- Medical comorbidities – Ambulatory Care Sensitive Conditions (ACS):
  - 1 member has 13; 2 have 8; 1 has 7; 2 have 6; 4 have 5; 6 have 3; and the rest have 2 or less.
  - 33 individuals have hypertension
  - 20 have asthma
  - 16 have metabolic disorder, lipid.
  - 46 (58%) have an Ambulatory Care Sensitive Condition (ACS)
## Hospitalization and ED Trends

<table>
<thead>
<tr>
<th>Year / Month</th>
<th>ED Visits - Behavioral</th>
<th>ED Visits - Non-Behavioral</th>
<th>Hospitalizations - Behavioral</th>
<th>Hospitalizations - Non-Behavioral</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/04</td>
<td>15</td>
<td>21</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>2015/05</td>
<td>21</td>
<td>24</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>2015/06</td>
<td>19</td>
<td>13</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>2015/07</td>
<td>28</td>
<td>40</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>2015/08</td>
<td>29</td>
<td>30</td>
<td>23</td>
<td>4</td>
</tr>
<tr>
<td>2015/09</td>
<td>40</td>
<td>29</td>
<td>27</td>
<td>4</td>
</tr>
<tr>
<td>2015/10</td>
<td>35</td>
<td>36</td>
<td>28</td>
<td>4</td>
</tr>
<tr>
<td>2015/11</td>
<td>27</td>
<td>33</td>
<td>22</td>
<td>4</td>
</tr>
<tr>
<td>2015/12</td>
<td>30</td>
<td>27</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>2016/01</td>
<td>31</td>
<td>31</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>2016/02</td>
<td>23</td>
<td>25</td>
<td>16</td>
<td>4</td>
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<tr>
<td>2016/03</td>
<td>23</td>
<td>35</td>
<td>10</td>
<td>3</td>
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<tr>
<td>2016/04</td>
<td>13</td>
<td>38</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>2016/05</td>
<td>21</td>
<td>30</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>2016/06</td>
<td>12</td>
<td>16</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

% Change from Jan to April (last month of complete medical data)  
-58% 23% -55% 167%
CHCS Multi-Morbidity

CHCS Multi-Morbidity - Top 25 Complex Disease States With Highest Per Capita Hospitalizations

- Select All
- 04. Antipsychotic/Mood Stabilizer Drugs, Anxiety Disorders, Depression, Drug/Alcohol Disorders, Personality Disorder, Schizophrenia
- 09. Antipsychotic/Mood Stabilizer Drugs, Anxiety Disorders, Asthma/COPD, Depression, Drug/Alcohol Disorders, Schizophrenia
- 14. Antipsychotic/Mood Stabilizer Drugs, Asthma/COPD, Depression, Drug/Alcohol Disorders, Schizophrenia
- 22. Antipsychotic/Mood Stabilizer Drugs, Anxiety Disorders, Depressive Disorders, Drug/Alcohol Disorders, Schizophrenia
- 23. Asthma/COPD, Drug/Alcohol Disorders, Mental Illness, Schizophrenia
- 25. Asthma/COPD, Chronic Pain, Coronary Heart Disease, Drug/Alcohol Disorders, Hypertension, Mental Illness, Seizure Disorders

<table>
<thead>
<tr>
<th>Catchment Area</th>
<th>County</th>
<th>Charlson Comorbidity Score</th>
<th>IL County Map - Count of Unique Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Select All</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td></td>
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<tr>
<td></td>
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<td>3</td>
<td></td>
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<tr>
<td></td>
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<td>4</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>5</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

- Total Patients: 9
- Population %: 11.392
- Total Spend: 0
- % of Total Spend: 0
- Hospital Admits: 45
- ED Visits: 116

Per Member Per Year Spend: 0.00
Max Member Per Year Spend Observed: 0.00
### ADMITS, BED DAYS, ED VISITS AND PMPM% CHANGE

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>IP ADMITS / 1000 (AUTH)</th>
<th>BED DAYS / 1000 (AUTH)</th>
<th>ED VISITS / 1000</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE</td>
<td>4,531</td>
<td>18,301</td>
<td>12,106</td>
</tr>
<tr>
<td>POST</td>
<td>1,942</td>
<td>7,288</td>
<td>8,385</td>
</tr>
<tr>
<td>DIFFERENCE</td>
<td>2,589</td>
<td>11,013</td>
<td>3,721</td>
</tr>
<tr>
<td>% DIFFERENCE</td>
<td>57%</td>
<td>60%</td>
<td>31%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME</th>
<th>MED PPM</th>
<th>RX PPM</th>
<th>TOTAL PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE</td>
<td>$2,375</td>
<td>$324</td>
<td>$2,699</td>
</tr>
<tr>
<td>POST</td>
<td>$1,217</td>
<td>$411</td>
<td>$1,629</td>
</tr>
<tr>
<td>DIFFERENCE</td>
<td>1,158</td>
<td>-87</td>
<td>1,070</td>
</tr>
<tr>
<td>% DIFFERENCE</td>
<td>49%</td>
<td>-27%</td>
<td>40%</td>
</tr>
</tbody>
</table>

6 Month Data: 53% increase in rx PMPM • 51% decrease in IP admits • 58% decrease in bed days • 25% decrease in ED visits • 30% decrease in total PMPM
Best Practice Pharmacy services
Top 5 Co-Morbid Diagnosed ACSC Population
Top 5 Care Gaps with the Highest ED Utilization
# Hospital and ED Utilization Comparison

<table>
<thead>
<tr>
<th>Agency</th>
<th>Total Population</th>
<th>Hospital Admits (per 1000 patients)</th>
<th>% Hospital Admits that are a 30-Day Re-Admit</th>
<th>Average Hospital LOS (per 1000 patients)</th>
<th>ED Visits (per 1000 patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency 1</td>
<td>1,418,518</td>
<td>119</td>
<td>20.51%</td>
<td>14</td>
<td>620</td>
</tr>
<tr>
<td>Agency 2</td>
<td>168,713</td>
<td>109</td>
<td>18.58%</td>
<td>13</td>
<td>537</td>
</tr>
<tr>
<td>Agency 3</td>
<td>282,520</td>
<td>111</td>
<td>21.33%</td>
<td>13</td>
<td>609</td>
</tr>
<tr>
<td>Agency 4</td>
<td>110,975</td>
<td>106</td>
<td>23.96%</td>
<td>14</td>
<td>541</td>
</tr>
<tr>
<td>Agency 5</td>
<td>158,225</td>
<td>161</td>
<td>24.01%</td>
<td>11</td>
<td>749</td>
</tr>
<tr>
<td>Agency 6</td>
<td>198,476</td>
<td>108</td>
<td>18.64%</td>
<td>14</td>
<td>651</td>
</tr>
<tr>
<td>Agency 7</td>
<td>136,409</td>
<td>136</td>
<td>21.71%</td>
<td>13</td>
<td>712</td>
</tr>
<tr>
<td>Agency 8</td>
<td>218,742</td>
<td>121</td>
<td>18.64%</td>
<td>18</td>
<td>575</td>
</tr>
<tr>
<td>Agency 9</td>
<td>144,458</td>
<td>111</td>
<td>17.23%</td>
<td>13</td>
<td>474</td>
</tr>
</tbody>
</table>
## Risk Ratios: Agency Comparators: Evidenced Based Medicine

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of 3 or More Psychotropics for 60 or More Days</td>
<td>1.22</td>
<td>1.14</td>
<td>1.27</td>
<td>1.29</td>
<td>1.09</td>
<td>1.57</td>
</tr>
<tr>
<td>Use of 2 or More Antipsychotics for 60 or More Days</td>
<td>1.96</td>
<td>1.77</td>
<td>2.33</td>
<td>1.96</td>
<td>1.50</td>
<td>2.86</td>
</tr>
<tr>
<td>Patient Failed to Refill an Antipsychotic within 30 Days of Prescription Ending</td>
<td>1.77</td>
<td>1.26</td>
<td>2.51</td>
<td>2.44</td>
<td>1.43</td>
<td>1.18</td>
</tr>
<tr>
<td>Use of an Atypical Antipsychotic at a Lower Than Recommended Dose for 45 or More Days</td>
<td>1.53</td>
<td>1.59</td>
<td>1.54</td>
<td>1.29</td>
<td>1.66</td>
<td>1.21</td>
</tr>
<tr>
<td>Use of 2 or More Atypical Antipsychotics for 45 or More Days</td>
<td>2.03</td>
<td>2.11</td>
<td>1.96</td>
<td>2.83</td>
<td>1.62</td>
<td>2.89</td>
</tr>
<tr>
<td>Patient Failed to Refill a Mood Stabilizer within 30 Days of Prescription Ending</td>
<td>2.11</td>
<td>2.21</td>
<td>1.30</td>
<td>2.09</td>
<td>2.96</td>
<td>2.87</td>
</tr>
<tr>
<td>Use of 2 or More Atypical Antipsychotics for 60 or More Days</td>
<td>2.02</td>
<td>2.24</td>
<td>1.86</td>
<td>3.01</td>
<td>1.66</td>
<td>2.64</td>
</tr>
<tr>
<td>Patient Failed to Refill Newly Prescribed Antidepressant Within 30 Days of Prescription Ending</td>
<td>0.83</td>
<td>1.32</td>
<td>0.71</td>
<td>1.77</td>
<td>0.66</td>
<td>0.65</td>
</tr>
<tr>
<td>Use of an Atypical and a Typical Antipsychotic for 60 or More Days</td>
<td>1.86</td>
<td>1.51</td>
<td>3.10</td>
<td>0.41</td>
<td>1.07</td>
<td>3.25</td>
</tr>
<tr>
<td>Use of 5 or More Psychotropics for 60 or More Days</td>
<td>1.24</td>
<td>1.00</td>
<td>1.47</td>
<td>1.08</td>
<td>0.95</td>
<td>1.96</td>
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<tr>
<td>Use of 2 or More Opioids for 60 or More Days</td>
<td>0.78</td>
<td>0.58</td>
<td>0.57</td>
<td>2.05</td>
<td>1.41</td>
<td>4.69</td>
</tr>
<tr>
<td>Use of an Antipsychotic at a Higher Than Recommended Dose for 45 or More Days</td>
<td>1.49</td>
<td>2.94</td>
<td>1.54</td>
<td>0.00</td>
<td>1.46</td>
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</tr>
<tr>
<td>Multiple Prescribers of the Same Class of Psychotropic Drug for 45 or More Days</td>
<td>1.10</td>
<td>0.48</td>
<td>0.98</td>
<td>0.78</td>
<td>1.36</td>
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<tr>
<td>Use of 2 or More Benzodiazepines for 60 or More Days</td>
<td>0.58</td>
<td>0.53</td>
<td>0.47</td>
<td>0.22</td>
<td>0.71</td>
<td>0.63</td>
</tr>
</tbody>
</table>
Client Success Stories

**Female**
Treatment includes personality disorder, depression, substance abuse (crack and alcohol), and metabolic syndrome. She has a long history of criminal involvement and homelessness. Hospitalizations have dramatically decreased and he has started engaging with treatment and attends appointments with her prescriber. She is now completing a 28 day inpatient residential substance abuse treatment program and will be linked with a transitional living facility upon completion.

**Male**
He received several criminal charges stemming from chronic poly-substance dependence. He is now beginning to engage with staff and has developed a plan for completing goals including obtaining his GED, remaining sober, and following through with mental health treatment.

**Female**
Treatment includes schizoaffective disorder and intellectual disabilities. Previously lived in a financially exploitive and abusive environment and was transitioned into a group home. She is now happy and has not required hospitalization.
Client Success Stories

**Female**
Treatment includes opiate dependence, anxiety, and diabetes. Using data from CMT we were able to understand the severity of this client’s substance abuse (opiates) as well as physical health conditions (diabetes). After losing custody of her children she has started engaging with us and is now attending appointments and will begin parenting classes.

**Male**
Treatment includes conduct disturbance, depressive disorder, psychosis, and PTSD. He had a history of about 2 hospital stays per month from 6/2015 until we began working with him near the end of January and has struggled with chronic homelessness. Hospital stays have decreased to one per month for inpatient stays. In addition, he is now following through with substance abuse treatment and has continued to participate in an inpatient residential substance abuse treatment program for the past three months.
“There has to be an easier way for me to get my wings.”

Clarence Oddboddy
Angel 2nd Class
“It’s a Wonderful Life”
QUESTIONS?