Future of Integration
Lessons Learned

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My Background

- Medicaid Director
- Previously DMH Medical Director – 20 years
  Practicing Psychiatrist
  CMHCs – 10 years
  FQHC – 18 years
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri  St. Louis

Celebrity Endorsements

“He is not only dull himself, he is the cause of dullness in others.” - Samuel Johnson

“He uses statistics as a drunken man uses lamp-posts... for support rather than illumination.” - Andrew Lang

“He can compress the most words into the smallest idea of any man I know.” - Abraham Lincoln
Big Trends

• Increased Coverage
• Increased Demand
• Focus of High Utilizers
• Increased Desire for Integration by Payers
• Shrinking Psychiatric Workforce

Drivers of Increased Demand

• ACA requires newly covered populations meet the parity requirements of Wellstone Domenici Parity Act
• Multiple parts of ACA require or incentivize integration of Behavioral Health and general medical care
• ACA insurance reforms and coverage expansions provide new coverage many people need and want BH services
• Stigma continues to drop releasing pent up demand
• In responding to recent press coverage of mass shootings increasing mental health services is more popular than gun control
Psychiatrist Shortage Overview

• Currently demand for psychiatrists exceeds the supply
• Demand for psychiatric workforce is increasing
• Psychiatric workforce is projected to shrink
• The current psychiatric care delivery model is not sustainable
• So what can be done differently?

Current Shortage

• Best data: Study by University of North Carolina commissioned by Health Resources and Services Administration (HRSA)
• Demonstrated shortages for all MH professionals, especially “prescribers”
  • 77% of U.S. Counties have “a severe shortage of prescribers, with over half their need unmet”
  • 96% of U.S. counties have “some unmet need”

Konrad et al, Psych Services, 60: 1307-14, 2009
Current Supply and Need for Psychiatrists

- Estimated need of 25.9 psychiatrists/100,000 population
  - With current population of 300,000,000, this is 78,000.
- Current supply is ~ 48,000 (~ 16/100,000)
- Current gap = at least 30,000
- Much greater supply vs. need gap for child and adolescent psychiatry (~ 7,500 total)

Sources: Konrad et al, Psych Services, 60: 1307-14, 2009

Demand for Psychiatrists Continues to Grow

- The Bureau of Health Professions predicts that demand for General Psychiatry services will increase nearly 20% between 1995 and 2020
- 100% increase in the need for Child and Adolescent Psychiatry
Supply of Psychiatrists has been flat for 20+ years

Note: there has been a linear increase in number of physicians overall during this time

Current Psychiatrists are Aging Out Fast

- Off all sub-specialties (35), Psychiatry is second oldest
  (Second only to Preventive Medicine)
- 55% of current psychiatrist are > age 55
Projected Supply and Demand of All Physicians 2010 - 2025

Source: AAMC Center for Workforce Studies, June 2010 Analysis

Anticipated Supply and Demand of Psychiatrists?

Source: www.integration.samhsa.gov
So, what to do...

- There is NO one magic bullet
- More and larger “help wanted” signs won’t work
- Warm bodies with prescription pads won’t work
- Locums Tenens isn’t “the solution”
- Tele-psychiatry isn’t “the solution”

Collaboration Models

- Clearly must change the way we do business
- Primary Care Physicians with Consulting Psychiatrist
- Advanced Practice Nurse Practitioners as LIPs with Collaborating Psychiatrists (practice agreements or prescriptive agreements)
- Psychologists with Supervising Psychiatrists
- Physician Assistants as psychiatrists’ extenders
Potential Options and Concerns

1. Primary Care Physicians take on more psychiatric patients – already overloaded and not doing the best job in treating people with psychiatric problems

2. Train more Psychiatrists – $100,000 per residency slot (times 45,000 = $4.5B)

3. Train more APRNs and Physician Assistants in Psychiatry – very little training in psychology or psychotherapy

4. Psychologists Prescribing Authority – What is “adequate training” in basic science medicine and clinical science medicine to prescribe?

Benefits of Co-Location and Integration

• Patients prefer it
• Percent complying with a referral rises from 15-20% to 40-60%
• Builds personal relationships – the foundation of any enduring arrangement
• Allows more accurate understanding of each other’s incentives, methods and constraints
• Opportunities for informal consultation
• Single clinical record reduces errors
• Facilitates converting BH clinicians into consultants to PCPs
Per Member Per Month Costs

<table>
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<th></th>
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<tr>
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<td>$1,600</td>
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<tr>
<td>Medicare</td>
<td>$200</td>
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</tr>
<tr>
<td>Medicaid</td>
<td>$800</td>
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Melek et al, Milliman Inc, 2013

MH/SU Costs in NY State’s Medicaid Program

<table>
<thead>
<tr>
<th></th>
<th>Behavioral Health costs</th>
<th>Physical Health costs</th>
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<tbody>
<tr>
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<td>$15,000</td>
</tr>
<tr>
<td>SU Disorder</td>
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<tr>
<td>No MH/SU Disorder</td>
<td>$10,000</td>
<td>$10,000</td>
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</table>
Health Home
Target Populations

Patients with Diabetes
- At risk for cardiovascular disease and a BMI > 25

Patients who have two of the following
- COPD/Asthma
- Diabetes (also as single condition)
- Cardiovascular Disease
- BMI>25
- Developmental Disabilities
- Use Tobacco

Individuals with a serious mental illness; or with other behavioral health problems who also have
- Diabetes
- COPD/Asthma
- Cardiovascular Disease
- BMI>25
- Developmental Disabilities
- Use Tobacco

Missouri’s Health Homes

Primary Care Health Homes
- Providers
  - 18 FQHCs
    - 67 Clinics
  - 6 Hospitals
    - 22 Clinics
    - 14 Rural Health Clinics
- Enrollment
  - 15,526 adults
  - 428 children
  - 15,954 total

CMHC Healthcare Homes
- Providers
  - 28 CMHCs
    - 120 Clinics/Outreach Offices
- Enrollment
  - 16,611 adults
  - 2,387 children
  - 18,998 total
Health Home Team
- Nurse Care Managers (1FTE/250pts)
- Care Coordinators (1FTE/500pts)
- Health Home Director
- Behavioral Health Consultants (primary care)
- Primary Care Physician Consultant (behavioral health)
- Learning Collaborative training
- Next day notification of Hospital Admissions

Performance Progress
A1c, LDL, and Blood Pressure
Good News
Small Changes Make a Big Difference

Blood cholesterol
- 10% ↓ = 30% ↓ in CVD (120-100)

High blood pressure (> 140 SBP or 90 DBP)
- ~ 6 mm Hg ↓ = 16% ↓ in CVD; 42% ↓ in stroke

Diabetes (HbA1c > 7)
- 1% point ↓ HbA1c = 21% dec in DM related deaths,
  14% decrease in MI, 37% dec in microvascular complications

Conclusions
A1c Control
- About 7% had uncontrolled A1c levels
- All cohorts with elevated A1c levels showed at least a 1 point reduction
- All cohorts with normal A1c levels increased by 0.1 point or less
Reduction in A1c Level

Baseline | 1 Yr Later | 2 Yrs Later
---|---|---
10.01 | 8.96 | 8.58

Goal: -1 point

Conclusions

LDL Control

- About 45% had uncontrolled LDL levels
- All cohorts with elevated LDL levels showed more than a 10% reduction
- All cohorts with normal LDL levels increased by 7 to 8 points but remained in the low 80’s
**Conclusions**

**Blood Pressure Control**

- 20%-24% had uncontrolled Blood Pressure levels
- All cohorts with elevated Blood Pressure levels showed more than a 6 point drop in both systolic and diastolic pressure
  - In every cohort, on average, Systolic pressure dropped below 140, and Diastolic pressure dropped below 90
  - Systolic and Diastolic pressure increased by 1 to 5 points in cohorts with normal Blood Pressure levels, with Systolic pressure averaging in the low 120's and Diastolic pressure averaging in the mid 70's
Reduction in Blood Pressure

Baseline 1 Yr Later 2 Yrs Later

Systolic

Diastolic

Goal: -6mm Hg

Hypertension and Cardiovascular Disease

Feb'12 Feb'13 June'13 Goal

LDL Cardio BP HTN
Disease Management
Diabetes
(2822 Continuously Enrolled Adults)*

June, 2013

29% of continuously enrolled adults

Hospital Follow Up

% Followed-up
% Med Rec.
Outcomes
Reduction of Hospitalization

Primary Care Health Homes
- Cost decreased by $51.75 PMPM
- Total cost reduction $23.1M

CMHC Healthcare Homes
- Cost decreased by $614.80 PMPM
- Total cost reduction $22.3M

Initial Estimated Cost Savings after 18 Months

Health Homes
- 43,385 persons total served (includes Dual Eligibles)
- Cost Decreased by $51.75 PMPM
- Total Cost Reduction $23.1M

DM3700
- 3560 persons total served (includes Dual Eligibles)
- Cost Decreased by $614.80 PMPM
- Total Cost Reduction $22.3M
Initial Estimated Cost Savings after 18 Months

CMHC Health Homes
- 20,031 persons total served (includes Dual Eligibles)
- Cost Decreased by $76.33 PMPM
- Total Cost Reduction $15.7 M

PC Health Homes
- 23,354 persons total served (includes Dual Eligibles)
- Cost Decreased by $30.79 PMPM
- Total Cost Reduction $7.4 M

Hospitalizations based on Discharge Diagnosis

- Medical
- Other BH
- CSTAR
- CPRC

Reductions
CPRC: 13.5%
CSTAR: 12.9%
Other BH: 14.3%
ER Visits based on Discharge Diagnosis

Lessons/Challenges

- Focused Targets
- Population Management
- Joint Project Teams
What Made it Possible?

Relationships

The Missouri Coalition of CMHCs
- Stability
- Trust

The State Medicaid Authority and State Budget Office
- Transparency
- Common Agenda

The Missouri Primary Care Association
- CMHC/FQHC Integration Initiative
S.M.R. Covey, *The Speed of Trust*
Behaviors that Promote Trust

**Character**
- Talk Straight
- Demonstrate Respect
- Create Transparency
- Right Wrongs
- Show Loyalty

**Character & Competence**
- Listen First
- Keep Commitments
- Extend Trust

**Competence**
- Deliver Results
- Get Better
- Confront Reality
- Clarify Expectations
- Practice Accountability

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**Partnership Principles**

**DON'T**
- Talk about your need first
- Expect to get something
- Limit assistance to a project
- Make it about this deal
- Push a specific position
- Withhold information
- Let them take their lumps

**DO**
- Ask about their needs first
- Give something
- Assist wherever you can
- Make it about the next 10
- Pursue common interest
- Reveal anything helpful
- Take one for the team
Agency Leadership Buy-In

- Implementation was led by DMH & Coalition
  - Helped standardize implementation
  - Paving the Way
  - Accreditation (CARF)
- Assist other programs to include HCH
- Time for in-house trainings
  - Assist other programs to include HCH

Joint Management Teams

Oversight Team
Advisory Team
Operations Team
- Implementation and Training
- Fiscal and Payment
- Evaluation
Oversight Team

Meets Monthly

Members
- Director of Governor’s Office of Budget
- Medicaid and MH Department Directors
- Director MO Coalition of CMHCs
- Director MO Primary Care Association
- HH Project Directors
- HH Project Managers

What is a Health Home?

Not just a Medicaid Benefit
Not just a Program or a Team
A System and Organizational Transformation
What is Different about Health Homes?

- Individual Practitioner
- Episodic Care
- Focus on Presenting Problem
- Referral to meet other Needs
- Managed Care
  - Manages access to care
  - Does not change clinical practice
- Integrated Primary/Behavioral Health Care Team
- Continuous Care
- Comprehensive Care Management
  - Coordinates care across the healthcare system
  - Data driven population management
  - Transforms clinical practice
  - Emphasizes healthy lifestyles and self-management of chronic health problems

Treatment as Usual  |  Health Homes

Why Share Data

What gets measured gets done
Data Uses

- Aggregate Reporting – performance benchmarking
- Individual drill down – care coordination
- Disease Registry – care management
  - Identify Care Gaps
  - Generate to-do lists for action
- Enrollment Registry – deploying data and payments
- Understanding – planning and operations
- Telling your story – presentation like this

Population Management

Selects those from whole population:
- Most immediate risk
- Most Actionable improvement opportunities

Aids in planning:
- Care for whole population
- New Interventions and Programs
- Early identification and Prevention
- Choosing and Targeting Health Education
Principles

- Use the Data you have before collecting more
- Show as much data as you can to as many partners as you can as often as you can
  - Sunshine improves data quality
  - They may use it to make better decisions
  - It’s better to debate data than speculative anecdotes
- When showing data ask partners what they think it means
- Treat all criticisms that results are inaccurate or misleading as testable hypotheses

More Principles

- Tell your data people that you want the quick easy data runs first. Getting 80% of your request in 1 week is better than 100% in 6 weeks
- Treat all data runs as initial rough results
- Important questions should use more than one analytic approach
- Several medium Data Analytic vendors/sources is better than on big one
- Transparent Bench Marking improves attention and increases involvement
Most Important Principle

- Perfect is the Enemy of Good
- Use an Incremental Strategy
- If you try figure out a comprehensive plan first you will never get started
- Apologizing for a failed prompt attempt is better than is better than apologizing for missed opportunity
**Data You Need to Manage**

- Eligibility/Enrollment Registry
- Payment System
- Work Process Tracking
  - Data reporting
  - Use of HIT Care management tools
  - Staffing as required and turnover
  - Attending training and Conference calls
- Aggregate Outcomes
- Individual Patient Look-Up/Drill down

**Data Sources**

Claims – Broad but not Deep, already aggregated
- Diagnosis
- Procedures including Hospital and ER
- Medications
- Costs

EMR Data Extracts – Deep but not Broad, need aggregating

Practice Reported – Administrative Burden
- Metabolic Values – Ht, Wt, BP, HbA1c, LDL, HDC
- Satisfaction and community function – MHSIP
- Staffing and Practice Improvement

Hospital Stay Authorization – Hospital Admissions
Comprehensive Care Management

- Identification and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identification and targeting care gaps
- Individualized planning with the patient

Treatment Team Meetings

- Primary Care Nurse Care Manager is a must
- Provide medical perspective
- Primary Care Nurse Care Manager brings primary consultation opinion
- Solidify primary & behavioral health interventions
Common Challenges

• Write a good treatment plan
  o Core Competency QA
    ✓ Treatment Plans
    ✓ Health Screenings
    ✓ Metabolic Screenings
    ✓ Progress notes

• Buy-in
  o Taking blood pressures
  o Training clients to care for their health care

• More work than staff

Great Mistakes I Have Made

• Underestimating the amount of time a number of training episodes it would take CMHC staff to understand the HH care delivery model

• Overestimating the amount of funding in the PMPM for physicians to have time off to attend training

• Not including a small PMPM payment to local PCPs and Hospitals to work with the CMHC – HHs

• Not enough Nurse Care Manager time at 1 FTE/250

• Getting the amount of Health Home Director time wrong
  o CMHC-HHs @ 1 FTE/500 is too much
  o PC-HHs @ 1 FTE/2500 is too little
Lessons Learned

- Do not underestimate the amount of technical assistance and training required by the providers.
- Monthly phone conferences for health home administrators and care managers.
- Quarterly face-to-face learning collaborative meetings.
- Weekly calls with practice coaches for individual sites.

Key Principle #1 – Keep It Simple

- For any individual choice point always choose the simplest solution.
- Your health home project will end up really complicated in the end anyway, why make it more so?
- You will almost certainly redesign your health home program after two years. You can address some of the finer points that you worry about then.
- Perfect is the enemy of good.
Surprises

Health education for clients, transfers

- Good results for clients
- Good results for family
- Good results for staff

What Makes it Possible?

- A Relationship of Basic Trust between:
  - Department of Mental Health
  - Mo HealthNet
  - State Budget Office
  - MO Coalition of CMHCs
  - MO Primary Care Association

- Transparent use of Health Information Technology to identify and monitor problems, and assess performance
- Willingness of all partners to tolerate risk
- Funding Primary Care Nurse Care Managers
- Lots of Training and Practice Coaching
As of June 2013

- **Approved State Plan Amendment(s) (12)**
- **Planning Grant (17)**

Note: States with stripes have both

http://www.nashp.org/med-home-map

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**CHANGE**

When the Winds of Change Blow Hard Enough, the Most Trivial of Things can turn into Deadly Projectiles.
Websites

www.nasmhpd.org/medicaldirector.cfm

www.dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm