Integrating Healthcare Through Population Health Management

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Co-facilitator

Slides for today's webinar will be available on the CIHS website:

www.integration.samhsa.gov
In the About Us/Innovation Communities 2017 tab

To participate
Use the chat box to communicate with other attendees

Use the question box to send a question directly to Dr. Parks.

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Setting the Stage
Dr. Joe Parks
National Council Behavioral Health Medical Director
IC Learning Objectives

- Screening and treatment of depression and diabetes
- Impact of comorbid depression and diabetes on treatment outcomes for both
- Development of screening protocols, treatment pathways, and disease registry to improve co-management of diabetes and depression
- Use of data to improve clinical workflows and outcomes - Population Health Management
- Develop work plan to achieve 2-3 goals related to one or more areas of sustainability:
  - Staff core competencies
  - Quality metrics/Key Performance Indicator Development/Analysis
  - Billing/Cost Analysis

Overview of Today's Webinar

- What is population health?
- What is population health management?
  - Why do we need it?
  - Good outcomes are dependent on patient behaviors.
  - People with a serious mental illness (SMI) are more ill.
- There is a psychiatry shortage.
- Let’s look at a health home example.
- How will the information presented in today’s webinar help you with your Innovation Community workplan goals?

Population Health Definitions

- The health of the population as measured by health status indicators and as influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services (Dunn and Hayes, 1999).
- A conceptual framework for thinking about why some populations are healthier than others as well as the policy development, research agenda, and resource allocation that flow from it (Young, 2005).

Health Rankings

<table>
<thead>
<tr>
<th>Country</th>
<th>Score</th>
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<tbody>
<tr>
<td>Japan</td>
<td>82</td>
</tr>
<tr>
<td>France</td>
<td>81</td>
</tr>
<tr>
<td>Australia</td>
<td>81</td>
</tr>
<tr>
<td>Canada</td>
<td>80</td>
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<tr>
<td>Germany</td>
<td>79</td>
</tr>
<tr>
<td>New Zealand</td>
<td>78</td>
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<tr>
<td>United Kingdom</td>
<td>77</td>
</tr>
<tr>
<td>United States</td>
<td>75</td>
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The IHI Triple Aim

Better Health for the Population
Better Care for Individuals
Lower Cost Through Improvement

How do you deliver PHM in any care setting?

Assess
Stratify
Implement Solutions
Measure & Report
Population Management Principles
- Population-based care
- Data-driven care
- Evidence-based care
- Patient-centered care
- Social determinants of health
- Team care
- Integration of behavioral and primary care

Population-based Care
- Don’t rely solely on patients to know when they need care and what care to ask for and from whom - use data analytics for outreach to high need/utilizer patients.
- Don’t focus on fixing all care gaps one patient at a time - choose selected high prevalence and highly actionable individual care gaps for intervention across the whole population.
- The population-based health care provider is the public health agency for their clinic population.

Data-driven Care
- Patient registries
- Risk stratification
- Predictive analytics
- Performance benchmarking
- Data sharing

Population Management
- Selects those from whole population:
  - Most immediate risk
  - Most actionable improvement opportunities
- Aids in planning:
  - Care for whole populations
  - New interventions and programs
  - Early identification and prevention
  - Choosing and targeting health education

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

Principles
- Use 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 percent of your request in 1 week is better than 100 percent 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 are better than one big one.
- Transparent benchmarking improves attention and increases involvement.

**Most Important Principle**
- Perfect is the enemy of good.
- Use an incremental strategy.
- If you try to figure out a comprehensive plan first, you will never get started.
- Apologizing for a failed prompt attempt is better than apologizing for a missed opportunity.

**Six Population Health Management Services**
1. Care management
2. Care coordination
3. Transitions of care management
4. Health promotion
5. Individual and family support
6. Referral to community services

**Comprehensive Care Management**
- Identifying and targeting of high-risk individuals
- Monitoring of health status and adherence
- Identifying and targeting care gaps
- Individualized planning with patient

**Step 1 – Create Disease Registry**
- Get historic diagnosis from administrative claims
- Get clinical values from metabolic screening, clinical evaluation and management, and care plans
- Combine into EHR Disease Registry (Central Data Registry, PROACT)
- Have online access available to all providers
Step 2 – Identify Care Gaps and ACT!
- Compare combined disease registry data to accepted clinical quality indicators
- Identify care gaps
- Sort patient groups with care gaps into agency specific to-do- lists
- Nurse care manager helps team decide who will act
- Set up indicated visits and pass on information with request to treat

Care Coordination
- Coordinating with the patients, caregivers, and providers
- Implementing plan of care with treatment team
- Planning hospital discharge
- Scheduling
- Communicating with collaterals

Why Behavioral Health Needs Population Management
- Legislation requires it
- People with SMI more ill
- Population management needs behavioral health
- Psychiatry shortage

Population Health Management
- Community health needs assessment requirements
- Expansion of prevention and wellness services
- Hospital readmissions reduction program
- Community-based care transitions program
- Accountable Care Organizations
- Patient-centered medical homes
- Health homes for chronic conditions
- Increased funding for health centers

Important Provider Competencies

Characteristics:
- Outcomes-oriented
- Enabled by technology
- Patient-centered
- Use of data and analytics
- Performance transparency
- Ability to partner across organizations

Care Coordination

Clinical Integration

Life Expectancy

Causes of Excess Mortality

- Smoking
- Obesity
- Inactivity
- Polypharmacy
- Under diagnosis of medical conditions
- Inadequate treatment of medical conditions

Per Member Per Month Costs

<table>
<thead>
<tr>
<th></th>
<th>Private Sector</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Mental Disorder</td>
<td>$0</td>
<td>$200</td>
<td>$400</td>
</tr>
<tr>
<td>Any Mental Disorder</td>
<td>$600</td>
<td>$800</td>
<td>$1,000</td>
</tr>
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Private Sector
Medicare
Medicaid

MH/SUD costs in NY State’s Medicaid Program

So, what to do...

- NO one magic bullet
- Integration of behavioral health and primary care
- Team care with everyone working at the top of their training
- Population health management
- Healthcare delivery based on deep partnerships

What is a Health Home?

- Not just a Medicaid benefit
- Not just a program or a team
- A system and an organizational transformation
Health Care Home Strategy

- Case management coordination and facilitation of healthcare
- Primary care nurse care managers
- Disease management for persons with complex chronic medical conditions, SMI, or both
- Behavioral health management and behavior modification as related to chronic disease management for persons with medical illness
- Preventive healthcare screening and monitoring by mental health providers
- Integrated primary care and behavioral healthcare

Health Home Strategy

- Health technology used to support service system
- “Care coordination” best provided by a local community-based provider
- Mental health community support workers who are most familiar with the consumer provide care coordination at the local level.
- Primary care nurse care managers working within each health home provide system support
- Behavioral health consultants in each primary care health home
- Statewide coordination and training support the network of health homes

What is Different about Health Homes?

<table>
<thead>
<tr>
<th>Treatment as Usual</th>
<th>Health Homes</th>
</tr>
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<tbody>
<tr>
<td>Individual practitioner</td>
<td>Integrated primary/behavioral health care team</td>
</tr>
<tr>
<td>Episodic care</td>
<td>Continuous care</td>
</tr>
<tr>
<td>Focus on presenting problem</td>
<td>Comprehensive care management</td>
</tr>
<tr>
<td>Referral to meet other needs</td>
<td>Coordinates care across healthcare system</td>
</tr>
<tr>
<td>Managed care</td>
<td>Uses data driven population management</td>
</tr>
<tr>
<td>Manages access to care</td>
<td>Transforms clinical practice</td>
</tr>
<tr>
<td>Does not change clinical practice</td>
<td>Emphasizes health lifestyles and self-management of chronic health problems</td>
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Health Home Target Populations

Primary Care Health Homes
- 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

CMHC Healthcare Homes
- Individuals with SMI 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
  - 23 FQHCs
  - 61 clinics
- 9 Hospitals
  - 36 clinics
- 3 Independent practices
  - 3 clinics
- Enrollment
  - 17,823 adults
  - 1,168 children
  - 18,991 total

CMHC Healthcare Homes
- Providers
  - 26 CMHCs
  - 120 clinics/outreach offices
- Enrollment
  - 20,877 adults
  - 3,359 children
  - 24,236 total

Health Home Team
- Nurse care managers (1FTE/250pts)
- Care coordinators (1FTE/500pts)
- Home health director
- Behavioral health consultants (primary care)
- Primary care physician consultant (behavioral health)
- Learning collaborative training
- Next day notification of hospital admissions
Six CMS Required Health Home Functions

1. Care management
2. Care coordination
3. Managing transitions of care
4. Health promotion
5. Individual and family support
6. Referral to community services

HCH Responsibilities

Hospital Admissions

- The importance of following up on hospital discharges
- A joint letter prepared by the Missouri Hospital Association and Missouri HealthNet was distributed to all hospitals describing the health home initiative and encouraged hospital cooperation.
- A draft Memorandum of Understanding (MOU) has been distributed to your CMHC administration to use as a guide in developing a MOU with hospitals serving your area.

Hospital Admissions

- Hospitals are required by most payers, including Missouri Medicaid, to contact the payer at the time of admission to receive an Initial Authorization of Stay.
- All-new authorizations for inpatient care are sent in an overnight flat file data transfer from the inpatient authorization unit to the health home analytics unit.
- An access database is used to automatically sort the patients by health home and generate an automated email listing those patients with new authorizations to each health home director.
- HCHs receive daily emails regarding hospital admissions.

Hospital Admissions

- Hospital discharges from the hospital must have a contact within 72 hours of discharge
- Nurse care managers must complete a medication reconciliation on HCH members discharged from the hospital
- Information regarding the enrollees' medications may be collected by the individual's CSS or case manager for review by the NCM

Emergency Room Visits

- In response to the anthrax scare following 9/11 all emergency rooms were required to send a notification of every emergency room visit to the state health department.
- All new emergency room (ER) visit notifications are sent in an overnight flat file data transfer from the state health department to the health home analytics unit.
- An access database is used to automatically sort the patients by health home and generate an automated email listing those patients with new ER visits to each health home director.
- HCHs receive daily e-mails regarding ER visits.

CMHC Health Home Performance Progress

LDL, A1C, and Blood Pressure
Metabolic Syndrome Screening

All CMHC Health Homes have attained a completion rate above 80%!

N= 6,553 (at 3.5 years)
N= 20,648 (Dec 2015)

A1C Levels Over Time

About 7% had uncontrolled A1c levels

1 POINT DROP IN A1C
• 21% ↓ in diabetes related deaths
• 14% ↓ in heart attack
• 31% ↓ in microvascular complications

LDL Levels Over Time

About 45% had uncontrolled LDL levels

10% DROP IN LDL LEVEL
• 30% ↓ in cardiovascular disease

Blood Pressure Changes Over Time

6 POINT DROP IN BLOOD PRESSURE
• 16% ↓ in CD
• 42% ↓ in stroke

Hospital Follow-up Jan. 2012 – July 2014

Adults continuously enrolled
N= 1,889 (at 3.5 years)
N= 4,526 (Dec 2015)
Initial Estimated Cost Savings After 18 Months

CMHC Health Homes
- 20,031 persons total served (includes dual eligibles)
- Cost decreased by $98.22 PMPM
- Total cost reduction $31.0 M

PC Health Homes
- 23,354 persons total served (includes dual eligibles)
- Cost decreased by $18.22 PMPM
- Total cost reduction $5.3 M

What Makes it Possible?
- A relationship of basic trust between:
  - Department of Mental Health
  - Missouri HealthNet (Medicaid)
  - State Budget Office
  - Missouri Coalition of CMHCs
  - Missouri Primary Care Association
- Transparent use of data instead of anecdotes to explore and discuss issues
- Willingness of all partners to tolerate and share risk
- Principled negotiation and Motivational Interviewing

What Makes it Possible?

Partnering Principles

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

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

SMR. Covey, *The Speed of Trust*

Behaviors that Promote Trust

- Character
  - Talk straight
  - Demonstrate respect
  - Create transparency
  - Right Wrongs
  - Show Loyalty
- Competence
  - Deliver results
  - Get better
  - Confront reality
  - Clarify expectations
  - Practice Accountability

- Character & Competence
  - Listen first
  - Keep commitments
  - Extend trust

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Questions?

Thank you for joining us today. Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.

If you have additional questions/comments, please send them to:
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Madhana Pandian – madhanap@thenationalcouncil.org