Population Health Management For Behavioral Health

MHA’s 2015 Annual Conference
June 3, 2015
Goals of the Affordable Care Act

- Improve the health of populations
- Lower per capita costs
- Improve the patient care experience
- Reform existing payment models and health care delivery systems, i.e. become an Accountable Care Organization (ACO)
- Share in “savings” that result from improving care quality and reducing cost for eligible Medicare populations
Primary Characteristics of an ACO or other Behavioral Health Integration (BHI) Model

- Cost and quality of health care services are managed under a range of payment options (capitation, fee for service, etc.)
- There are processes in place to measure and report on performance outcomes
- Physicians affiliated with the hospital or healthcare system, particularly those with a strong primary care base, are supportive of this initiative
How does behavioral health fit in?

- There is a clear, confirmed link between physical health and mental health.
- In a given year, one of four persons will have a diagnosable mental health disorder.
- Patients with a serious mental illness, particularly older adults, have multiple comorbid medical problems.
- The volume and acuity of behavioral health patients in primary care offices and emergency departments confirms the need for timely access to behavioral health resources.
- An ACO with a behavioral health component, or other BHI model, is an ideal structure for managing care and costs.
Data Collection and Analysis

Data to be collected for utilization projections include:

- Locations (ex: primary care offices, EDs)
- Staffing
- Capabilities
- Current services
- Community assessments v. national norms
## Behavioral Health Volume Utilization Estimates: Eligible Medicare Covered Lives

<table>
<thead>
<tr>
<th>Total Covered Lives</th>
<th>Expected Covered Lives with BH Issue (25% of Covered Lives)</th>
<th>SMI Patients (19.8% of Covered Lives)</th>
<th>Likely to Receive BH Treatment through EAP Intervention (14.3% of Covered Lives) and PCP Medication Management</th>
<th>Referred Out of Practice For Treatment</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>Inpatient Treatment (4.0% of Covered Lives)</td>
<td>Private Therapist (1.7% of Covered Lives)</td>
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<td>Structured Outpatient (3.3% of Covered Lives)</td>
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Process

- Evaluate all patients using PHQ-2 questionnaire
  - inquires about the frequency of depressed mood over the past two weeks
- Utilize Patient Care Coordinators (PCCs) to refer patients
- Refer patients with moderate and high severity behavioral health issues for assessment
- Utilize call center with toll-free/24 hour telephonic support
Process (continued)

- Provide education and collateral information to staff, patients and caregivers
- Assist patient to obtain resources to comply with treatment recommendations
- Monitor patient compliance with treatment plan
- Coordinate communication between PCPs, clinic staff and behavioral health specialists
Population Health Management
Treatment Protocol for Behavioral Health
Patients screened using PHQ-2 with a positive response will follow on with PHQ-9. Additional assessment and care management needs of the patient are determined by the care manager.

**CARE OPTIONS APPROPRIATE TO LEVEL OF SEVERITY AND ONGOING CARE MANAGEMENT**

- **Severe Severity and Complexity**
  - Treatment Team: Primary Care Physician (PCP), Behavioral Health Specialist(s), Care Manager, Psychiatrist
  - Acute Level of Care Entry Resources:
    - On-site behavioral health evaluation
    - 24/7 Call Center
    - Assistance with community resources
    - Consultation with behavioral health specialists
    - Referral of patient to higher level of care (i.e., inpatient or outpatient services)
    - Care Manager manages ongoing communication between Treatment Team and level of care

- **Moderate Severity and Complexity**
  - Follow-up care management phone calls to patient and patient’s family/support system
  - Check for medication side effects
  - Peer support

- **Mild Severity and Complexity**
  - Care Manager manages ongoing communication between Treatment Team and level of care

**CONTINUING CARE**

- Repeat of PHQ-9 post-treatment
- Follow-up care management phone calls to patient and patient’s family/support system
- Check for medication side effects
- Peer support

**NOTE:** Dependent on the Medical Home's location and resources, the Care Manager and Behavioral Health Specialist may be physically present, available remotely via a Call or Access Center, or a combination of both. The Care Manager and Behavioral Health Specialist roles may be filled by the same person.
Examples of Outcomes

Intermountain Health System

Patients who have depression and diabetes have their diabetes in better control when treated at MHI clinics.
Examples of Outcomes

MHI reduces costs — for the patient and for Intermountain. MHI total savings to the insurance plan (SelectHealth) are significant.

- Patients savings across all service: $1,392 - $725 = $667
- This amounts to **11.1% savings off overall annual average cost** (as measured by allowed charges) for SelectHealth patients with newly diagnosed depression.
Examples of Outcomes

Physicians and Intermountain leadership can track how we’re doing.
Diamond Pilot Project:
Lincoln County Medical Center, NM

For a covered population of approximately 20,000, goals achieved in 2013 included:

- Of 264 patients seen in the LCMC ED for behavioral health issues, only one returned to the ED for assistance
- Annual savings estimated at $310,000 in ED costs
- Patient satisfaction with the behavioral health services exceeded the 90\textsuperscript{th} percentile
Community Assistance Program Helps Reduce Emergency Department Use

**THE PROBLEM**
Lincoln County Medical Center's Emergency Department was inundated with patients presenting with stress, substance/drug abuse and behavioral issues—utilizing numerous resources while adding to the hospital's uncompensated care.

“I was seen in the ED four times for my problem and don’t think I will need ED services again due to the counseling services I received. The world needs this role model for community mental health intervention services.”
~ LCCAP Patient

“I was treated in the ED five times for what I thought were heart problems but turned out to be stress related. I don’t think I will need the ED anymore for this problem because of the information and excellent services I received.”
~ LCCAP Patient

**THE SOLUTION**
The Lincoln County Community Assistance Program (LCCAP) provides short-term, solution-focused therapy, resulting in patients getting more appropriate and cost-effective care at more appropriate venues.

**THE RESULTS**
Program launched in October 2011. As of February 2013:
- 306 patients have called hotline
- 281 callers have had an average of three face-to-face counseling sessions each
- None of the 281 has returned to the ED for care

Program Cost: $239,000/year
ED Cost of Care Avoided: $310,000 (to date)

**THE PROGRAM**
Face-to-face counseling sessions in three Lincoln County communities

- Toll-free Hotline
  24/7/365
  providing triage and counseling by professional licensed staff

**LESSONS LEARNED**
- Service is not meant to replace 911, so we changed the language from mental health ‘crises’ to mental health ‘concerns.’
- Important to begin with a clear objective of the 24-hour hotline. Determine if it will be staffed with counselors for mental health triage, used for initial intake and scheduling, or a combination of both.
- Must have an ongoing and highly visible awareness campaign in the community.
- Ongoing training and collaboration with community caregivers and professionals is necessary.
- Requires a highly motivated and talented staff.

Lincoln County Medical Center is a Critical Access Hospital located in the Village of Ruidoso in Lincoln County, New Mexico. Lincoln County is located 120 miles north of El Paso, Texas, and 180 miles southeast of Albuquerque, New Mexico.

LCCAP PROVIDES
- Comprehensive assessment
- Short-term individual or family counseling
- Referrals to appropriate venues of care including:
  - Physician services
  - Ongoing psychotherapy
  - Community resources such as skills training, family education, community agencies and social support systems
- Services to all residents of Lincoln County regardless of age or financial resources
Questions

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- Population Health
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- Telehealth
- Cardiopulmonary Rehabilitation
- “Treatment in Place” at senior living facilities