One Provider’s Ongoing Journey to Build a Culture of Cost Competency in a Changing Healthcare Landscape

Special Acknowledgement to: Dr. Brian Yates, American University
(Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs)

Les Sperling,
CEO
Central Kansas Foundation
CKF “OLD” STRATEGY

1) Become integral part of Health Home
2) Implement SBIRT in Primary and Acute Care Settings
3) Reduce recidivism to High Cost Care Settings
4) Demonstrate impact of SUD on general health
5) Increase capacity for SUD patients to access primary health and oral health care
6) Full integration of SUD services into Primary and Acute Care Settings
CKF “NEW” STRATEGY

Do we need this?
Question: Do global payment options offer Behavior Health providers more clinical flexibility and financial security?
Answer: To Be Determined.......by YOU!
SALARIES

Utilities??

RENT

OFFICE SUPPLIES

Postage

Computers/Software

Benefits!!

EHR
A Kansas Reality Check

Provider: “We are not sure we want to be a Health Home Provider.”

MCO: “Well, Health Homes are here to stay and if you don’t participate, we will find providers who will.”
Our Top Five Items for Implementation

1) Thorough review of service structure
2) Utilize technology
3) Costs—Cost/Unit of Service
4) Patient as Consumer—Study and address the patient Hassle Map
5) Go where the patients are—Integration
1) Thorough Review of Service Structure

- Fee for service to Population Health
- Improve engagement strategies
- Flexible and mobile workforce
- Expanded role for Peer Mentors/Recovery Coaches
2) Utilize Technology

- Smart Phone Applications in support of recovery
- Web based scheduling and monitoring
- Predictive analytics
- Data
3) Costs – Cost/Unit of Service

- Determine individual patient cost, not program cost
- Determine cost benefit of lower recidivism and increased engagement
4) Patient as Consumer–Study and Address the Patient Hassle Map

- Address ease of access to services
- Hassle map should include global issues, not just agency issues.
5) Go where the patients are—Integration

- Partner with primary, acute care, and other health care settings
- Co-locate staff in high recidivism areas
Case Study #1

Your state’s Medicaid MCOs are implementing Medicaid Health Homes. They contact your agency and want to negotiate PMPM rates for one or all of the services below for patients with one chronic health condition and at risk for SUD. The MCO will be paid $147.50 PMPM and will take 12% off the top for administration. Is this good business for your agency? Services to be provided:

• Comprehensive Care Management
• Health Promotion
• Comprehensive Transitional Care
• Care Coordination
• Member and family support services
• Referral and community supports and services
Determine Cost per Patient/Program

- Total program cost over defined period of time divided by the total number of patients served.

- This process is helpful but it assigns the same cost to each patient when, in reality, patients use different amounts of resources within the same program.
Determine Cost/Resource/Patient

- Transform Direct Staff Time Into Costs
- Record Hours/Procedure/Patient (Direct and Indirect)
- Determine Hourly Cost for Direct and Indirect Staff
- Develop Cost per Unit Resource
- Cost of Procedure/Patient
Data Required

- Diagnoses
- Service utilization/patient/year (include as much primary, acute, dental, and mental health care as possible)
- Cost/procedure/patient/year
- Impact of additional costs associated with model implementation (i.e., medication, peer mentors, additional transportation)
- Estimate of cost increases over the span of contract
- Negotiate appropriate outcomes
- Utilize proven case rate and capitation formulas

Watch National Council Webinars produced by Kathy Reynolds, Joan King, and Jeff Capobianco!!!!!!!!
Salina Regional Health Center

• 300 Bed Acute Care Regional Health Center–Level III Trauma Center
• 27,000 ED presentations per year
• Alcohol/Drug DRG was 2\textsuperscript{nd} most frequent re-admission

• Services provided
  ✓ 24–7 coverage of ED
  ✓ Full time SUD staff on medical and surgical floors
  ✓ Warm hand off provided to all SUD/MH services
  ✓ Universal Screening and SBI

Outcomes

• Re-admission DRG moved from 2\textsuperscript{nd} to off the list
• 70% of alcohol/drug withdrawal LOS were 3 days or less
• 83% of SUD patients triaged in ED were not admitted
• 58% of patients recommended for further intervention attended first two appointments (warm hand off)
• Adverse patient and staff incidents decreased by 60%.
• CKF detox admissions increased 450% in first year
• 300% increase in commercial insurance reimbursement
Challenges

- Mapping cost data into EHR
- Accepting additional risk in managing costs within PMPM or Case Rate
- Traditional models of service provision won’t work
- Resistance from staff
- Managing concurrent transition to “at risk” while still meeting financial goals