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Future of Integration Lessons Learned

August 11, 2014

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Joe Parks, MD

Director, MO HealthNet

Dr. Parks serves as the Director of MO HealthNet, Missouri's Medicaid authority in Jefferson City, Missouri. He also holds the position of Distinguished Research Professor of Science at the University of Missouri – St. Louis and is a Clinical Assistant Professor of Psychiatry at the University of Missouri, Department of Psychiatry in Columbia. He practices psychiatry on an outpatient basis at Family Health Center, a federally funded community health center established to expand services to uninsured and underinsured patients in central Missouri. Dr. Parks has authored or coauthored a number of original articles, monographs, technical papers, and reviews on Behavioral Health services delivery and policy.

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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

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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

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Big Trends

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

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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

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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?

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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

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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

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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

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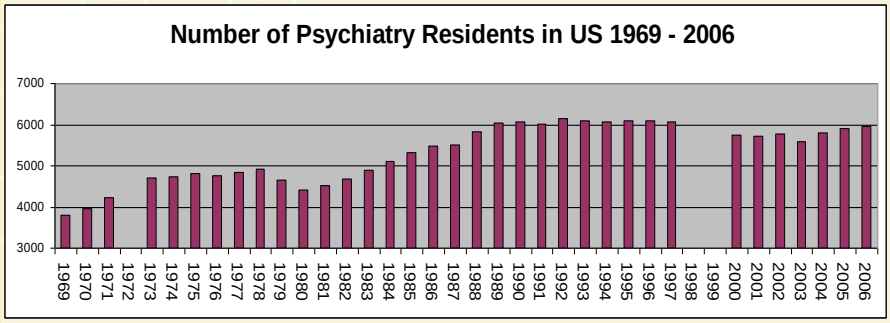
Supply of Psychiatrists has been flat for 20+ years



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

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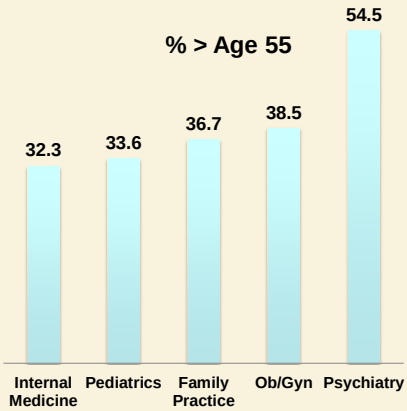
Current Psychiatrists are Aging Out Fast

- Off all sub-specialties (35), Psychiatry is second oldest
  (Second only to Preventive Medicine)
- 55% of current psychiatrist are > age 55

Percent of MDs by specialty over age 55



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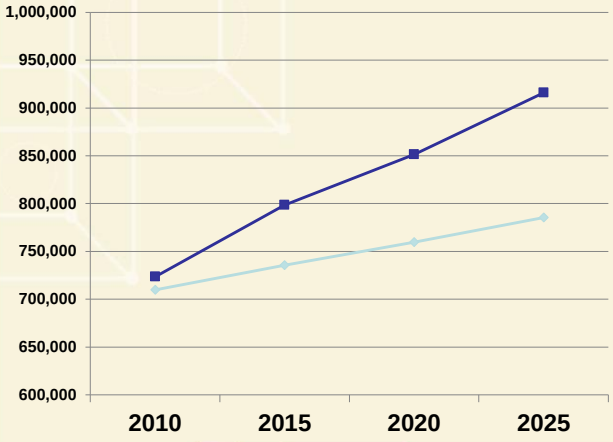
Projected Supply and Demand of All Physicians 2010 - 2025



Source: AAMC Center for Workforce Studies, June 2010 Analysis

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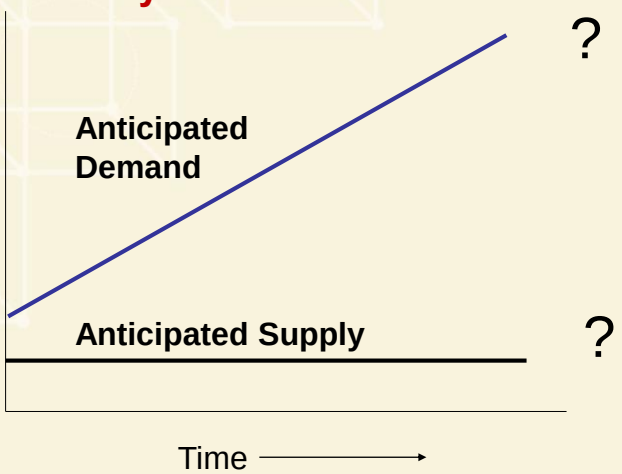
Anticipated Supply and Demand of Psychiatrists?



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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"

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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

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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?

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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

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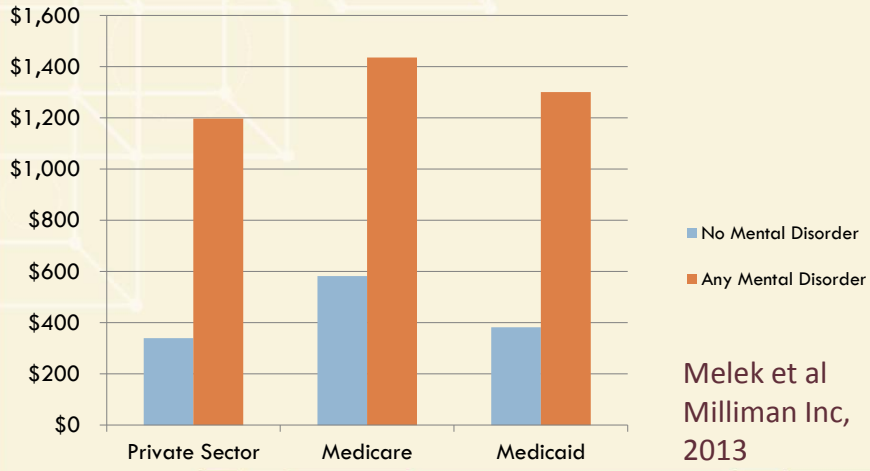
Per Member Per Month Costs



Melek et al
Milliman Inc, 2013

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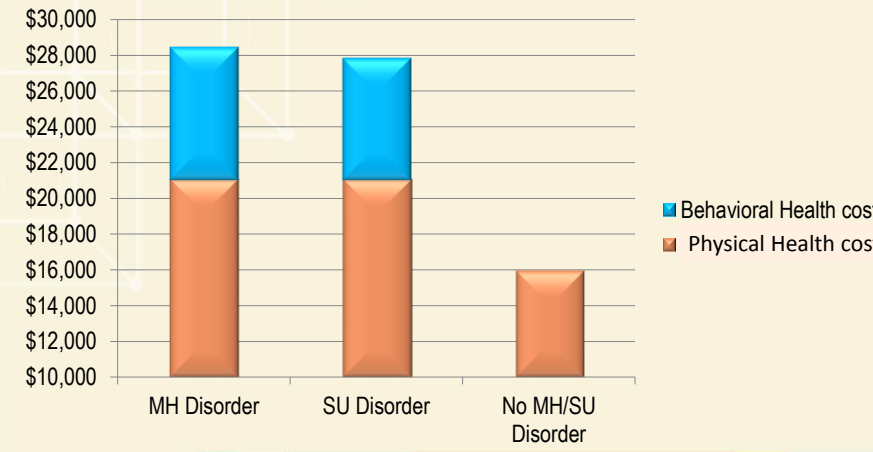
MH/SU Costs in NY State's Medicaid Program



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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

Primary Care Health Homes

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

CMHC Healthcare Homes

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Missouri's Health Homes

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

Primary Care Health Homes

- Providers
  - 28 CMHCs
    - 120 Clinics/Outreach Offices
- Enrollment
  - 16,611 adults
  - 2,387 children
  - 18,998 total

CMHC Healthcare Homes

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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

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Performance Progress

A1c, LDL, and Blood Pressure

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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

Stratton, et al, BMJ 2000
Hennekens CH. *Circulation* 1998;97:1095-1102.
Rich-Edwards JW, et al. *N Engl J Med* 1995;332:1758-1766.
Bassuk SS, Manson JE. *J Appl Physiol* 2005;99:1193-1204

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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**

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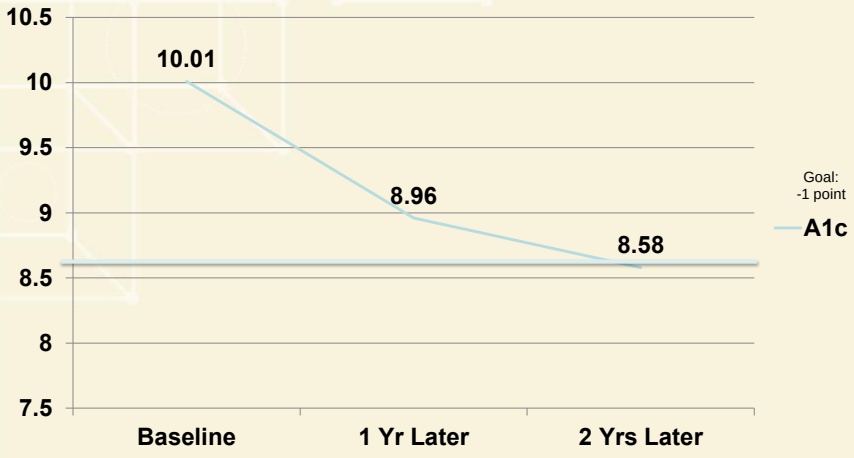
Reduction in A1c Level



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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

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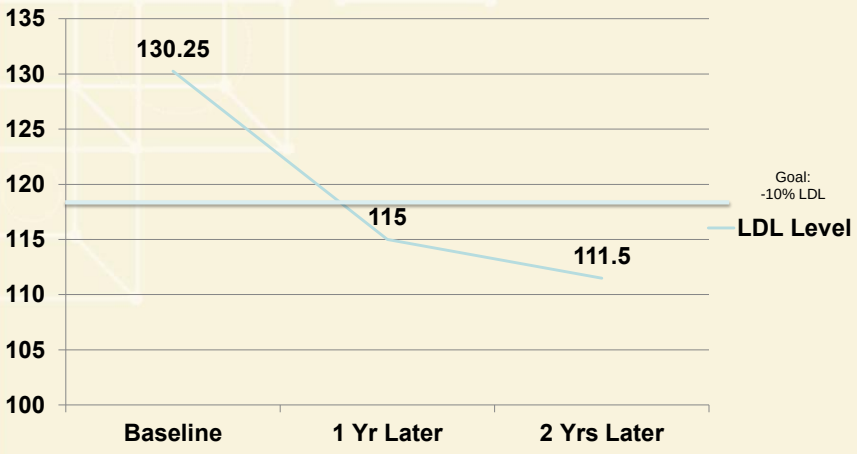
Reduction in LDL Level



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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

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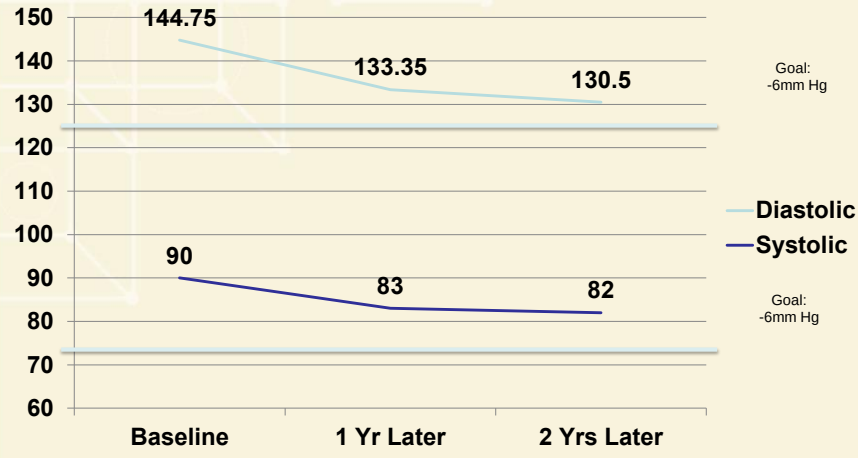
Reduction in Blood Pressure



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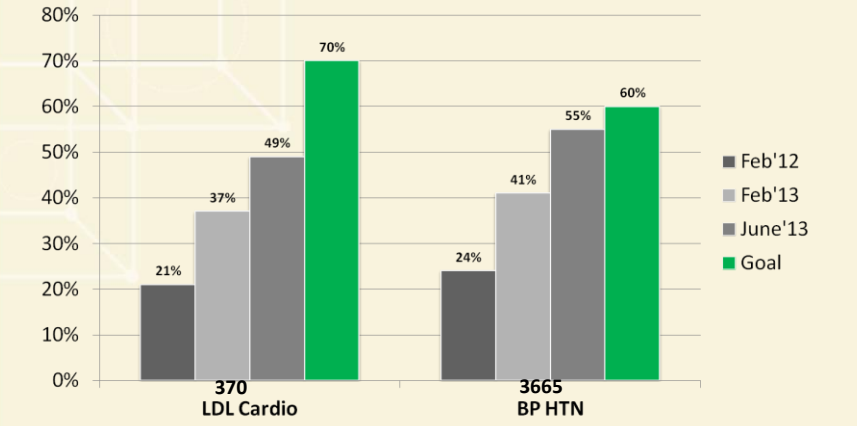
Hypertension and Cardiovascular Disease



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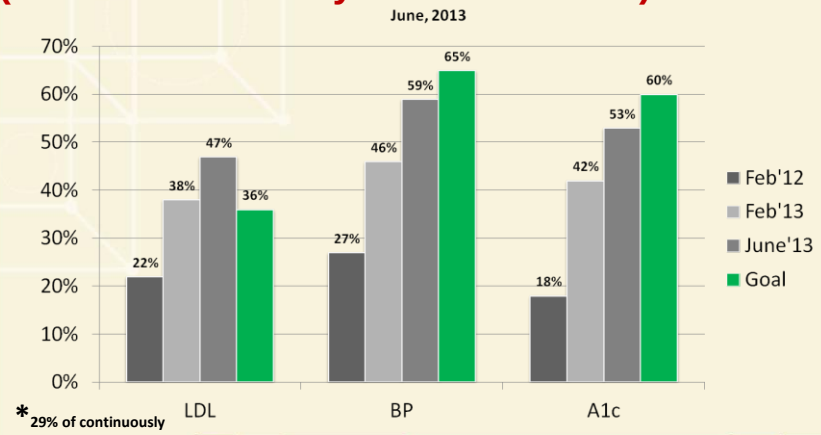
Disease Management
Diabetes
(2822 Continuously Enrolled Adults)*



*29% of continuously enrolled adults

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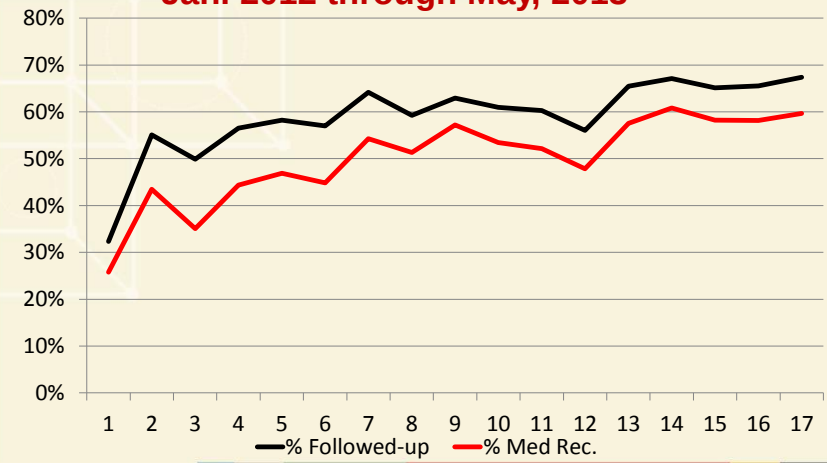
Hospital Follow Up
Jan. 2012 through May, 2013



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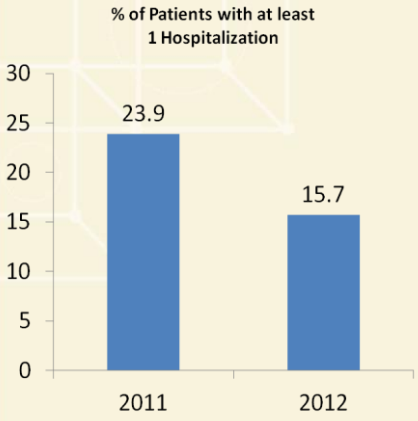
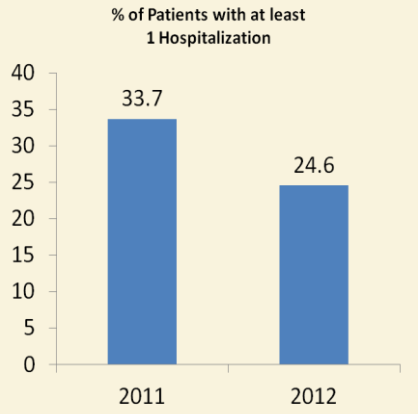
Outcomes
Reducing Hospitalization



Primary Care Health Homes



CMHC Healthcare Homes

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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

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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

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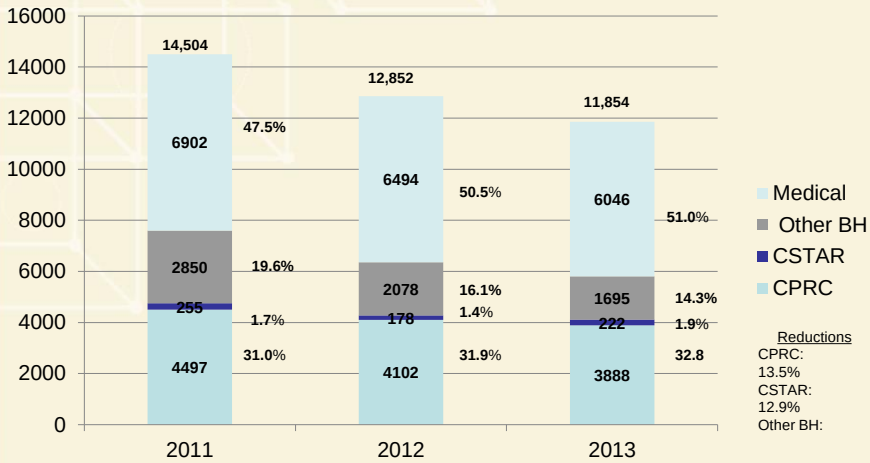
Hospitalizations based on Discharge Diagnosis



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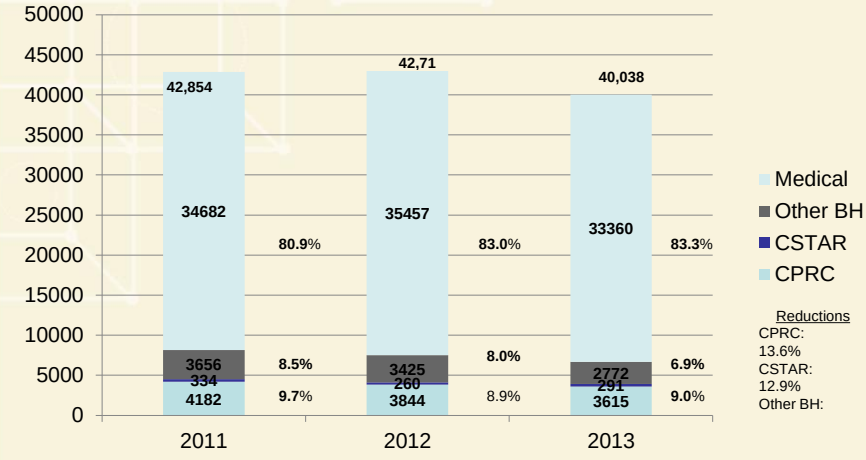
ER Visits based on Discharge Diagnosis



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Lessons/Challenges

- Focused Targets
- Population Management
- Joint Project Teams

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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

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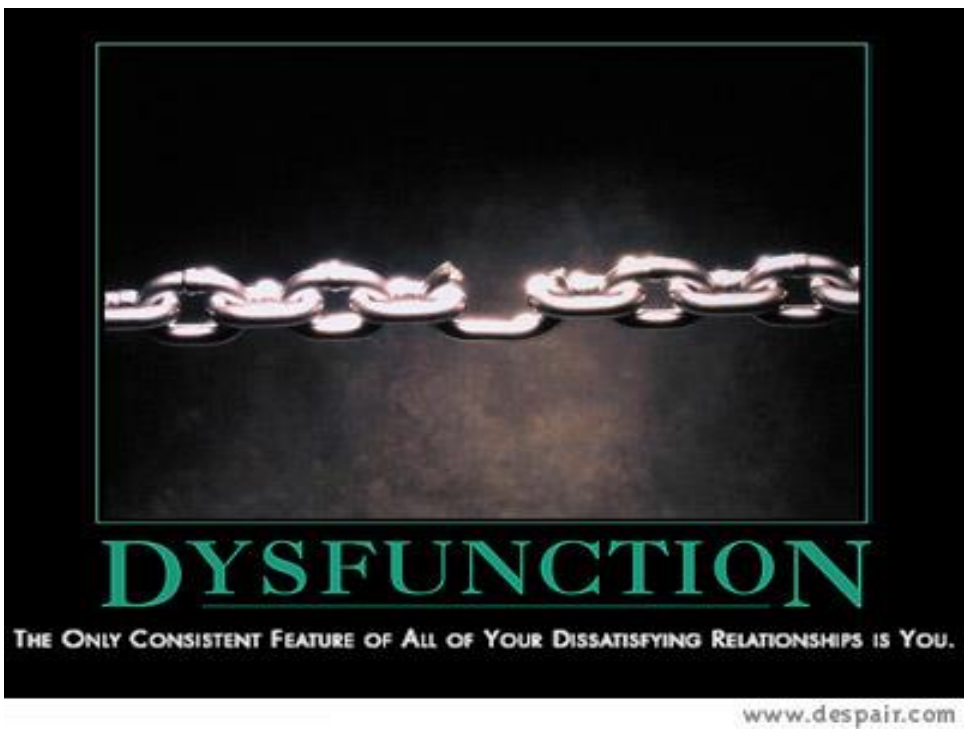

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S.M.R. Covey, The Speed of Trust
Behaviors that Promote Trust

> 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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Partnership Principles

DON'T	DO
- Talk about your need first	- Ask about their needs first
- Expect to get something	- Give something
- Limit assistance to a project	- Assist wherever you can
- Make it about this deal	- Make it about the next 10
- Push a specific position	- Pursue common interest
- Withhold information	- Reveal anything helpful
- Let them take their lumps	- Take one for the team

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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

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Joint Management Teams

Oversight Team

Advisory Team

Operations Team

- Implementation and Training
- Fiscal and Payment
- Evaluation

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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

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What is a Health Home?

Not just a Medicaid Benefit

Not just a Program or a Team

A System and Organizational Transformation

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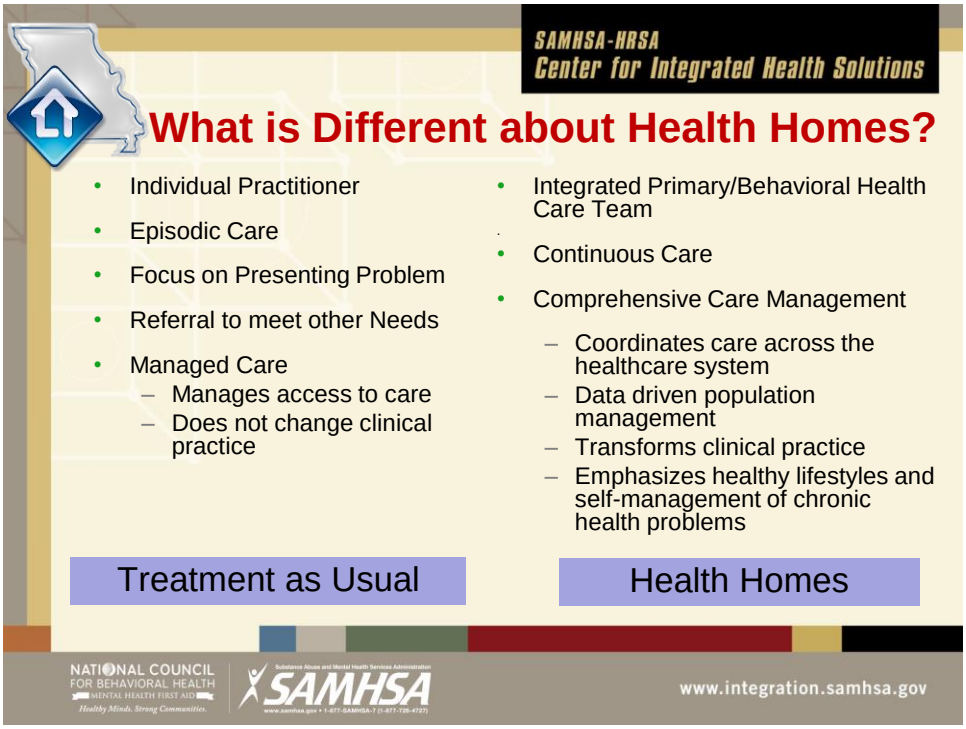
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What is Different about Health Homes?
Individual Practitioner
Episodic Care
Focus on Presenting Problem
Referral to meet other Needs
Managed Care
Manages access to care
Does not change clinical practice
Integrated Primary/Behavioral Health Care Team
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
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Why Share Data
What gets measured gets done
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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

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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

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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

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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

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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

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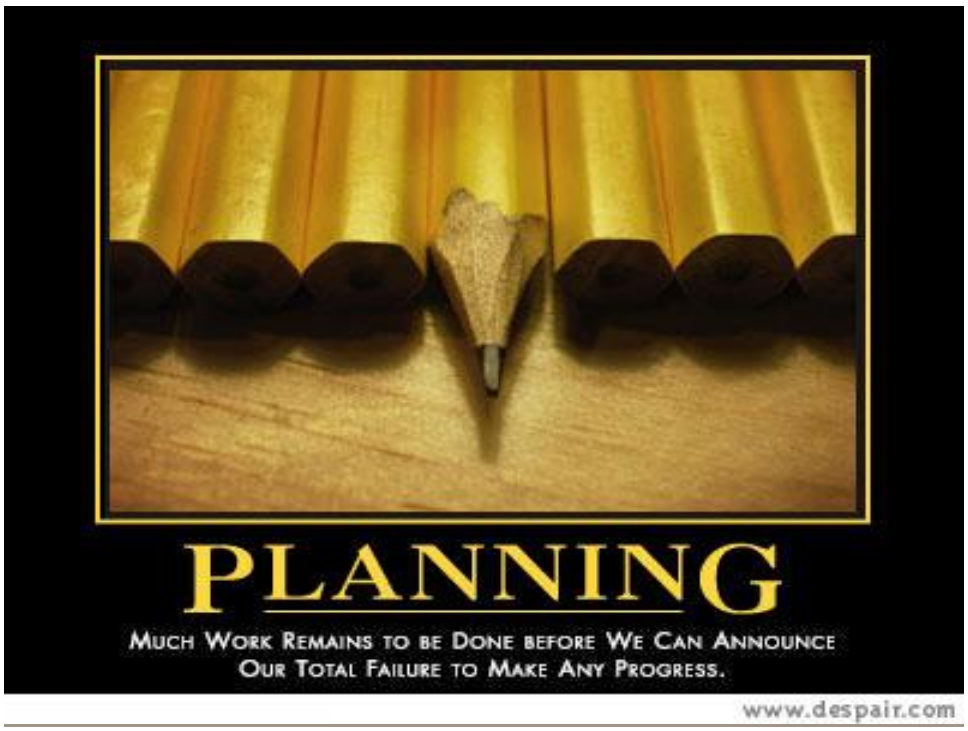

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Data You Need to Manage

- 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

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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

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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

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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

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Common Challenges

- Write a good treatment plan
  - Core Competency QA
    - ✓Treatment Plans
    - ✓Health Screenings
    - ✓Metabolic Screenings
    - ✓Progress notes
- Buy-in
  - Taking blood pressures
  - Training clients to care for their health care
- More work than staff

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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
  - CMHC-HHs @ 1 FTE/500 is too much
  - PC-HHs @ 1 FTE/2500 is too little

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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

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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

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Surprises

Health education for clients, transfers

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

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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

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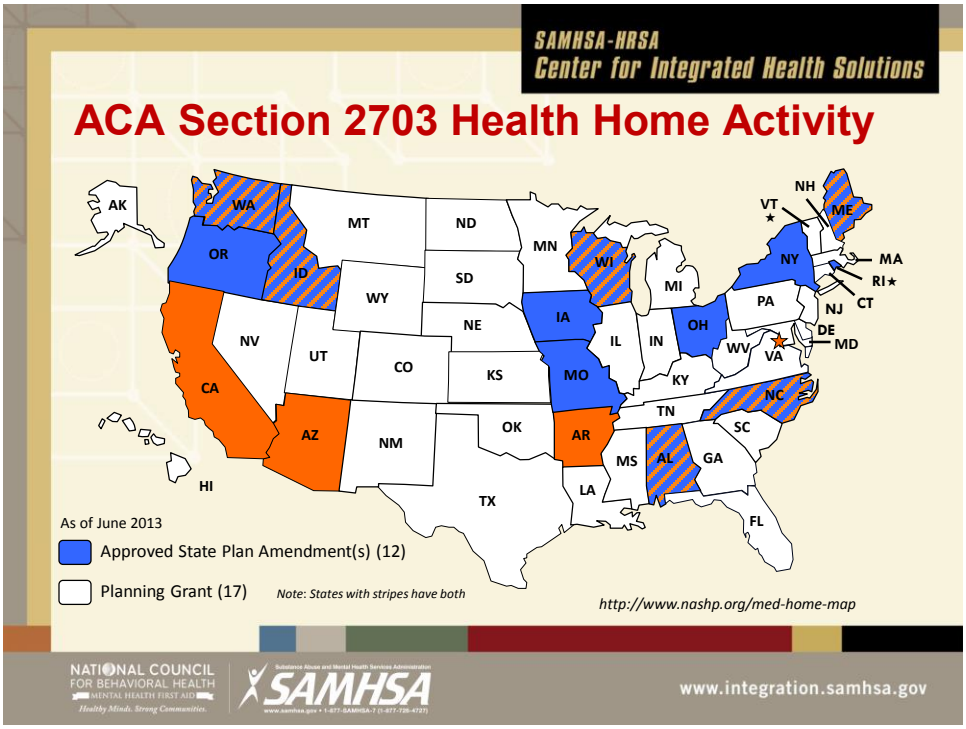
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ACA Section 2703 Health Home Activity
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DE
MD
As of June 2013
Approved State Plan Amendment(s) (12)
Planning Grant (17)
Note: States with stripes have both
http://www.nashp.org/med-home-map
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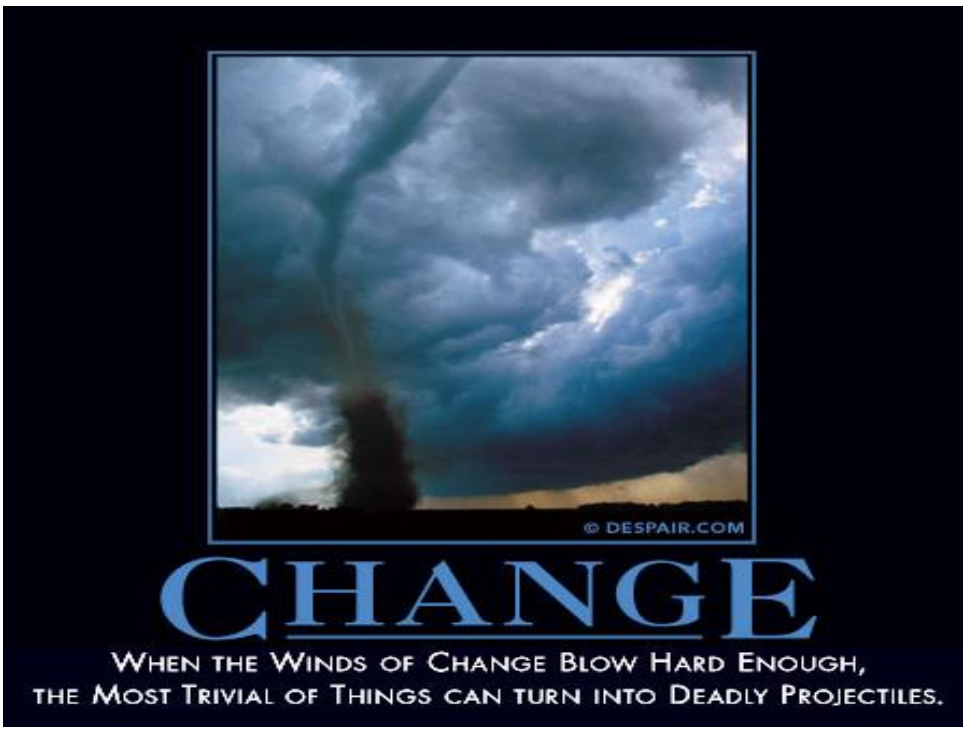
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CHANGE
WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

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Websites

www.nasmhpd.org/medicaldirector.cfm

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

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