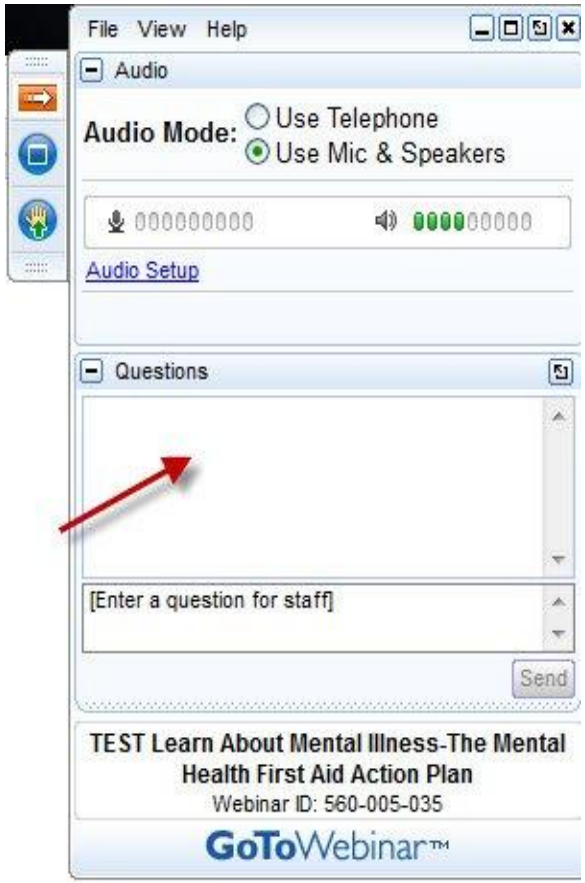
SAMHSA-HRSA
CENTER for INTEGRATED
HEALTH SOLUTIONS

Integrating Primary Care & Wellness: Sustaining Integrated Care Innovation Community

March 2016

Our format…



Structure

Short comments from experts

Specifics from their point of view

Polling You

Every 20-minutes

Finding the “temperature” of the group

Asking Questions

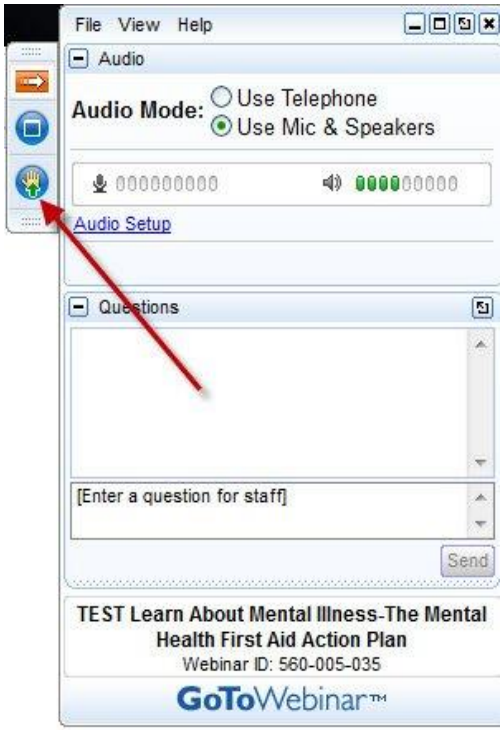
Watching for your written questions

Follow-up and Evaluation

Ask for what YOU want or expect

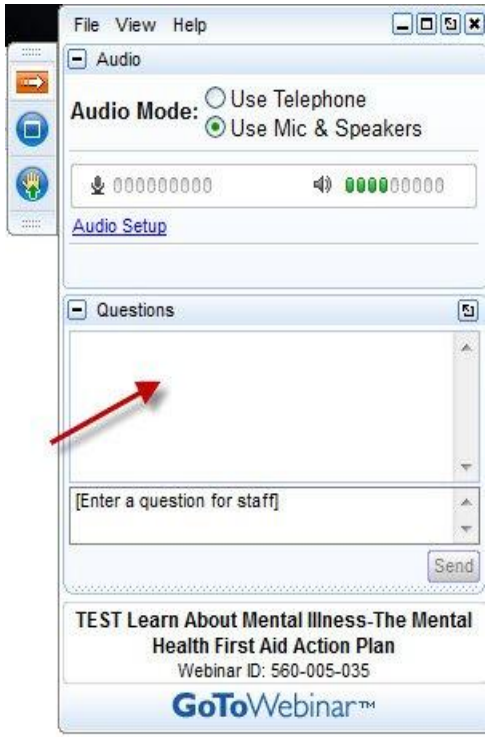
Ideas and examples added to the AOS Resource Center

How to ask a question during the webinar



If you dialed in to this webinar on your phone please use the "raise your hand" button and we will open up your lines for you to ask your question to the group. **(left)**

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. **(right)**



Overview of Today's Webinar

- Review of the Innovation Community Work Plan Themes
- Using Data to Achieve Sustainability Integrating Primary and Behavioral Healthcare
- Wrap-up Questions
- Looking Forward-Next Steps

Work Plan Goal Themes Across Participants

1.) Training Staff in Principles & Practices of Integrated Health/Wellness

2.) Care Coordination (e.g., linking w/ specialty & primary care, etc.)

3.) Smoking Cessation Programming Implementation

4.) Reduce ED/Hospital

4.) Data/Electronic Tracking (e.g., registry optimization, dashboard creation, etc.)

5.) Financing

Work Plan Progress

- As of today your work plan should be approximately 1/3 complete
- Work Plans are living documents that change based on the terrain you have covered and are approaching/have in your sights
- Remember the two biggest benefits of this Innovation Community are the chance to share/problem solve and receive targeted resources

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Using Data to Achieve Sustainability Integrating Primary and Behavioral Healthcare

Joe Parks, MD

March 2016

My Background

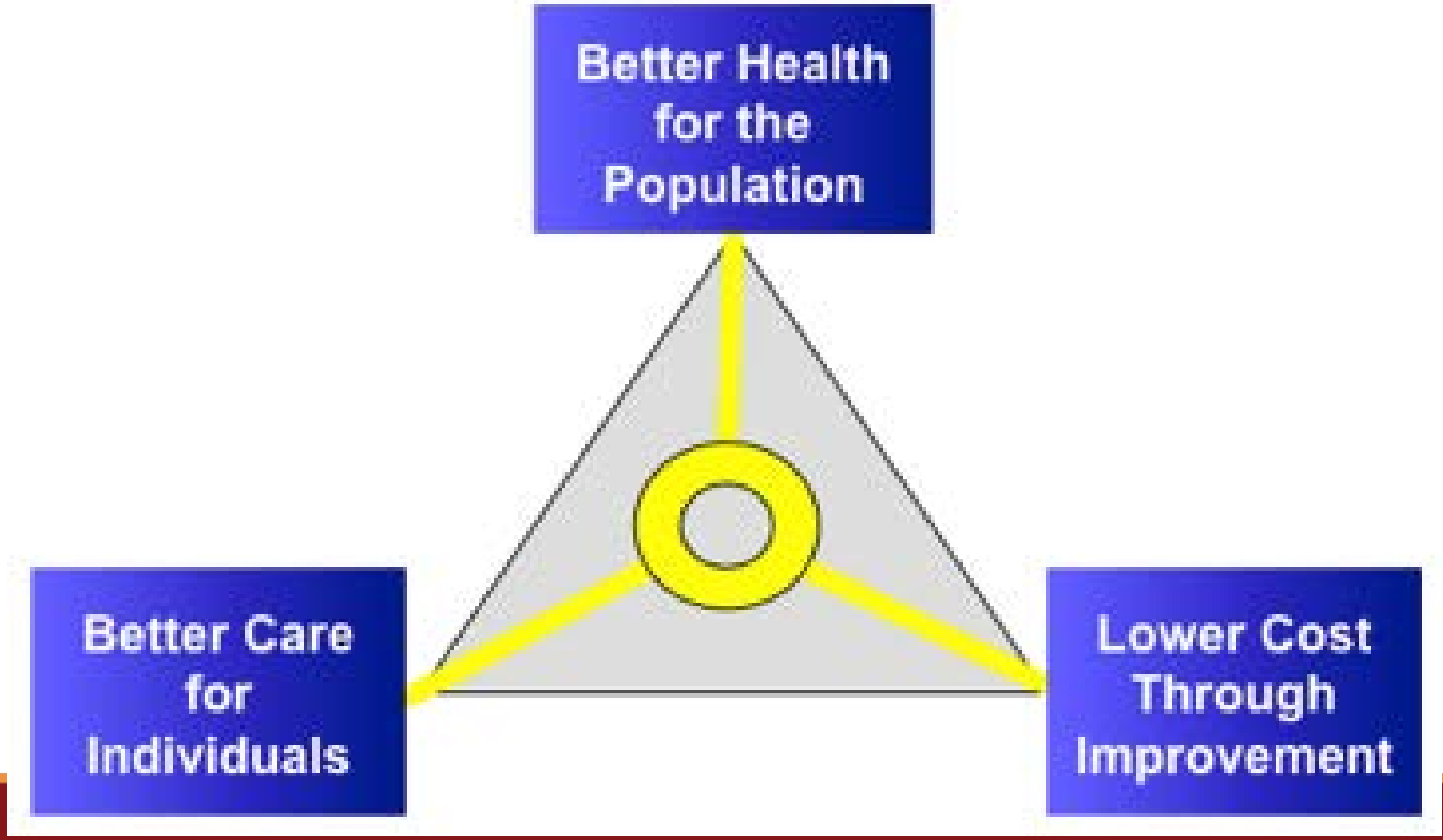
- Medicaid Director
- Previously DMH Medical Director – 20 years
  - Practicing Psychiatrist
  - CMHCs – 10 years
  - FQHC – 18 years
- Distinguished Professor, Missouri Institute of Mental Health, University of Missouri –St. Louis
- Adjunct Professor of Psychiatry – University of Missouri Columbia

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).

The IHI Triple Aim

Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs



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

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

Population Management Principles

- Population-based Care
- Data-driven Care
- Evidence-based Care
- Patient-centered Care
- Addressing Social Determinates of Health
- Team Care
- Integration of Behavioral and Primary Care

Data-Driven Care

- Patient Registries
- Risk Stratification
- Predictive Analytics
- Performance Benchmarking
- Data Sharing

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

Step 1 – Create Disease Registry

- Get Historic diagnosis from administrative claims
- Get clinical values from metabolic screening, clinical evaluation and management, care plans
- Combine into EHR Disease Registry (Central Data Registry, PROACT)
- 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 patients 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 info with request to treat

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
- Others – Lots!!

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 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 one week is better than 100% in six 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 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 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

PLANNING

MUCH WORK REMAINS TO BE DONE BEFORE WE CAN ANNOUNCE OUR TOTAL FAILURE TO MAKE ANY PROGRESS.

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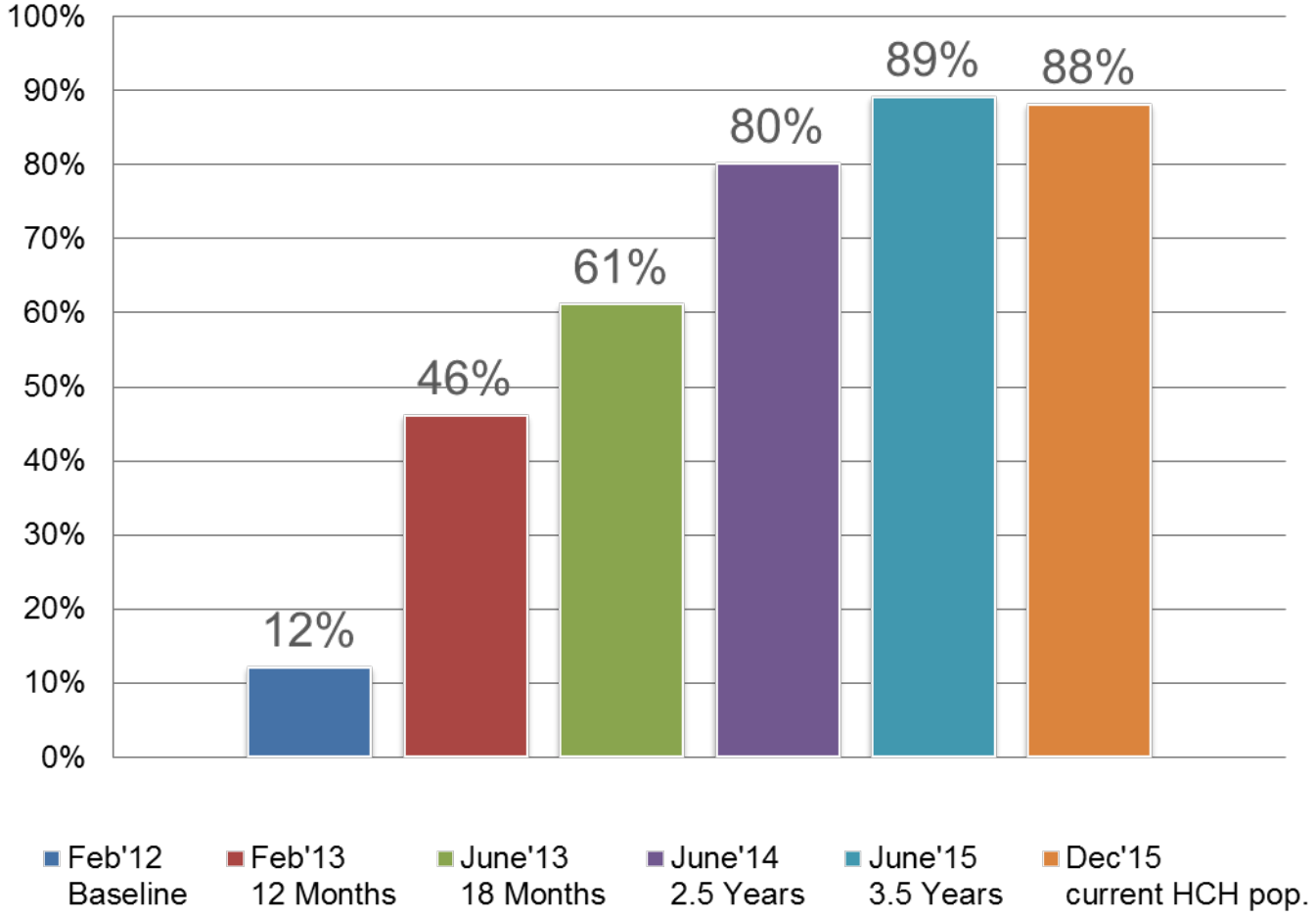
CMHC Health Home Performance Progress

LDL, A1C, and Blood Pressure

METABOLIC SYNDROME SCREENING



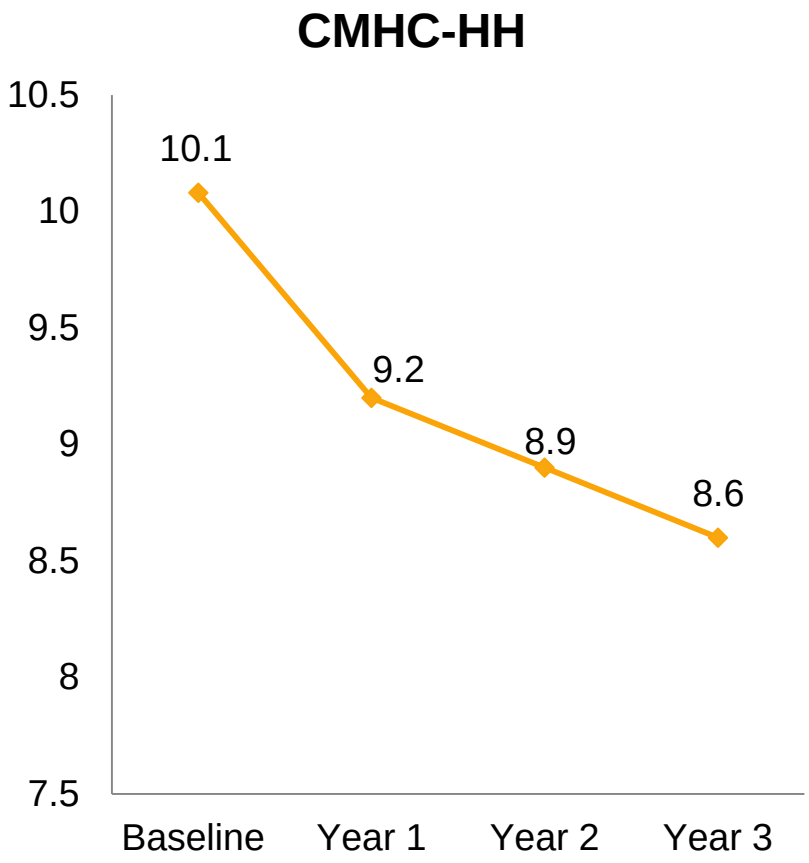
All CMHC Health Homes have attained a completion rate above 80%!

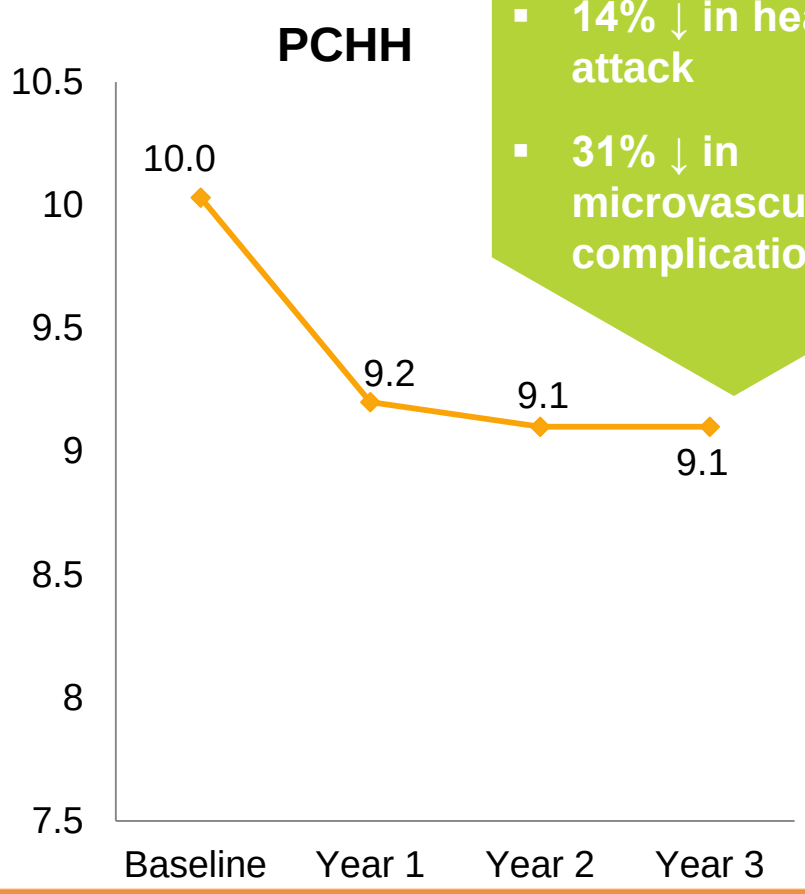
N= 6,553 (at 3.5 years)

N= 20,648 (Dec 2015)

A1C Levels Over Time

About 7% had uncontrolled A1c levels





1 POINT DROP IN A1C

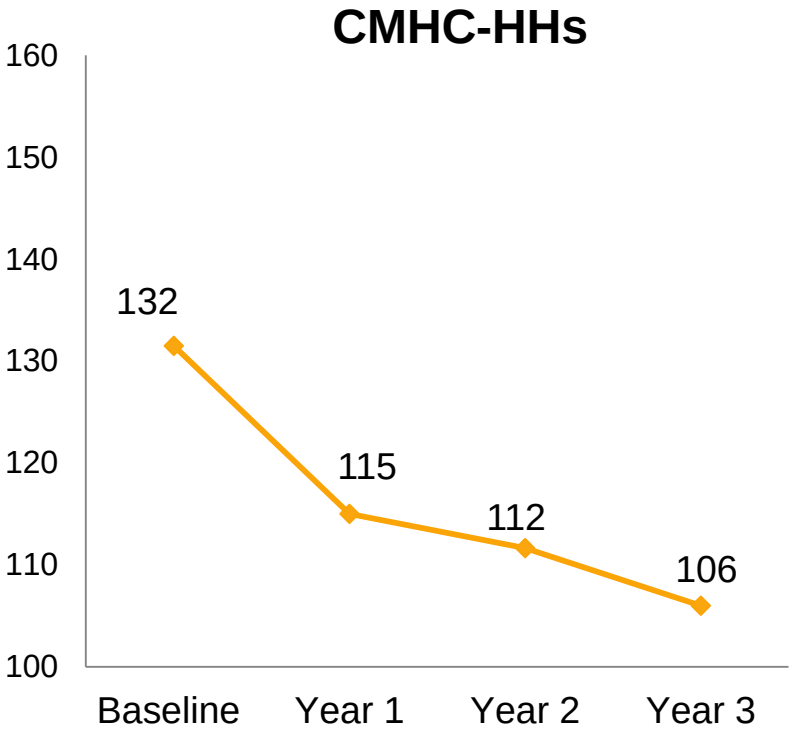
- **21% ↓ in diabetes related deaths**
- **14% ↓ in heart attack**
- **31% ↓ in microvascular complications**

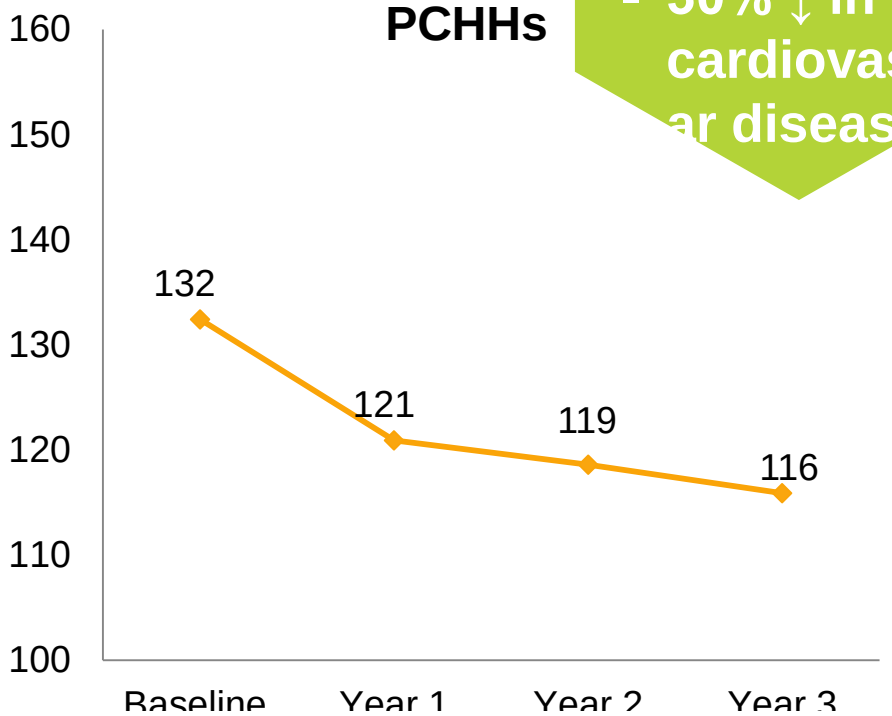
LDL Levels Over Time

About 45% had uncontrolled LDL levels

10% DROP IN LDL LEVEL

- **30% ↓ in cardiovascular disease**



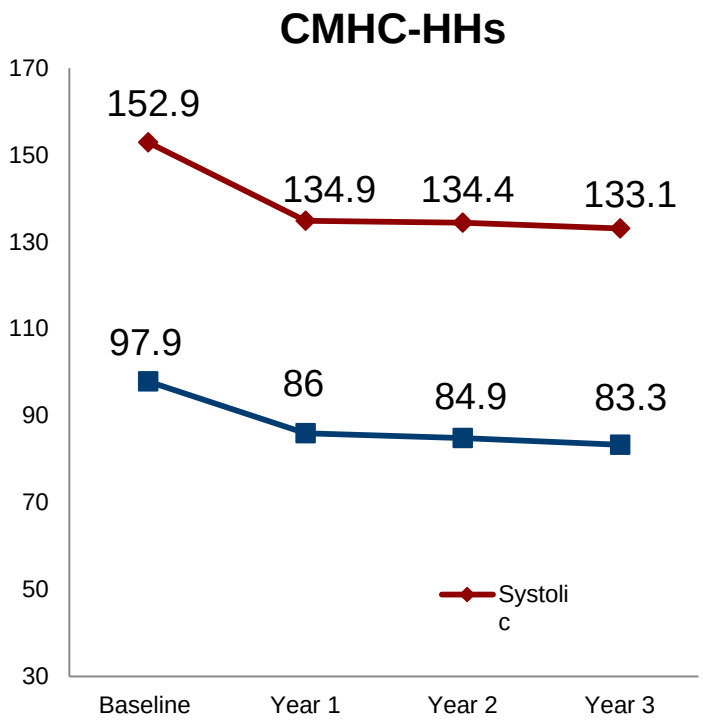


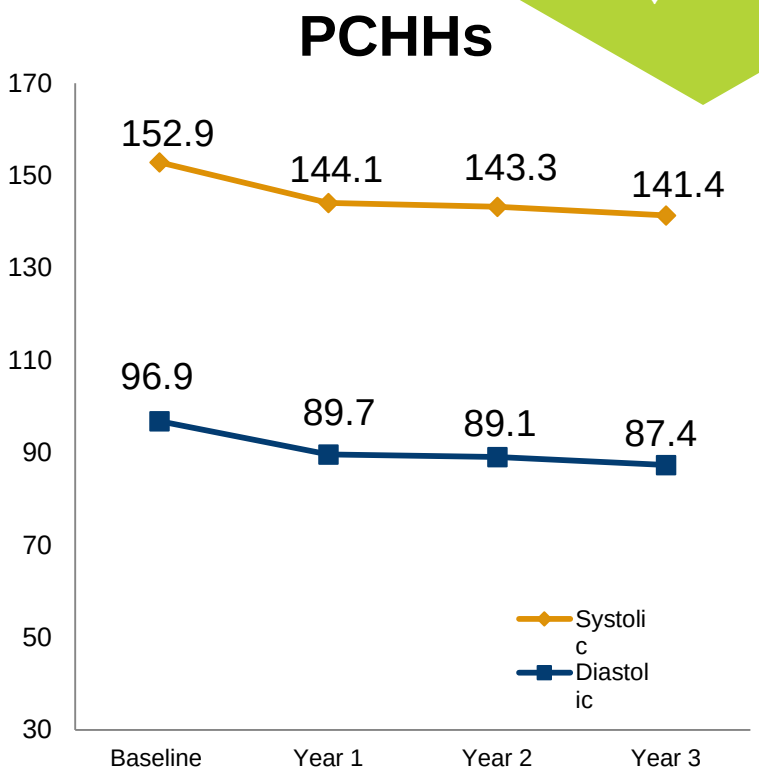
Blood Pressure Changes Over Time

6 POINT DROP IN BLOOD PRESSURE

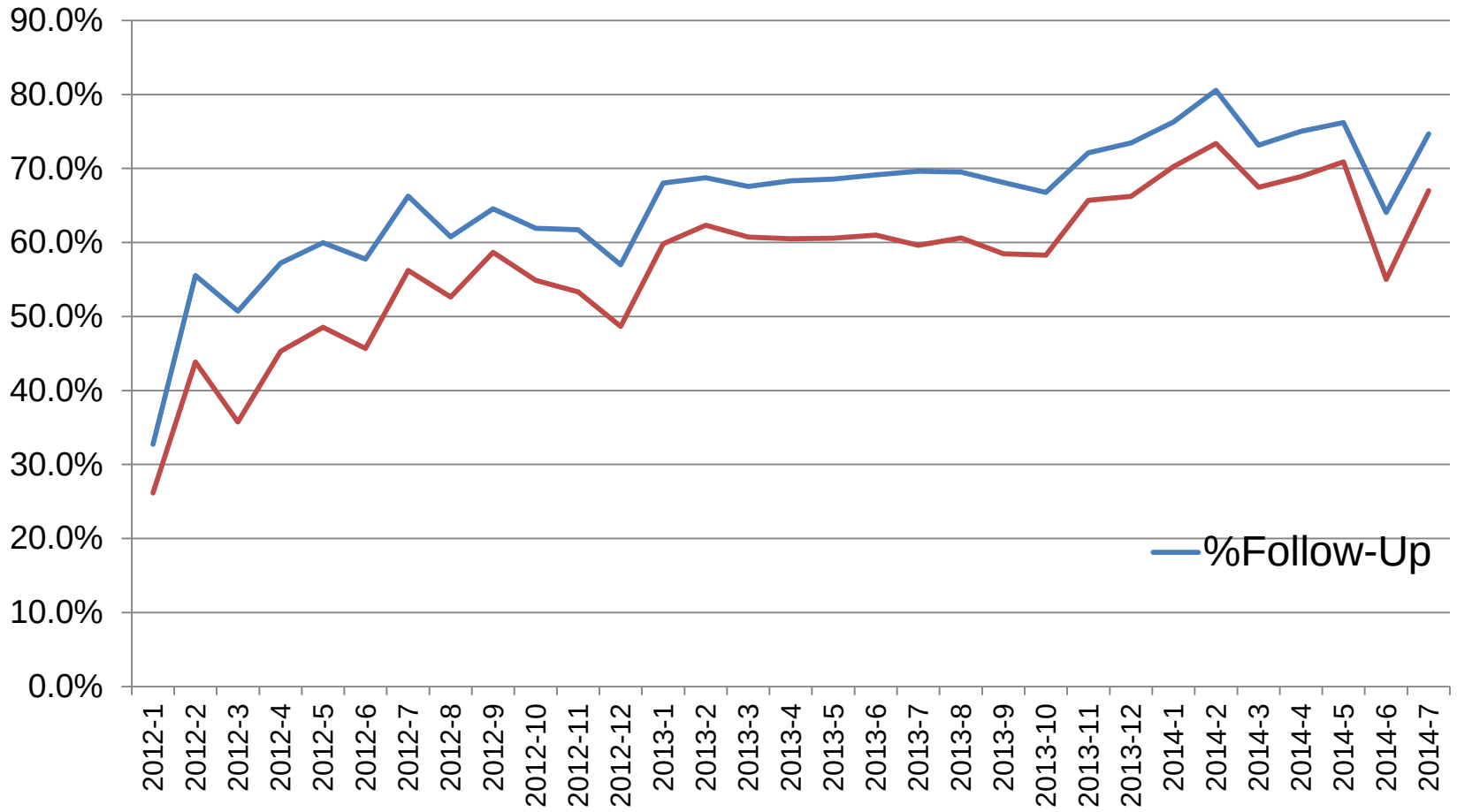
- 16% ↓ in CD
- 42% ↓ in stroke

20-24% had uncontrolled BP levels

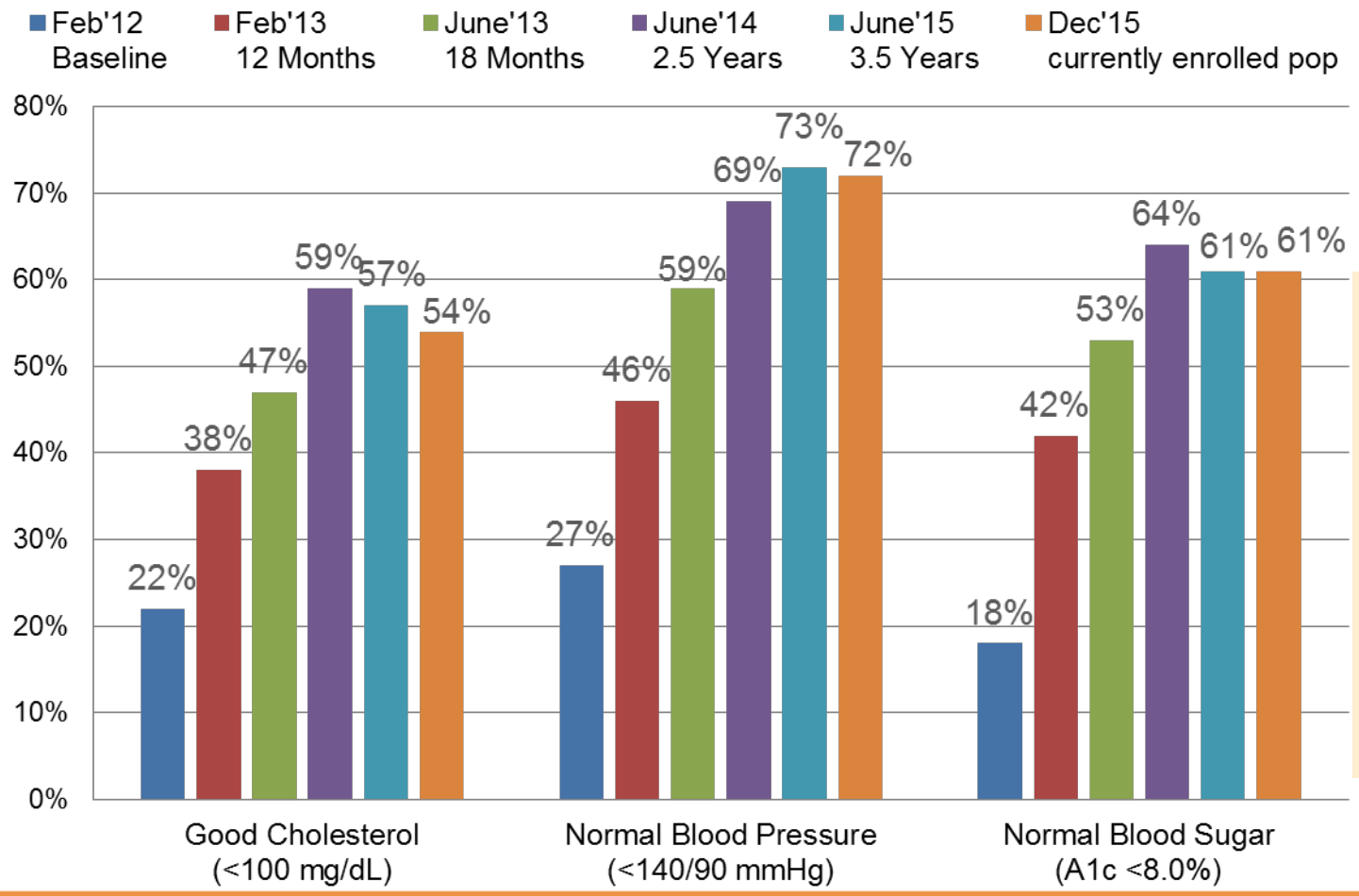




Hospital Follow-up Jan 2012 through July 2014



DIABETES

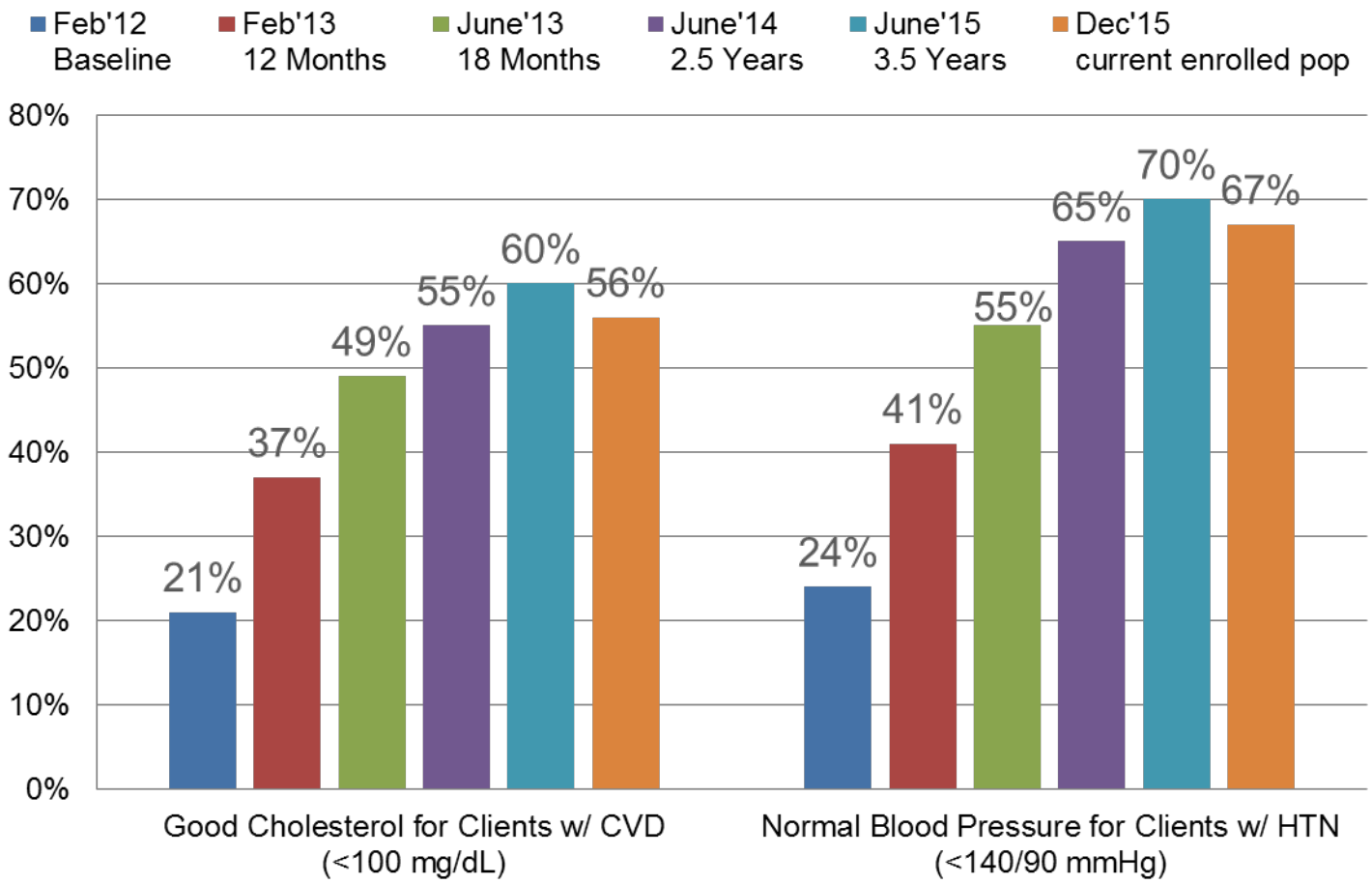


Adults continuously enrolled

N= 1,889 (at 3.5 years)

N= 4,526 (Dec 2015)

HYPERTENSION & CARDIOVASCULAR DISEASE



Adults continuously enrolled

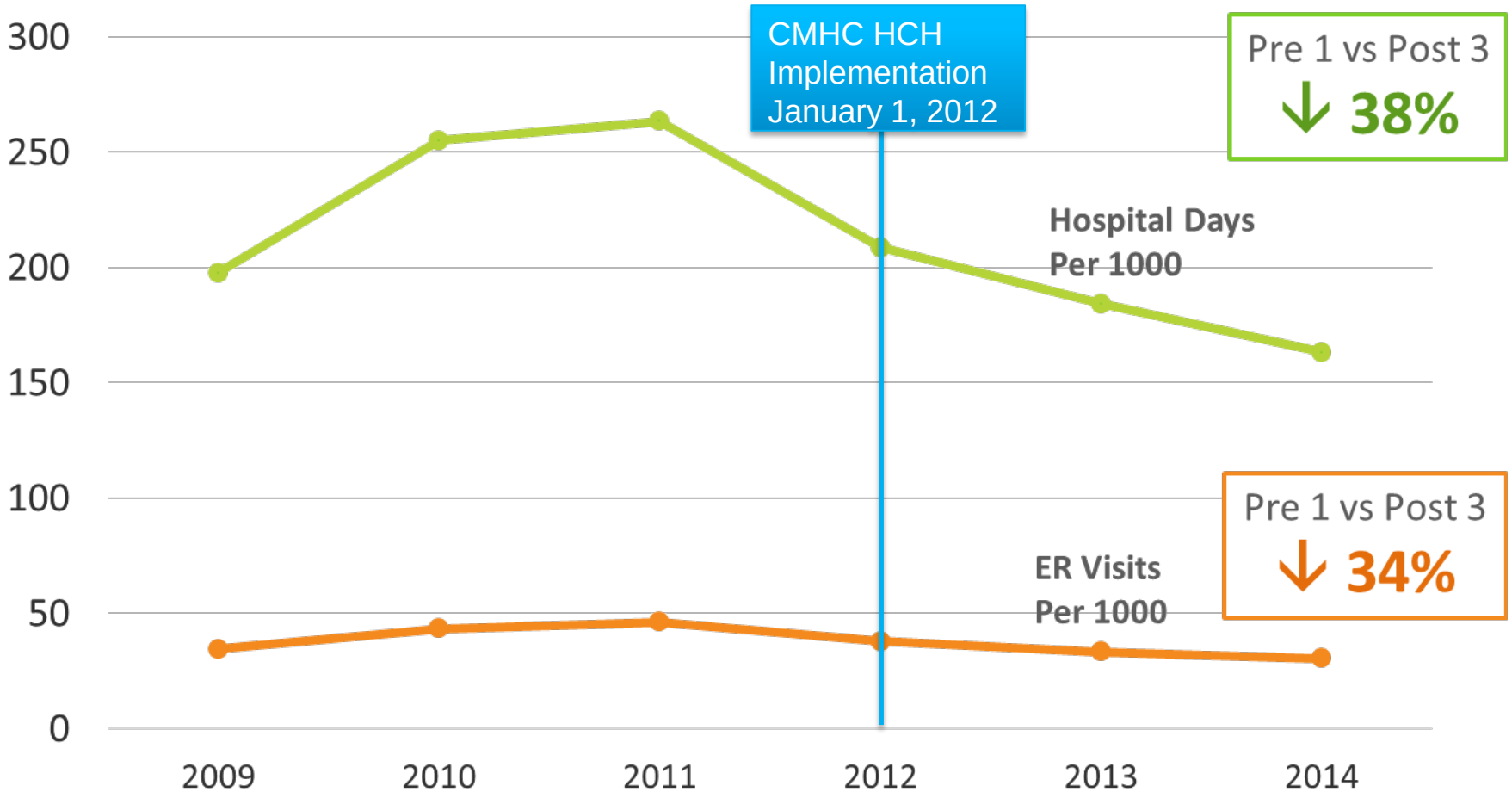
CVD N= 232 (at 3.5 years)

CVD N= 564 (Dec 2015)

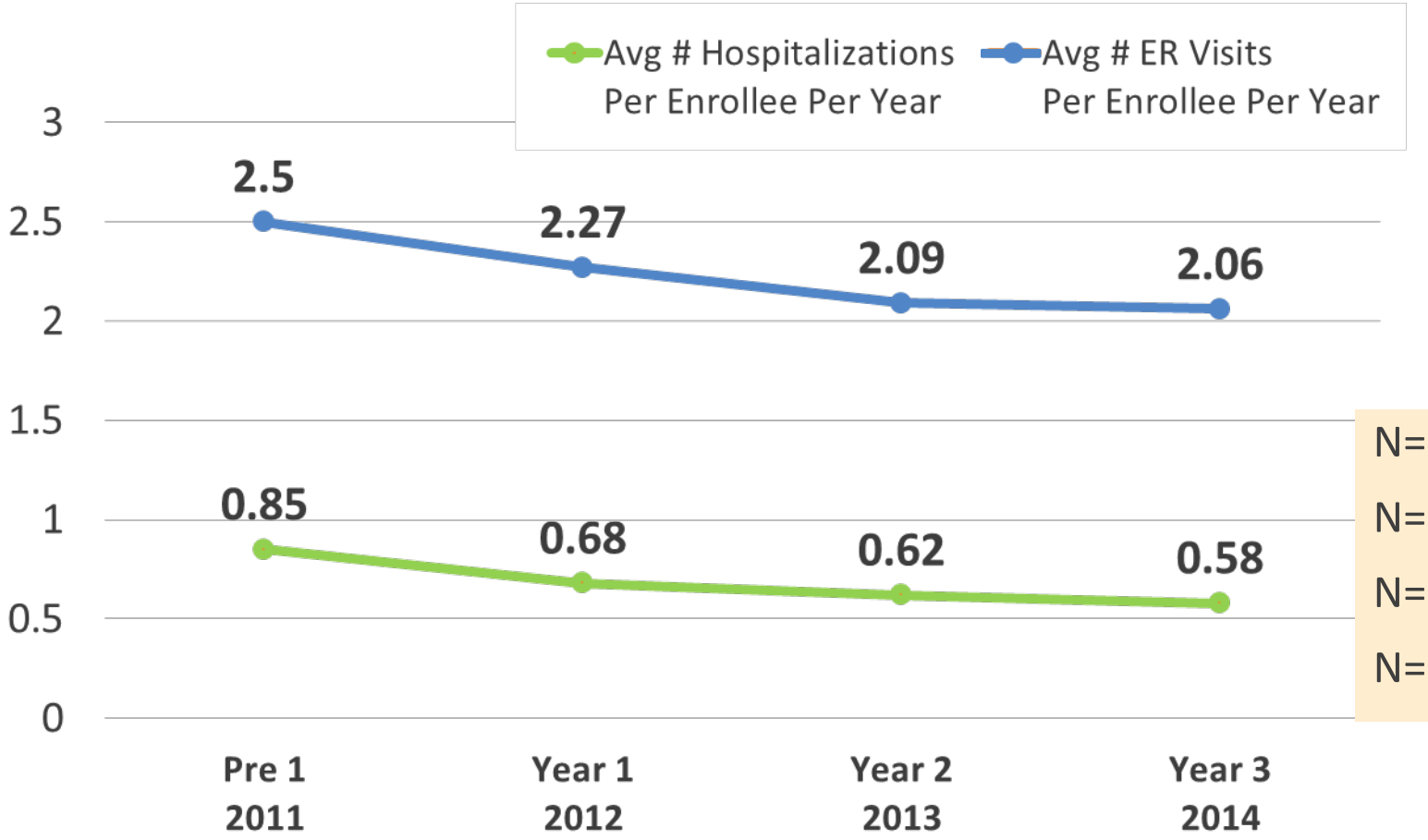
HTN N= 2,401 (at 3.5 years)

HTN N= 6,111 (Dec 2015)

ER & HOSPITAL DAYS PER 1,000



AVERAGE # OF ER & HOSPITAL ENCOUNTERS



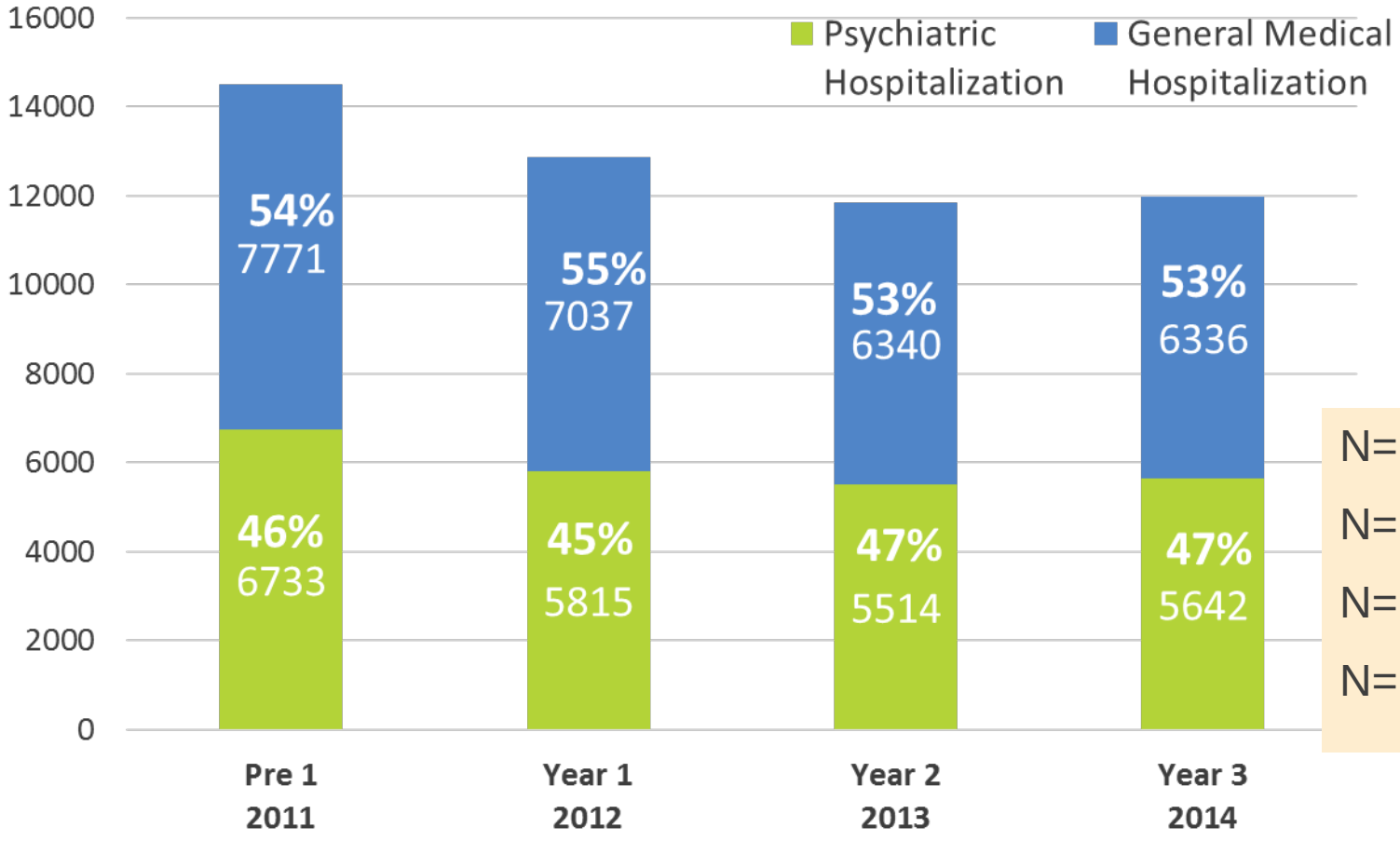
N= 17,084 (2011)

N= 18,776 (2012)

N= 19,103 (2013)

N= 20,345 (2014)

HOSPITAL ENCOUNTERS



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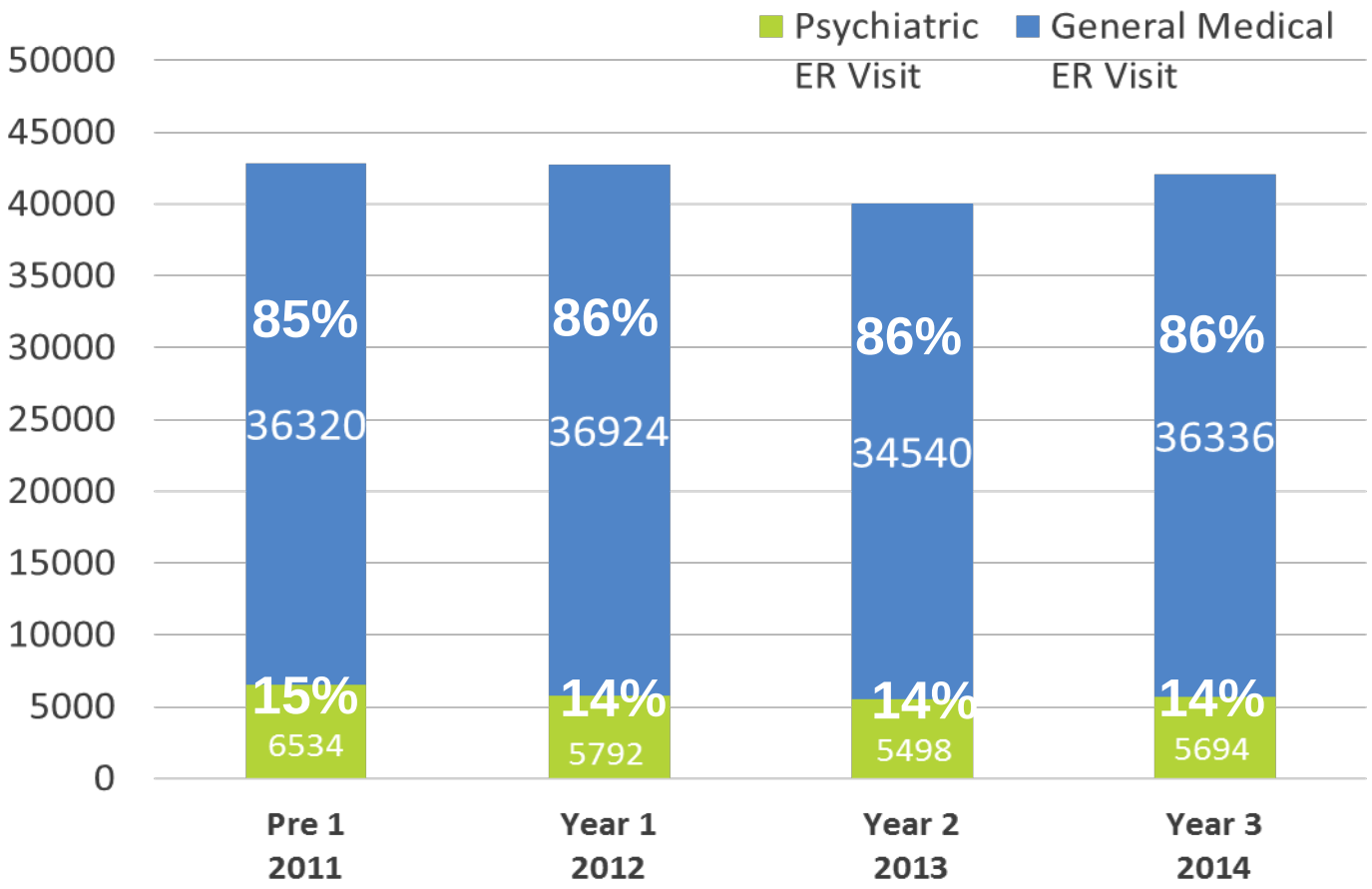
ER ENCOUNTERS



N= 17,084 (2011)

N= 18,776 (2012)

N= 19,103 (2013)

N= 20,345 (2014)

Cost Savings Year 1 (2012)

Health Homes have saved Missouri an estimated

$36.3 million

SAVINGS = $60 PMPM

Community Mental Health Center Healthcare Homes have saved Missouri

$31 million

SAVINGS = $98 PMPM

DM3700 subset saved

$22.8 million

SAVINGS = $395 PMPM
(4,800 lives)

Some Successful Approaches

- Convert some services funding into an ASO contract to help the state manage
- Use peer pressure to help the state manage your underperforming peers
- Write your BAAs very broadly
  - Many parties, not just two
  - Broad functions, not just one project
- Don’t confuse legal advice with court orders

High Impact Performance Indicators

- Medication Adherence
- Follow up after discharge
- Asthma
  - Being on inhaled corticosteroid
  - Adherence to inhaled corticosteroid
- Medication Assisted Treatment for SUDs

Some Successful Approaches

- Hot Spotting
- Convert some services funding into an ASO contract to help the state manage
- Use peer pressure to help the state manage your underperforming peers
- Write your BAAs very broadly
  - Many parties, not just two
  - Broad functions, not just one project
- Don’t confuse legal advice with court orders

What Makes it Possible?

- A Relationship of basic trust between:
  - Department of Mental Health
  - MO HealthNet (Medicaid)
  - State Budget Office
  - MO Coalition of CMHCs
  - MO 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

Provide Information to Other Healthcare Providers

- HIPAA permits sharing information for coordination of care
- Nationally consent not necessary
- Exceptions:
  - HIV
  - Substance abuse treatment – not abuse itself
  - Stricter local laws

DYSFUNCTION

THE ONLY CONSISTENT FEATURE OF ALL OF YOUR DISSATISFYING RELATIONSHIPS IS YOU.

Partnership 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

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

CHANGE

WHEN THE WINDS OF CHANGE BLOW HARD ENOUGH,
THE MOST TRIVIAL OF THINGS CAN TURN INTO DEADLY PROJECTILES.

Resources

NASMHPD Technical Reports

http://www.nasmhpd.org/publications/NASMHPDPublications.aspx

Healthcare Home Source documents page

http://dmh.mo.gov/mentalillness/introcmhchch.html

Missouri CMHC Healthcare Homes

http://dmh.mo.gov/mentalillness/mohealthhomes.html

Questions/Discussion

Next Steps…

- April Webinar will focus on Financing presenters will be from Cherokee Health Systems
- Get Ready for April/May Coaching Calls—schedule will go out next week
- Please be sure to fill-out the survey that will be sent following this webinar