# CCBHC-E National Training and Technical Assistance Center

*Population Health Management Series*

*Session 2*

July 27, 2023

CCBHC-E National Training and Technical Assistance Center

*Funded by Substance Abuse and Mental Health Services Administration and operated by the National Council for Mental Wellbeing*

# Acknowledgements and Disclaimer

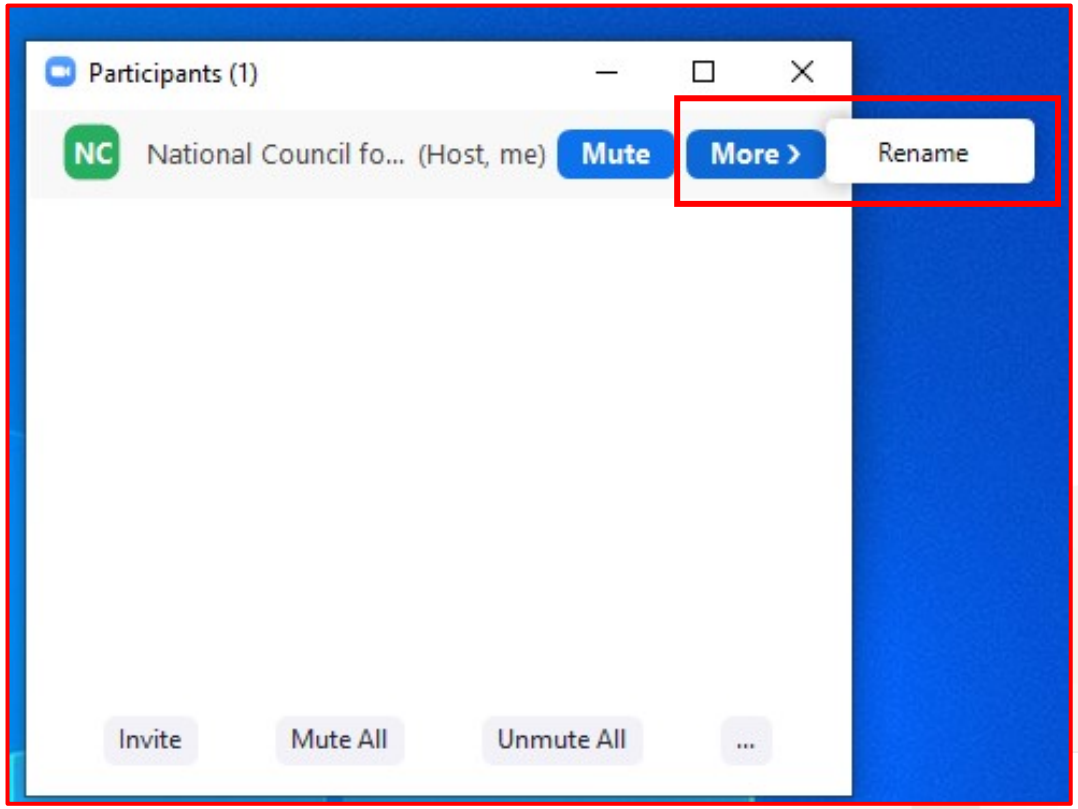
*This session was made possible by Grant Number 1H79SM085856 from the Substance Abuse and Mental Health Services Administration (SAMHSA). Its contents are solely the responsibility of the authors and do not necessarily represent the official views, opinions, or policies of SAMHSA, or the U.S. Department of Health and Human Services (HHS).*



NATIONAL COUNCIL for Mental Wellbeing

# Logistics

- **Please rename yourself so your name includes your organization.**
  - *For example:*
    - Blaire Thomas, National Council
  - *To rename yourself:*
    - Click on the **Participants** icon at the bottom of the screen
    - Find your name and hover your mouse over it
    - Click **Rename**
- If you are having any issues, please send a Zoom chat message to **Kathryn Catamura, National Council**

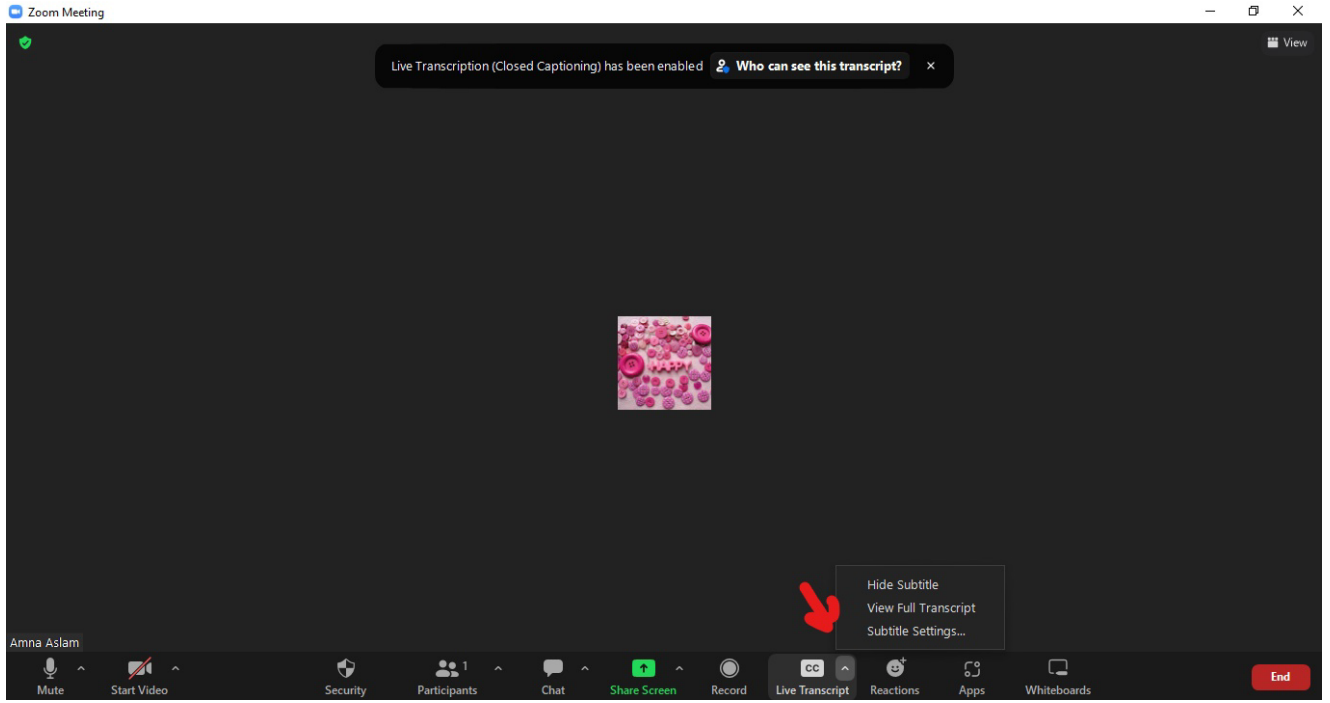





NATIONAL COUNCIL for Mental Wellbeing

# How to Enable Closed Captions (Live Transcript)

Next to “Live Transcript,” click the arrow button for options on closed captioning and live transcript.

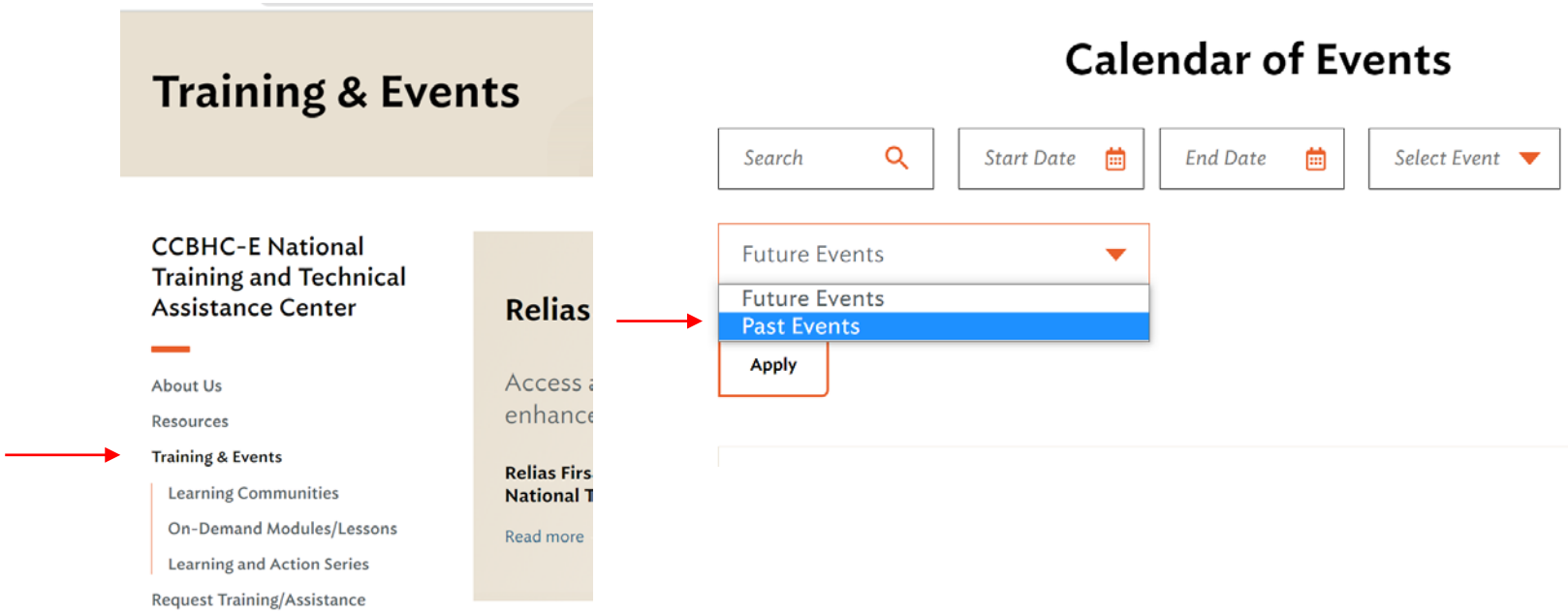





NATIONAL COUNCIL for Mental Wellbeing

# **Today's Session:** Slides and Recording

**Slides and the session recording link will be available** on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.






NATIONAL COUNCIL for Mental Wellbeing

# Today's Objectives

- Increase knowledge of how to engage in risk stratification
- Identify strategies for how risk stratification can address health disparities
- Explore health and wellness programs and resources



NATIONAL COUNCIL for Mental Wellbeing

# CCBHC Population Health Management Learning Series

Purpose

*Designed for CCBHC grantees interested in learning about the core principles of population health management (PHM). This series will build on the foundational concepts covered in the Optimizing Data Series, this series will expand and advance on effective PHM approaches and strategies to drive clinical care decisions focusing on topics including risk stratification to identify gaps in care, continuous quality improvement to identify and address health disparities and using advanced data analytics assess to patient needs and support.*



NATIONAL COUNCIL for Mental Wellbeing

# Population Health Management Learning Series

**Today's Session**

- Risk Stratification

**Next Session**

- *August 24, 2023 (from 3pm – 4:30pm ET)*: Preventative Healthcare and Predicative Data Analytics



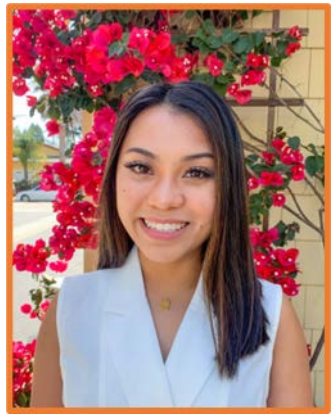
NATIONAL COUNCIL for Mental Wellbeing

# Your Learning Series Team

**Renee Boak, MPH**
Consultant and Subject Matter Expert

**Clement Nsiah, PhD, MS**
Director

**Blaire Thomas, MA**
Project Manager



**Kathryn Catamura, MHS**
Project Coordinator



NATIONAL COUNCIL *for* Mental Wellbeing

# Today's Presenters

**Renee Boak, MPH**
National Council, Coach and SME

**Jeff Capobianco, PhD**
National Council, Coach and SME

**Courtney Sheehan LPC**
CHR, Senior Program Director



NATIONAL COUNCIL for Mental Wellbeing

# Poll Questions

- Is your organization currently practicing risk stratification?
- What type of health and wellness supports is your organization offering (provide response options that include health and wellness groups- list details in chat-, care coordination with community wellness supports, other- insert in chat-, and not yet
- Has your CCBHC looked for disparities in how/which services are being accessed?



NATIONAL COUNCIL for Mental Wellbeing

# Recap: Elements of Population Health Management

1. Responsive to clients' preferences, strengths, abilities, needs, cultures and values
2. Data-driven population identification - uses data to identify characteristics, discover needs, and provide actionable steps
3. **Stratification (i.e., sorting) of the population based on client characteristics and needs**
   - **May change based on data or the individual's changing needs**
4. Delivery of culturally relevant interventions: prevention, treatment, referrals, and follow-up
   - Coordination with community providers and resources to meet needs
   - Consideration of CLAS standards
5. Measurement-based care/outcomes monitoring - examines the responsiveness to interventions and client experiences; drives the quality improvement process
6. Accountability for outcomes (e.g., value-based payment models)



NATIONAL COUNCIL *for* Mental Wellbeing

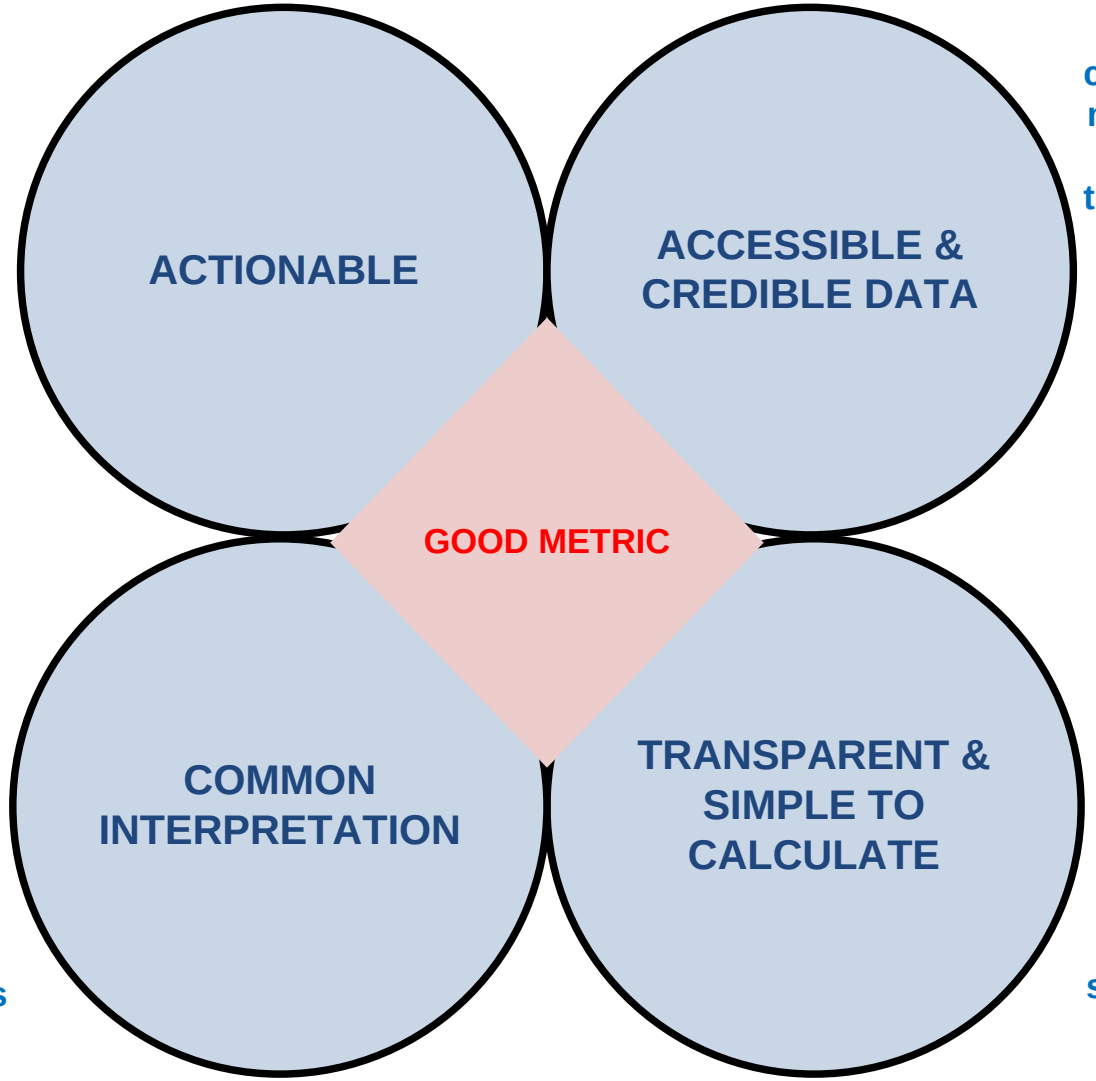
# Risk Stratification

The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs. For example, out of every 1,000 patients in a panel, there will likely be close to 200 patients (20%) who could benefit from more intensive support. This 20% of the population accounts for 80% of the total health care spending in the United States. Of these “higher need” patients, five percent (5%) account for nearly half of U.S. health expenditures. Health care spending for people with five or more chronic conditions is 17 times higher than for people with no chronic conditions.

- National Association of Community Health Centers (NACHC)

When metric changes the cause & required actions are clear

Data can be collected with modest effort from source that is trusted




Staff know what the metric means

Method for generating metric is shared & well understood

Data Fluency: Empowering your organization with effective data communication (2014). Gemignani, Gemignani, Galentino & Schuermann

# Risk Stratification: Concept & Practice

- Risk Stratification as a practice is continuous…meaning need assessment is ongoing with the goal of maintaining or improving wellness not reacting after stepped up care is needed.
- Studies have found the most expensive 5% of patients can be broken into three categories:
  1. One-time unanticipated events (35%)
  2. Chronic conditions related events to maintain wellness (35%)
  3. Preventable events (30%)
- For this reason it is imperative all staff who engage clients are assessing for risk factors. For example:
  - Organization screening for patients last urgent care/emergency department use since last visit
  - Using repeated measures to inform current risk status (e.g., PHQ9, Social Health Screens, etc.)
  - Using "no show" screeners to prevent no shows
  - Asking clients their opinion of their current health status.

Source: Managing the Most Expensive Patients A new primary-care model can lower costs and improve outcomes (2020) by Robert Pearl and Philip Madvig https://hbr.org/2020/01/managing-the-most-expensive-patients



NATIONAL COUNCIL for Mental Wellbeing

# Steps in Risk Stratification

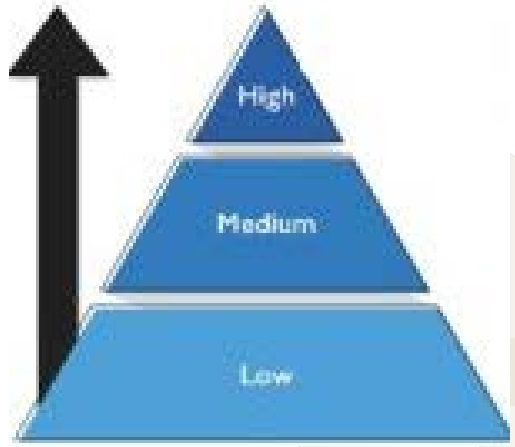
- **Step 1:** Compile a List of individuals receiving services; include individuals who are actively receiving services as well as anyone who is assigned (or authorized) but disengaged.
- **Step 2:** Sort individuals risk factors, or health status conditions
- **Step 3:** Stratify individuals receiving services to segment the Population into groups
- **Step 4:** Design population specific models of care and interventions; consider establishing cohorts of highly complex, high-risk, rising-risk, and low-risk



NATIONAL COUNCIL for Mental Wellbeing

# Risk Groups

- **Highly complex.** A small group of individuals, likely less than 5% of the population, with the greatest care needs. This group likely has multiple complex conditions that often include psychosocial barriers. Care models and interventions for this population require intensive and pro-active care management  emergency or unnecessary acute care services.
- **High-risk**. Individuals with multiple risk factors that when not managed, often result in transitioning into the highly complex population (about 20% of the population). This population of individuals benefit from structured case management and one on one support in management of medical, social, and care coordination needs.






NATIONAL COUNCIL for Mental Wellbeing

# Risk Groups (cont.)

- **Rising-risk.** A group of individuals who have one or more chronic conditions or risk factors, and who move in and out of stability with managing their condition(s). This population of individuals benefit from models of care that manage risk factors for more than one diagnosis or condition. Common risk factors include: obesity, smoking, and blood pressure.
- **Low-risk.** This population of individual who are stable or healthy with minor conditions that can be easily managed. The mode of care for this population aims to keep them healthy and engaged in the health care system.

REAL LIFE. REAL HOPE.

# Risk Stratification Model:
# Integrated Care Coordination (ICC)

Courtney Sheehan, LPC
Senior Program Director/CCBHC Project Director
Community Health Resources (CHR) Windsor, CT

- CHR is the most comprehensive, non-profit behavioral healthcare provider in Connecticut. **The first agency in CT to meet Certified Community Behavioral Health Clinic (CCBHC) standards.**
- Offering a wide range of personalized services for children, families and adults whose lives have been touched by mental illness, addiction or trauma.
- Our largest outpatient offices are in Manchester and Enfield, with smaller offices throughout central and eastern Connecticut and several community-based programs.
- **CHR's mission** is to help adults, children and families find **Real Hope** for the challenges of **Real Life** through an array of community- based mental health, substance use, child welfare, supportive housing, foster care, prevention and wellness services, and integrated care. Our name embodies our commitment to community-based care, instilling hope for a healthy, happy and productive future, and utilizing all available resources to achieve change. CHR is proud to provide services that achieve **Real Quality** with **Real Results**.
- Over 800 experienced professionals, including licensed therapists, psychiatrists, child psychiatrists, case managers, and people with lived experience who provide expert care to more than
- Serve 25,000 people each year, in a variety of urban, suburban and rural communities in 2/3 of Connecticut.
- Accredited by The Joint Commission, licensed by the state and have repeatedly been voted among the Top Workplaces in Connecticut by the *Hartford Courant*.

# CHR CCBHC Status

**2018**

- **CT FIRST;** CHR's first CCBHC grant funding. This enabled CHR to become the first agency in the state of Connecticut to meet CCBHC criteria. Opened on site specialized Primary Care services.

**2020**

- **CT NOW;** This critical CCBHC-E grant allowed us both expand and continue to provide all essential 9 Core CCBHC services during the pandemic.

**2022**

- **CT HOPE;** CCBHC IA funding to expand CCBHC services to rural and surrounding areas of Eastern Connecticut
- **CT ESSENTIAL;** CCBHC IA funding to support Improvement and Advancement of our CT NOW CCBHC work including participation in the Implementation Science Project (ISP)

# Overview: Child and Family Risk Stratification Model

**Purpose:**

As part of our CCBHC work we wanted to identify youth who were in ***highest need*** of Child and Family Integrated Care Coordination (ICC) Wraparound services.

**Process:**

A Child and Family committee met to define risk stratification criteria and review data along with the data support supervisor. We then provided the specifications to the IT department to design the report. We went through a process of refining the reports so they can be used across Child and Family Clinical programs.

**Results:**

Increased collaboration on high need cases, identification of youth who need to be re-engaged through the pandemic, and ultimately engaging youth and families in Integrated Care Coordination services. ***Over 80% of children and families involved in ICC services showed improved OHIO Scale Scores***

# Used Evidence-based approaches

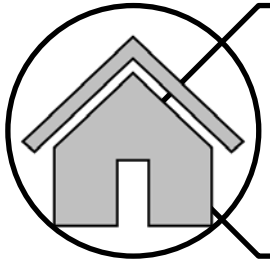
| | | |
|---|---|---|
| ACE's<br>Adverse Childhood Experiences training | Childhood Trauma Screen | Caregiver Strain Questionnaire (CGSQ) |
| Zero Suicide Protocol | Wraparound Model | Ohio Scales |

# Developed Risk Stratification Criteria

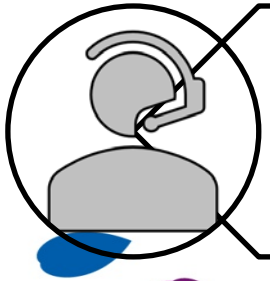
Tier I Highest Risk: Meets *all 3* criteria

Tier 2: Meets *any 1* of criteria

1 or more Emergency Department visits or inpatient stay 6 months prior to admission



1 or more Out of Home placement(s) in lifetime prior to admission

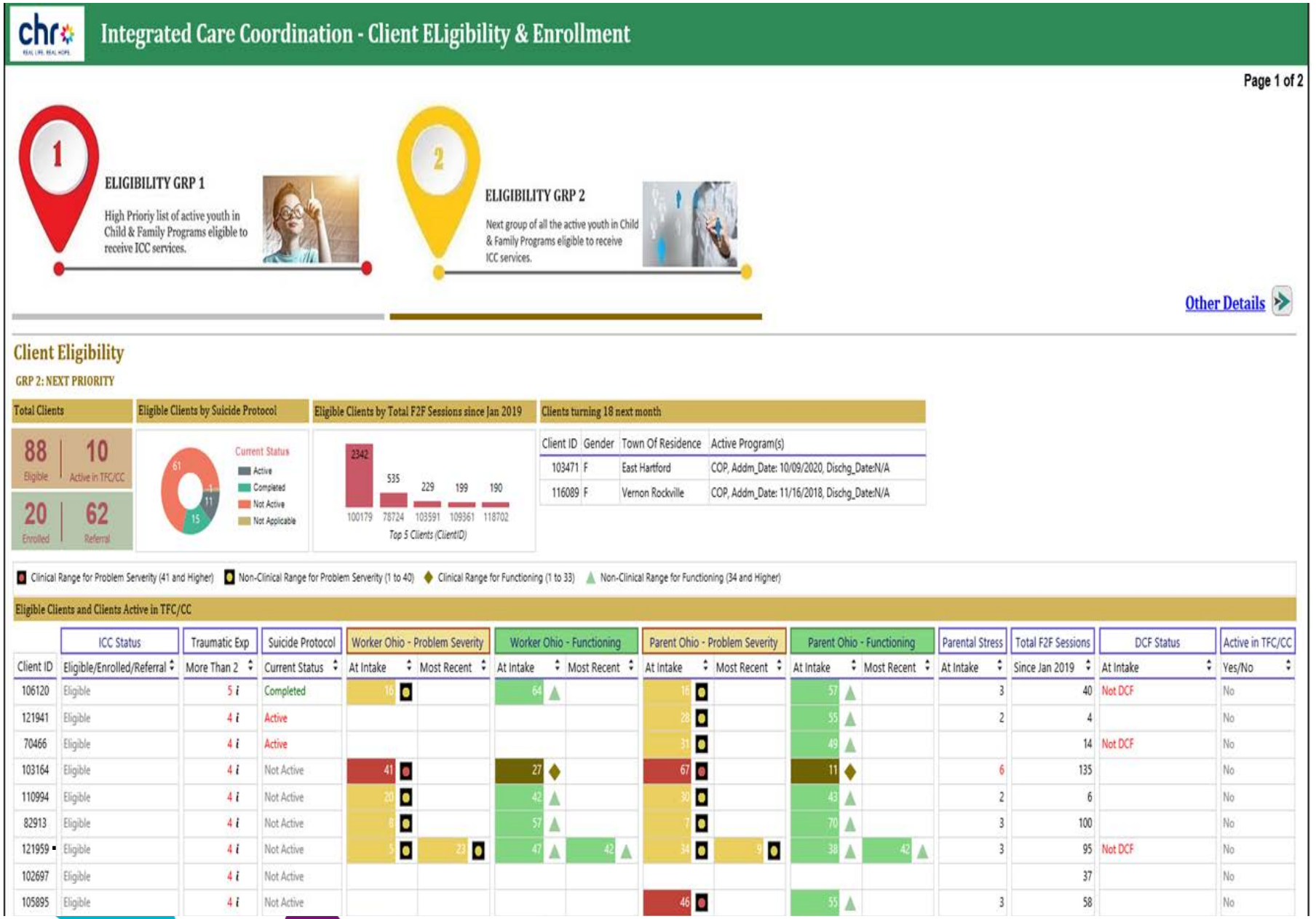


1 or more Crisis team visits

# Developed Report Specifications

- Age
- Town
- Suicide Protocol Status
- Primary Employee assigned
- Diagnoses
- Face to Face date and provider
- Physical Conditions at Intake
- Special Needs at Intake
- Parental Areas of need at Intake
- Type of traumatic experiences at Intake
- Number of traumatic experiences
- Current Treatment Teams
- ICC Engagement Status
- Treatment Foster Care (TFC) Status
- Care Coordination (CC) status
- Suicide Protocol Status
- Worker Ohio Problem Severity in clinical range >41
- Worker Ohio Functioning score in clinical range <33
- Parent Ohio Problem Severity in clinical range >41
- Worker Ohio Functioning score in clinical range <33
- Parental Stress measures “How much stress does the caregiver feel at the present time (1-6 scaling)
- Number of Face to Face visits
- Department of Children & Families (DCF) Status

# Finalized Report Format



# Integrated Care Coordination - Client ELigibility & Enrollment

Page 1 of 2

**1** **ELIGIBILITY GRP 1**

High Priority list of active youth in Child & Family Programs eligible to receive ICC services.

**2** **ELIGIBILITY GRP 2**

Next group of all the active youth in Child & Family Programs eligible to receive ICC services.

Other Details

## Client Eligibility

GRP 2: NEXT PRIORITY

**Total Clients**

| 88 | 10 |
|---|---|
| Eligible | Active in TFC/CC |
| 20 | 62 |
| Enrolled | Referral |

**Eligible Clients by Suicide Protocol**

Current Status: Active, Completed, Not Active, Not Applicable

61, 1, 11, 15

**Eligible Clients by Total F2F Sessions since Jan 2019**

| 100179 | 78724 | 103591 | 109361 | 118702 |
|---|---|---|---|---|
| 2342 | 535 | 229 | 199 | 190 |

Top 5 Clients (ClientID)

**Clients turning 18 next month**

| Client ID | Gender | Town Of Residence | Active Program(s) |
|---|---|---|---|
| 103471 | F | East Hartford | COP, Addm_Date: 10/09/2020, Dischg_Date:N/A |
| 116089 | F | Vernon Rockville | COP, Addm_Date: 11/16/2018, Dischg_Date:N/A |

Clinical Range for Problem Severity (41 and Higher) | Non-Clinical Range for Problem Severity (1 to 40) | Clinical Range for Functioning (1 to 33) | Non-Clinical Range for Functioning (34 and Higher)

**Eligible Clients and Clients Active in TFC/CC**

| | ICC Status | Traumatic Exp | Suicide Protocol | Worker Ohio - Problem Severity | | Worker Ohio - Functioning | | Parent Ohio - Problem Severity | | Parent Ohio - Functioning | | Parental Stress | Total F2F Sessions | DCF Status | Active in TFC/CC |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Client ID | Eligible/Enrolled/Referral | More Than 2 | Current Status | At Intake | Most Recent | At Intake | Most Recent | At Intake | Most Recent | At Intake | Most Recent | At Intake | Since Jan 2019 | At Intake | Yes/No |
| 106120 | Eligible | 5 | Completed | 16 | | 64 | | 16 | | 57 | | 3 | 40 | Not DCF | No |
| 121941 | Eligible | 4 | Active | | | | | 28 | | 55 | | 2 | 4 | | No |
| 70466 | Eligible | 4 | Active | | | | | 31 | | 49 | | | 14 | Not DCF | No |
| 103164 | Eligible | 4 | Not Active | 41 | | 27 | | 67 | | 11 | | 6 | 135 | | No |
| 110994 | Eligible | 4 | Not Active | 20 | | 42 | | 30 | | 43 | | 2 | 6 | | No |
| 82913 | Eligible | 4 | Not Active | 8 | | 57 | | 7 | | 70 | | 3 | 100 | | No |
| 121959 | Eligible | 4 | Not Active | 5 | 23 | 47 | 42 | 34 | 9 | 38 | 42 | 3 | 95 | Not DCF | No |
| 102697 | Eligible | 4 | Not Active | | | | | | | | | | 37 | | No |
| 105895 | Eligible | 4 | Not Active | | | | | 46 | | 55 | | 3 | 58 | | No |

# Established Workflows to Determine Eligibility for ICC Engagement

## Families currently receiving services

- Eligibility data pulled from EHR using risk stratification model. Added to ICC registry for staff to engage.

## New families entering services

- Intake screening
- EMPS (Emergency Mobile Psychiatric Services) screenings
- Multi-disciplinary Team meetings

# Lessons Learned

## 2 Risk tiers was key

- Stratifying risk in 2 Tiers allowed us to remain focused on prioritizing access for highest need children and the flexibility to balance overall utilization of program resources when we had capacity for more engagements.

## Comprehensive report specs beneficial

- Establishing comprehensive data points on our ICC report had multiple benefits. Including supporting staff efficiencies, strengthening measurement based-care and multi-disciplinary team approaches to care coordination and whole person care.

# Lessons Learned……

## Crisis as opportunity for growth

- Families were most receptive to seeking ICC around a crisis event. This was a beneficial engagement approach allowing us to meet families where they were at, and to provide helpful services during times of high family strain.

## LOS's were longer

- In order to serve as many families as possible, we aimed for an average 4 month LOS.  Once engaged, families preferred, or did better with longer LOS's. Longer lengths of stays were helpful as families were often addressing intergenerational trauma/ACE's.

# Lessons Learned….

## Flexibility = Strength

- Testing our data early on, and using a CQI approach throughout the project allowed us to adapt our risk criteria, workflows, engagement approaches, LOS's etc. to best serve program goals. Both our workforce and families benefited from our ability to adapt.

## Families did better with ICC services

- Integrated Care Coordination (ICC) serves were provided to 199 families with complex needs.  80% experienced improvements in OHIO Scales functionality scores and 82% experienced problem severity reductions AEB improved OHIO scale scores.

# Q&A

Questions or Collaboration?

Please reach out to csheehan@chrhealth.org

Courtney Sheehan, LPC
Senior Program Director/CCBHC Project Director
Community Health Resources (CHR) Windsor, CT

# Resources

- National Association of Community Health Centers' Risk Stratification
- Toolkit for Designing and Implementing Care Pathways
- Tobacco Control and Prevention Toolkit
- Understanding Motivational Interviewing and SBIRT in Tobacco Cessation Masterclass Workshop
- Journey to a Tobacco-free Certified Community Behavioral Health Clinic (CCBHC): A Conversation
- Incorporating Trauma-Informed Approaches in Tobacco Cessation Services
- Taking Mental Health and Substance Use Organizations Tobacco Free
- Taking Your Facility Tobacco Free
- Health Equity Toolkit
- A Toolkit to Advance Racial Health Equity in Primary Care Improvement



NATIONAL COUNCIL for Mental Wellbeing

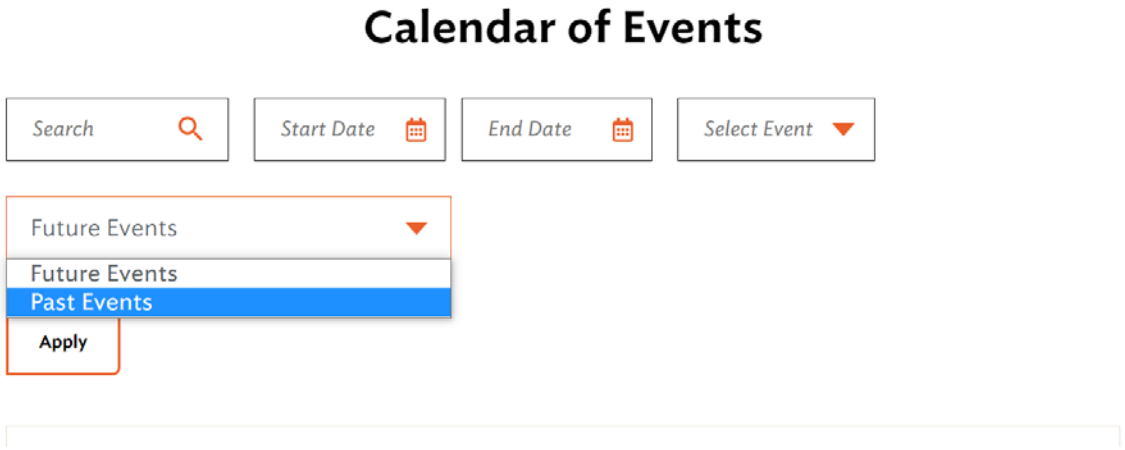
# Closing

- Next Session: *August 24, 2023 (from 3pm – 4:30pm ET)*: Preventative Healthcare and Predicative Data Analytics

# Thank You!

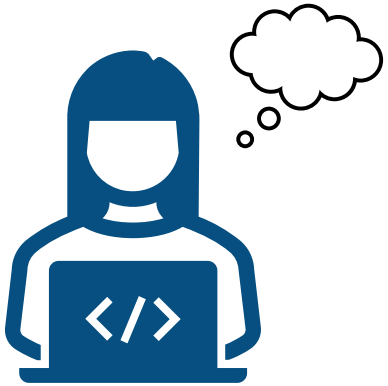
**Thank you for attending today's event.**

Slides and the session recording link will be available on the CCBHC-E NTTAC website under "Training and Events" > "Past Events" within 2 business days.




**Your feedback is important to us!**

Please complete the brief event survey that will open in a new browser window at the end of this meeting. Your input helps us improve our support offerings and meet our SAMHSA data metrics.





NATIONAL COUNCIL for Mental Wellbeing