The simple story of people with BH disorders

- They die on average 25 years earlier than those that don’t have BH disorders
  - Average life span is US
- Lack of integrated care results in poorer outcomes
- They cost the systems tons and tons of money (see next slide)
- Comparatively speaking….They lead a reduced quality of life
  - it could be so much better if we were all more effective
“Super-utilizers” of healthcare - people with complex physical health, behavioral health, and social issues who have high rates of utilization for ER and hospital services.

- More than 80% of Medicaid super-utilizers have a comorbid mental illness.
- An estimated 44% of “super-utilizers” have a serious mental illness

- 5% of the US pop accounts for 49% of healthcare spending (Ave. $43,212 expense/person/year)
- 50% of the US pop accounts for just 3% of healthcare spending (Ave. $253 expense/person/year)
Possible Solutions / Strategies

- Have to reform the healthcare delivery system

- DSRIP – Delivery System Reform Incentive Payments – a multi-year (stepped approach) initiative to walk the healthcare system through major changes (Year 1-5)

- The strategy is to use payment levers to improve (Medicaid) behavioral health outcomes, encourage integration with physical health, and decrease unnecessary utilization and spending.
  - The goals are that we use resources more efficiently and effectively and people actually get better and they stay better.
VBC Payment Model – Triple Aim

Value-Based Care Payment Model

- Improve Quality
- Enhance Patient Experience
- Lower Overall Costs of Care

Reimbursement from Payer
"I'm not telling you it's going to be easy - I'm telling you it's going to be worth it."

-Art Williams
How to monitor – our data and PSYCKES data --- and, what to monitor – how are these metrics actually defined:

- **Diabetes screening** for individuals with schizophrenia and/or bipolar using antipsychotic meds – HbA1C testing
- **Diabetes monitoring** for individuals with schizophrenia – HbA1C and LDL testing
- **CVD Monitoring** individuals with Schizophrenia and CVD – LDL testing
- **Follow-Up After Hospitalization** for mental illness within 7 Days / 30 Days – linkage within 7 days, if not 7 then 30
- **Anti-psychotic med adherence** for individuals with schizophrenia – dispensed & remained on med > 80% of their TX episode
- **Antidepressant Med Mgmt. (Acute)** – DX Major Dep / new antidepressant / % remain on med > 84 days
- **Antidepressant Med Mgmt. (Chronic)** – (continuation from above measure) DX Major Dep / % remain on med > 180 days
- **Engagement in SUD TX**
  - New episode of care - % that initiate TX within 14 days of DX of PS1 or if coming from bedded program w/14 days of dc
  - Engagement of AOD TX - % that had 2 or more additional services of AOD TX within 30 days of the initiation visit (PS1)

- **SUD TX Initiation** (14 days), **Engagement** (30 days), **Retention** (180 days)
- **Others to come in future likely**
  - Hep C testing / counseling offered
  - HIV testing / counseling offered
  - F/U TX after withdrawal services
  - MAT access and Rx

- Already a metric for SUD

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**Metrics/Goals Defined – State Level**

- **Hep C testing**
- **HIV testing**
- **F/U TX after withdrawal services**
- **MAT access and Rx**

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**Horizon Health Services**
Organizational Change Efforts

- Changes put into place throughout entire organization to improve patient outcomes and measure performance

- IT and Data
- Clinical education and training
- Operational Changes

Horizon Health Services
Behavioral Health Screening Measures

**Data / IT**
- Added flags in Cerner for tracking
- Enhanced medical assessment in chart to include CVD/DM screening
- Developed tagging system in Cerner for on-going tracking and future notification capability

**Clinical Education & Training**
- RN’s retrained to increase blood draw competency
- Medical education handouts and protocol developed for patient education regarding importance of screenings, risks...
- HealtheLINK retraining for staff for patient look-up and review of clinical record

**Organizational**
- Hired phlebotomist for on-site blood draws, now available at all sites
- Began ensuring linkage with health homes and primary care services
- Developed Provide written lab requisition for clients who prefer to go to an outside lab
- Developed workflows and clinical interventions for normal/abnormal results
PDSA

- Orders were being written and given to patients for community blood draws...completion of lab work was very low
  - contracted on-site phlebotomist
- Horizon nursing staff uncomfortable with performing blood draws
  - Retrained staff to improve competency and comfort
- Lab work completed outside of Horizon, no record in Horizon EHR
  - Staff trained on HealtheLINK patient look-ups to improve clinical record and prevent duplicative testing
Medication Adherence Measures

- Have adopted similar data tracking, clinical education and organizational changes to apply to antipsychotic and antidepressant medication adherence improvement

- Working to establish relationships and protocols for home delivery with community pharmacies for “tagged” patients

- Working with community pharmacies to obtain information regarding patient medication data
On-going tracking is vital

- PSCYKES data sets used to track overall performance, as well as provide individual patient information for each flagged measure
- Data lag remains a large barrier for timely implementation of relevant programs to flagged patients
- Patient attribution also a barrier when tracking organizational performance

<table>
<thead>
<tr>
<th>DSRIP Indicator Compliance vs Baseline</th>
<th>DOH QARR 5/1/17 (pulled Nov 17)</th>
<th>DOH QARR 6/1/17</th>
<th>DOH QARR 7/1/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1: Diabetes Screening</td>
<td>Eligible = 747</td>
<td># with QI Flag = 173</td>
<td>% Compliance = 76.84%</td>
</tr>
<tr>
<td>Indicator 2: Diabetes Monitoring</td>
<td>Eligible = 74</td>
<td># with QI Flag = 19</td>
<td>% Compliance = 74.32%</td>
</tr>
<tr>
<td>Indicator 3: Cardiovascular Monitoring</td>
<td>Eligible = 9</td>
<td># with QI Flag = 2</td>
<td>% Compliance = 77.78%</td>
</tr>
<tr>
<td>Indicator 4: Adherence to Antipsychotic</td>
<td>Eligible = 339</td>
<td># with QI Flag = 193</td>
<td>% Compliance = 43.07%</td>
</tr>
<tr>
<td>Indicator 5: Antidepressant</td>
<td>Eligible = 562</td>
<td># with QI Flag = 249</td>
<td>% Compliance = 55.69%</td>
</tr>
</tbody>
</table>

Note: Open* = clients with an active assignment during the month the data was pulled (sept, oct, nov)
7 and 30 day MH Follow-up

- Developed warm hand-off procedures with local inpatient BH services
- Established relationship manager contact for hospital discharge planners to facilitate connection, patient-centered scheduling and barrier reduction
- Began pilot of home visits for “flagged” patients with history of missed appointments
- Created PS1 report for better monitoring of all incoming referrals
We have a responsibility to effect change

- Can no longer do singular interventions – one patient/one therapist
- Has to be collaborative care \textit{expanded}
- = Organizational teams (counselors/medical staff, etc.) \textit{WITH ALL STAKEHOLDERS:}
  - Patient, Family, HH, HMO, PC, Hospital, etc.
- No longer relying on deficit funding and/or FFS or Single Payment model
- Unless we all do well, nobody does well, including the patient!
IF YOU LISTEN TO YOUR BODY WHEN IT WHISPERS, YOU WONT HAVE TO HEAR IT SCREAM.
Diabetes – Type II

Combined metabolic characteristics which predispose a person to Diabetes and CVD

- Elevated waist circumference
- Men > 40”, Women > 35”
- Elevated triglycerides > 150
- Elevated fasting glucose > 100, and/or HgbA1c >6
- Elevated LDL > 100
Cardiovascular Disease (CVD)
Risk factors for Diabetes and CVD

- Family History
- Overweight/Obesity
- Sedentary Lifestyle
- Smoking
- MENTAL ILLNESS
- Certain medications
- HTN

Over 90% of this risk is attributed to *life-style factors that can be modified*, for example: obesity, smoking, adherence to TX plan.

Some antipsychotic medications are linked to increased risk of Diabetes/CVD
- most likely d/t high risk lifestyles and side effects of obesity related to medications
Intervention Objectives:

- Identify individuals who are high risk for, or who currently have diabetes and/or CVD.
- Educate
  - Discussing the importance of ongoing testing of HbA1c and LDL.
  - What are those tests and why are we asked to monitor?
HbA1c and LDL blood tests

- The HbA1c test (also known as “A1c”), is a blood test that correlates with a person’s average blood glucose level over a span of a few months (usually 3 mo).
  - It is used as a screening and diagnostic test for pre-diabetes and diabetes.

- LDL cholesterol (also known as “bad” cholesterol). Elevated levels are associated with increased risk of heart disease.
Talking points

- Asking/encouraging patients to get these tests is the same as talking to them about obtaining their lithium levels or getting a TB test, or tested for Hep C or STD’s….or, or, or….

- Knowing this information can help us better structure interventions that promote their wellbeing
DSRIP-(Delivery System Reform Incentive Payment Program)

- the purpose is to fundamentally restructure the health care delivery system, with the primary goal of reducing avoidable hospital use by 25% over 5 years.

- BH organizations have to broaden/expand reach into physical health arena
The mind and body are not separate. What affects one, affects the other.
Team Work! Collaboration!

SU/MH Clinician and Team
Residential Services
CCS
Administrative Team
Mental Health Team
Family
Parent Family Support Coordinator
MAT/Psyh Services
Health Homes
Facilities
Medical
SU/MH Patient
Reminder: The simple story of people with BH disorders

- They die on average 25 years earlier than those that don’t have BH disorders
  - Average life span is US is 79.8 years
  - = People with BH D/O’s are dead by age 55
- Lack of integrated care results in poorer outcomes
- They cost the systems tons and tons of money (see slide 3)
- Comparatively speaking….They lead a reduced quality of life
  - it could be so much better if we were all more effective
OPPORTUNITY
OPPORTUNITY!!!

- Organizations must be leaders in high quality and evidence based care

- We have an obligation and an opportunity to increase our effectiveness and help our patients achieve overall improved health.

- To influence and transform how healthcare is delivered

- To help create a part of the healthcare system that is truly better
  - for our patients
  - for our communities
  - for us