Healthcare Reform: Service Delivery Restructure

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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

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The Problem

"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)

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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.

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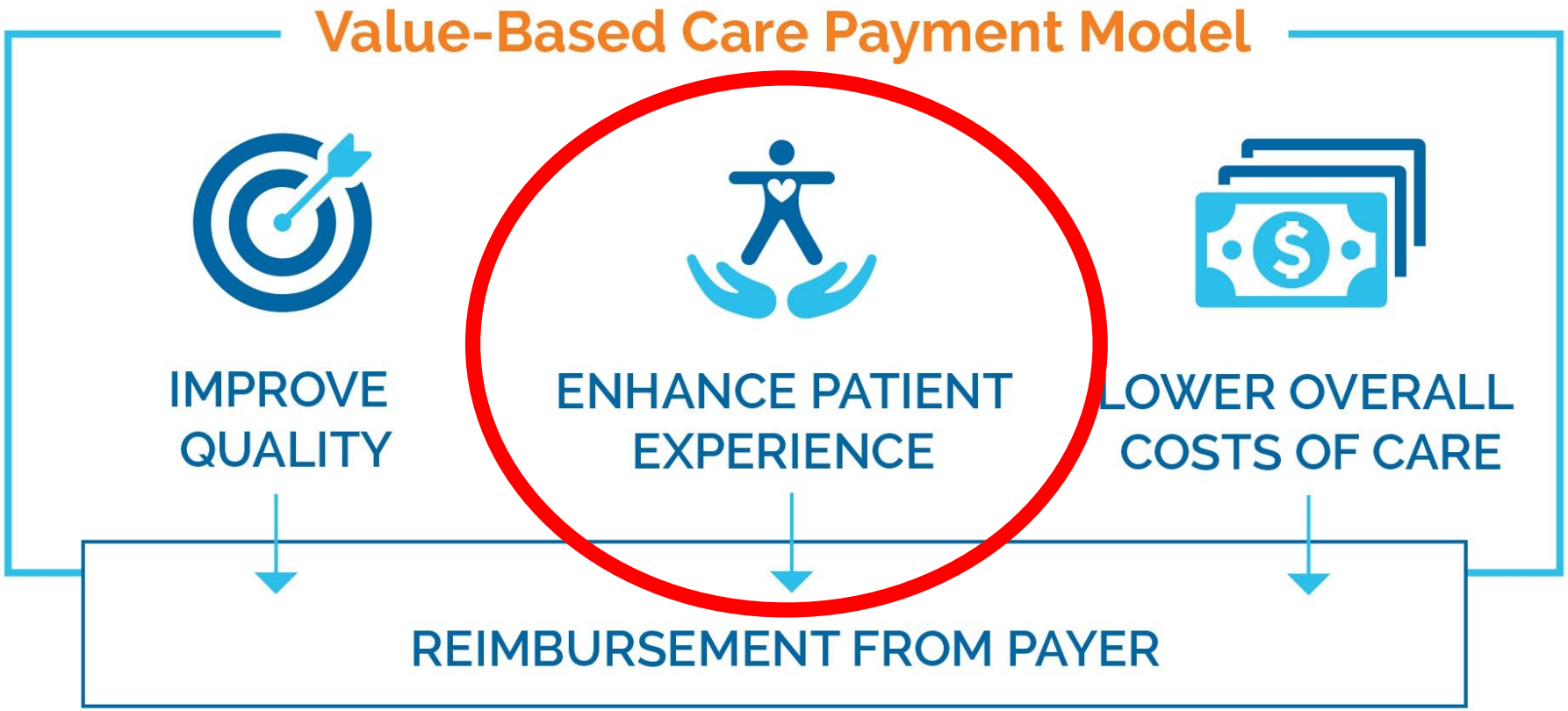
VBC Payment Model – Triple Aim



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"I'm not telling you it's going to be easy - I'm telling you it's going to be worth it."
-Art Williams

advance healthcare | SHOP

Metrics/Goals Defined – State Level

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

- **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

- 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)**

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Organizational Change Efforts

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

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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

Using data to drive system change

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

Week beginning	Patients in Diagnostic pool per PSYCKES/QARR	Patients not screened in over one year(=flagged)	Patients in need of screen actively enrolled	# of Lab Orders written and given to cts	Labs Completed	Labs still needed	Non-Compliance with Measure per PSYCKES	Regional %	Statewide %
12/17/2017	750	165	96		0	96	23.07%	23.40%	20.56%
12/24/2017	750	165	96		2	94	23.07%	23.40%	20.56%
12/31/2017	750	165	91	5	2	89	23.07%	23.40%	20.56%
1/7/2018	747	168	91	23	2	89	23.16%	23.55%	20.54%
1/14/2018	747	168	89	38	0	89	23.16%	23.55%	20.54%
1/21/2018	747	168	89	41	2	87	23.16%	23.55%	20.54%
1/28/2018	747	168	89	35	1	88	23.16%	23.55%	20.54%
2/4/2018	774	194	108	38	3	105	23.00%	23.50%	20.44%
2/11/2018	774	194	95	46	2	93	23.00%	23.50%	20.44%
2/18/2018	774	194	95	46	2	93	23.00%	23.50%	20.44%
2/25/2018	774	194	95		1	94	23.00%	23.50%	20.44%
3/4/2018	764	174	96		1	95	22.77%	23.07%	20.42%
3/11/2018	764	174	94		1	93	22.77%	23.07%	20.42%
3/18/2018	764	174	93		0	93	22.77%	23.07%	20.42%
3/25/2018	764	174	93		2	91	22.77%	23.07%	20.42%
4/1/2018			92		1	91			
4/8/2018			91		1	90			
4/15/2018			90		2	88			
4/22/2018			90		0	90			
4/29/2018			90		0	90			
5/6/2018			90		34	56			
5/13/2018			91		34	57			
5/20/2018			91		34	57			
5/27/2018			91		34	57			
6/3/2018	766	182	128		34	94	23.76%	22.95%	19.97%
6/10/2018	766	182	128		34	94	23.76%	22.95%	19.97%

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

DSRIP Indicator Compliance vs Baseline	DOH QARR 5/1/17 (pulled Nov 17)				DOH QARR 6/1/17				DOH QARR 7/1/17			
	Eligible	# with QI Flag	% Compliance	Open*	Eligible	# with QI Flag	% Compliance	Open*	Eligible	# with QI Flag	% Compliance	Open*
Indicator 1: Diabetes Screening	747	173	76.84%	110	774	178	77.00%	102	764	174	77.23%	103
Indicator 2: Diabetes Monitoring	74	19	74.32%	11	72	18	75.00%	12	73	19	73.97%	10
Indicator 3: Cardiovascular Monitoring	9	2	77.78%	1	7	2	71.43%	1	5	1	80.00%	1
Indicator 4: Adherence to Antipsychotic	339	193	43.07%	146	342	190	44.44%	137	333	185	44.44%	144
Indicator 5: Antidepressant	562	249	55.69%	92	583	252	56.78%	97	581	260	55.25%	124

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 **EXPANDED**
- = Organizational teams (counselors/medical staff, etc.) *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!

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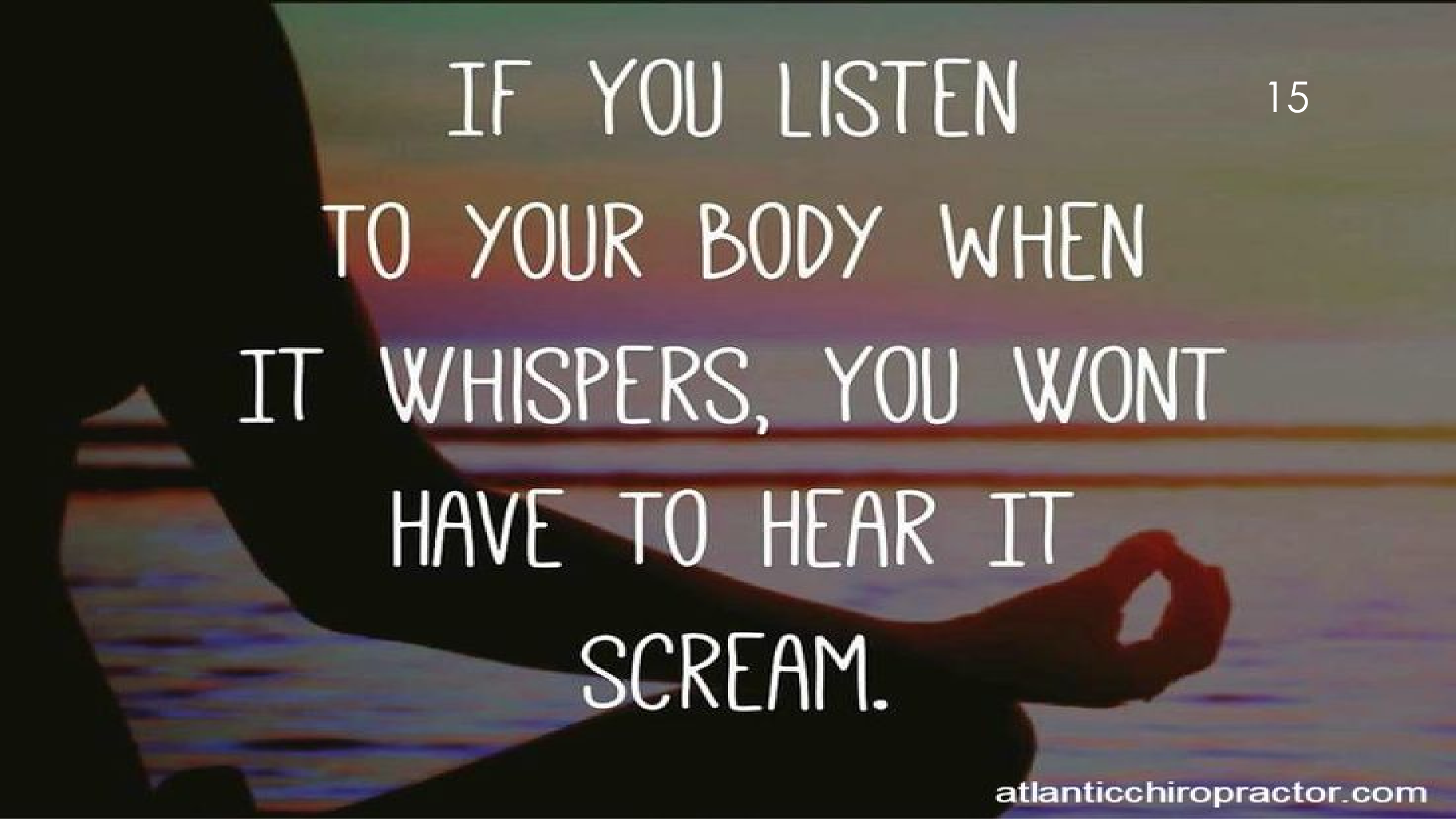
IF YOU LISTEN
TO YOUR BODY WHEN
IT WHISPERS, YOU WONT
HAVE TO HEAR IT
SCREAM.
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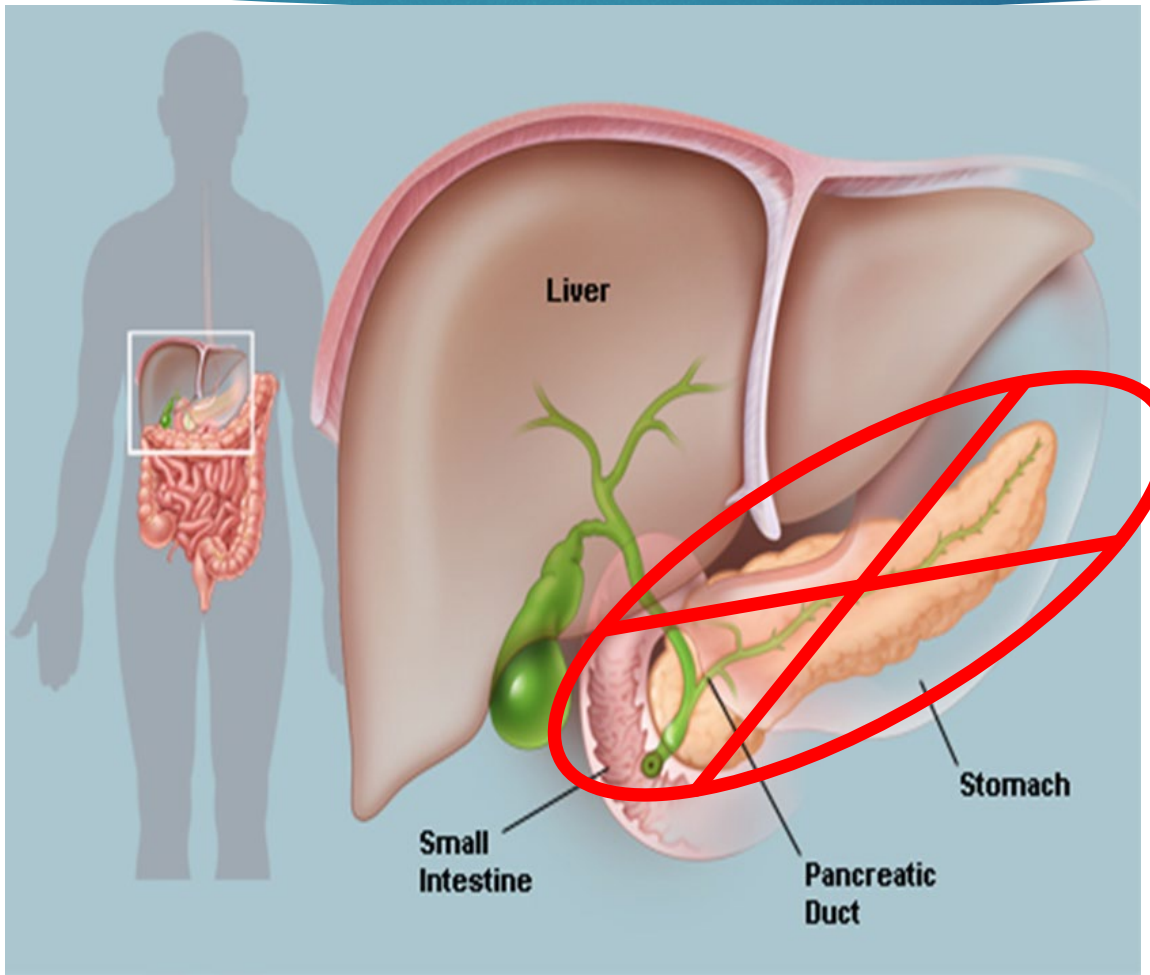
Diabetes – Type I

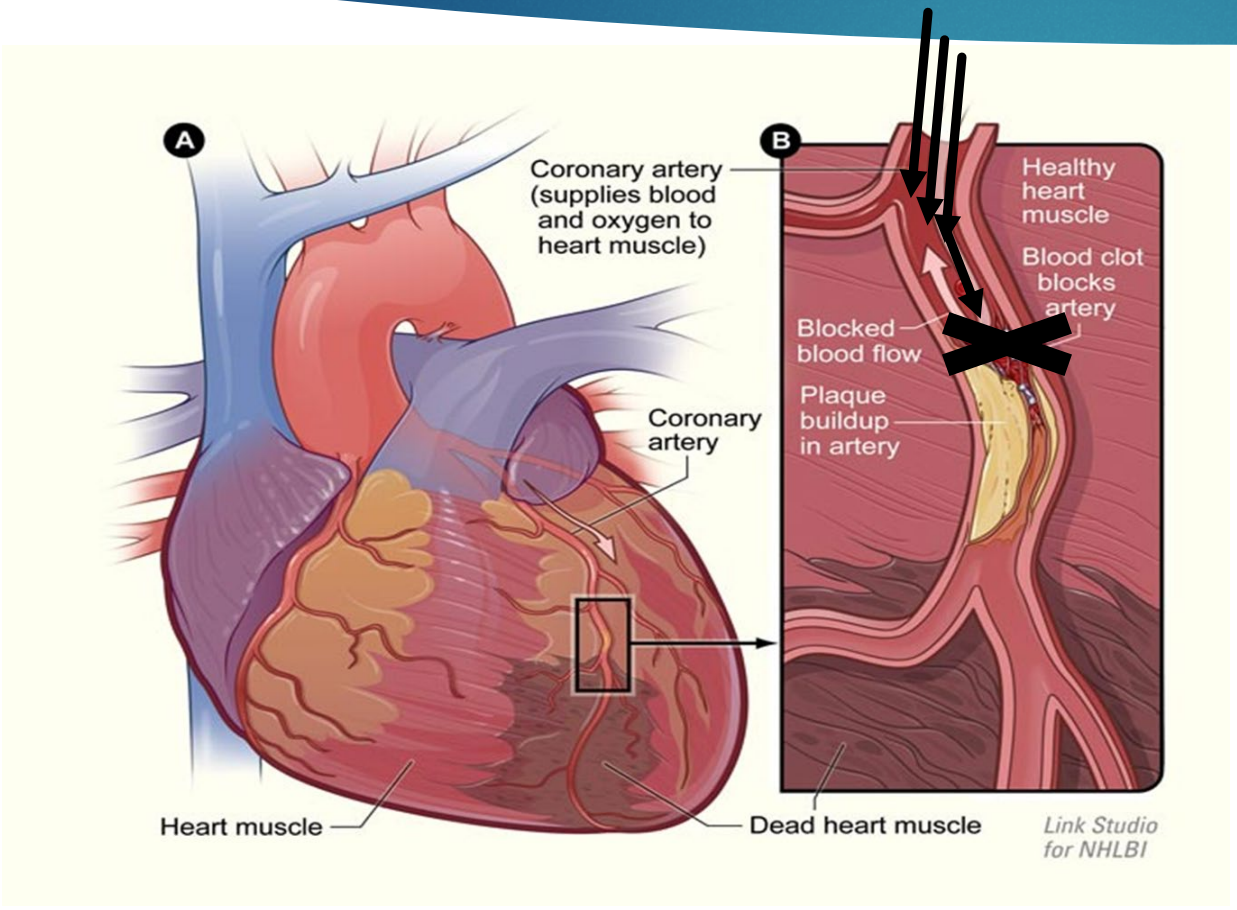


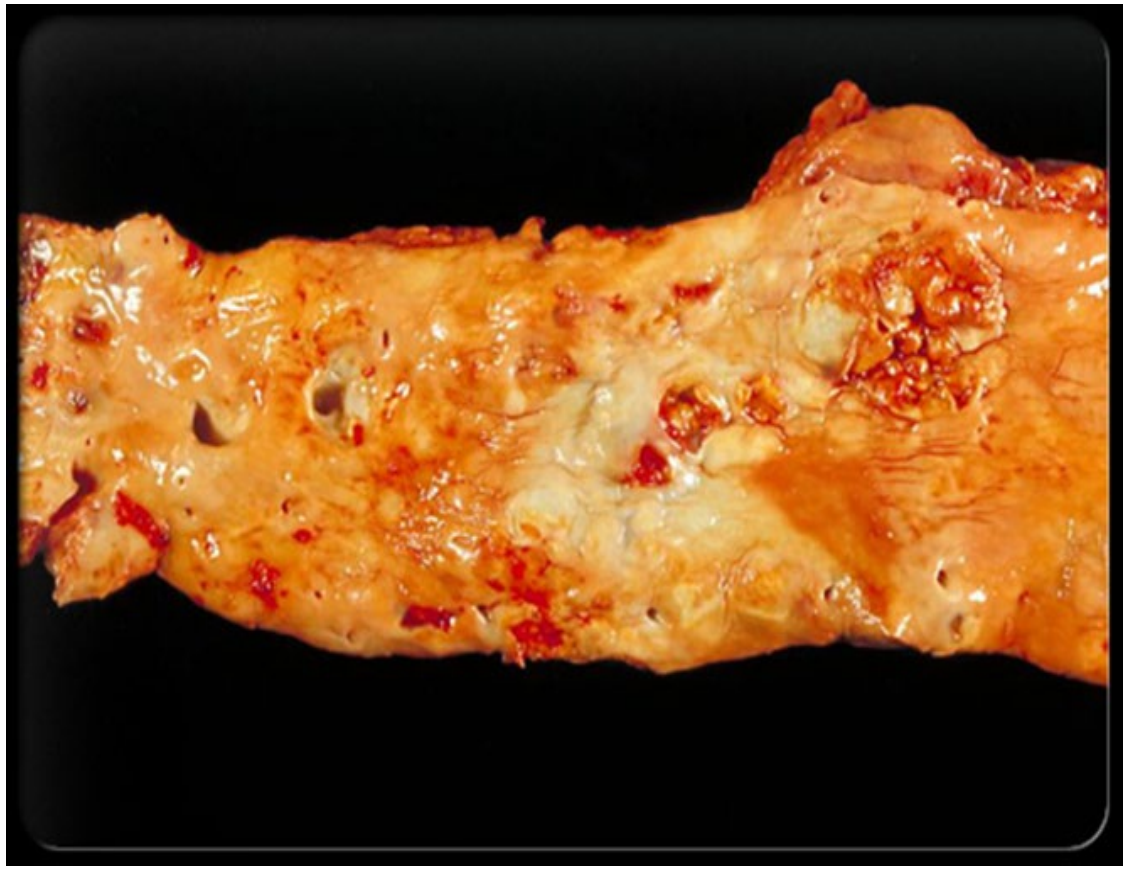
Diabetes – Type II

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?

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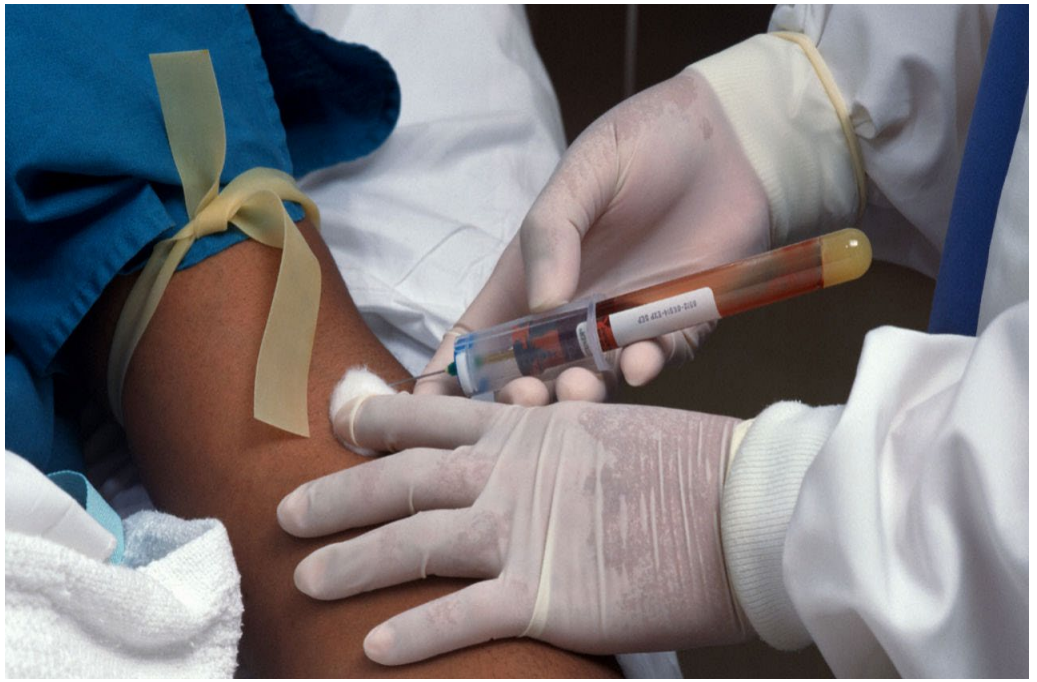
HbA1c and LDL blood tests

- 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.



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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

How it lands on your desks in the programs…

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

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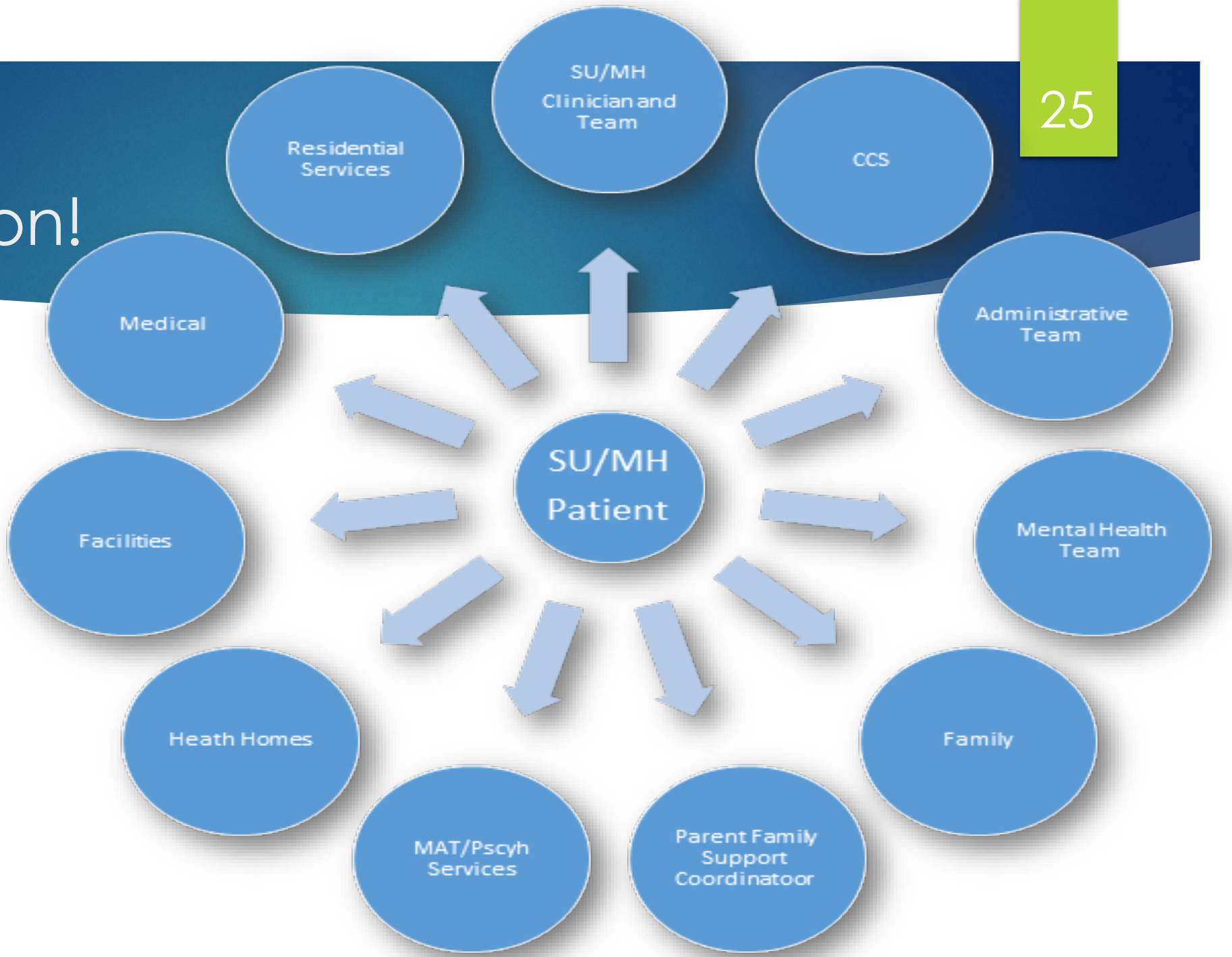
“

The mind and body are not separate. What affects one, affects the other.

”

Team Work! Collaboration!



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

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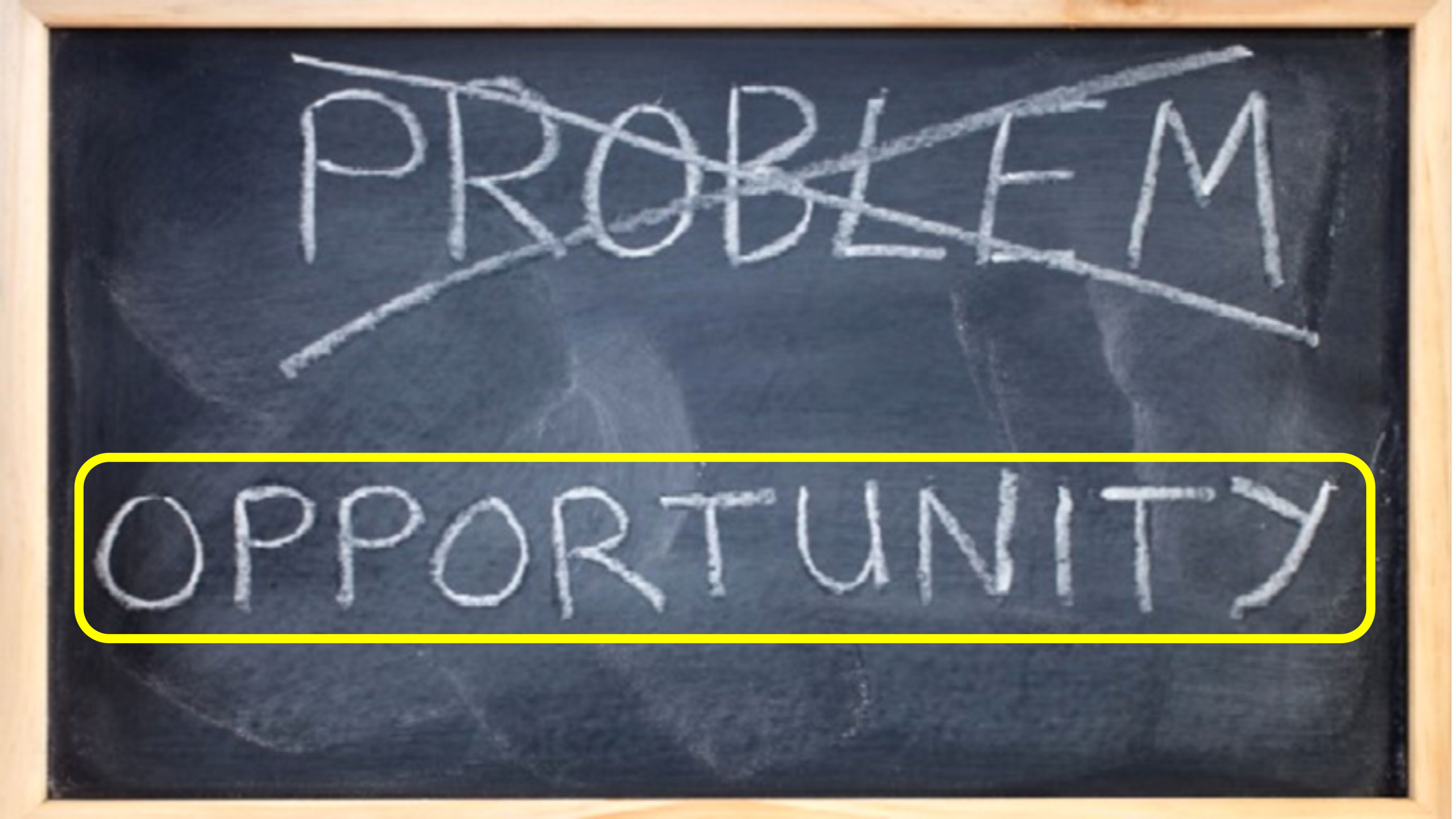
PROBLEM
OPPORTUNITY

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*

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