How Can Population Based Care Models Be Applied to Improve Health Outcomes for Persons with Serious Mental Illness

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Outline

Population-Based Care and SMI
Marc Avery
1. Definition
2. Importance
3. Supporting evidence

Jennifer Clancy
1. Organizational Considerations
2. The Convening Organization
3. Barriers
4. Examples

DISCLOSURES

Employment:
Associate Director for Clinical Services, Division of Integrated Care and Public Health and AIMS Center (Advancing Integrated Mental Health Solutions)
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Contracts (current & recent)
California Institute of Behavioral Health Solutions
Wyoming Health Care Authority
Telehealth Corporation
Psychiatric Advisor Magazine

NO FINANCIAL RELATIONSHIPS THAT PRESENT A CONFLICT OF INTEREST FOR TODAY’s PRESENTATION
I WILL NOT DISCUSS OFF LABEL OR INVESTIGATIONAL USE OF MEDICATIONS OR OTHER TREATMENTS

Marcs Avery, MD

Building on 25 years of Research and Practice in Integrated Mental Health Care
**Definition 1:**
Population based care means ensuring outcomes for all patients in a group with a targeted condition.

**Definition 2:**
Population Based Care Means – Not allowing our patients to fall between the cracks.

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1. Tufts Managed Care Institute Newsletter, November 2000
   [http://www.tmai.org/downloads/topic11_00.PDF](http://www.tmai.org/downloads/topic11_00.PDF)
2. Jurgen Unutzer, AIMS Center, University of Washington

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**Mental Disorders**
- Are common, disabling, expensive, and with high mortalities.
- Are mostly chronic conditions that require deliberate / persistent follow up.
- A small percentage of persons in need of mental health get any services.

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**Where does population based care “fit in”?**

- Patient Centered / Team Based Care
- Population-Based
- Measurement-Based Treatment to Target
- Evidence-Based
- Accountable

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**Why Population Based Care for SMI Persons?**
- System and Payment Reform
  - Expanded Coverage
  - Accountable Care Organizations
  - Health Home
- Control of Escalating Costs
- Clinical Effectiveness

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*Multiple investigators, references available by request.*
Why are Persons with Severe Mental Illness more Vulnerable to “Falling Through the Cracks”?

**Systems Issues**
1. Payment system that discourages recovery
2. Episodic treatment authorizations
3. Services that often favor crisis intervention over disease management.
4. Fragmented service network

**Patient and Provider Issues**
1. Stigma
2. Patient Health Behaviors
3. Clinical Inertia

**Effects are Bidirectional**

**Mental Illness Results in Increased MEDICAL COSTS**

- 50% higher Annual Health Care Costs regardless of # medical illnesses

**Chronic disease score**

Sometimes the patients who need us most 
are the ones we forget..

<table>
<thead>
<tr>
<th>Group 1</th>
<th>Group 2</th>
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<tbody>
<tr>
<td>Punctual</td>
<td>Misses Appointments</td>
</tr>
<tr>
<td>Articulate</td>
<td>Disorganized</td>
</tr>
<tr>
<td>Polite</td>
<td>Angry, agitated</td>
</tr>
<tr>
<td>Engaging</td>
<td>Reserved</td>
</tr>
<tr>
<td>Compliant / Adherent</td>
<td>Isolative, Avoidant</td>
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<tr>
<td>Responsive</td>
<td>Rejecting</td>
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<tr>
<td>Has transportation</td>
<td>Lacks transportation</td>
</tr>
<tr>
<td>Good support system</td>
<td>Lacks social supports</td>
</tr>
<tr>
<td>Clinically straightforward</td>
<td>Complex and Confusing</td>
</tr>
<tr>
<td>Culturally Similar</td>
<td>Culturally Dissimilar</td>
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</tbody>
</table>

Good News! We have evidence and increasing experience with models of care that work better!

Primary Care Locus
- IMPACT / Collaborative Care
- TEAMcare
- Behavioral Health Consultant / Cherokee Model

Community Behavioral Health Locus
- P-Care
- Health Promotion Activities
- SAMSHA-PBHCI

From: O’Conner, Patrick, et. Al, Clinical Inertia and Outpatient Medical Errors, 2005 AHRQ, Advances in Patient Safety

IMPACT Team Care Model
(Patient Centered Healthcare Home for Behavioral Health)

Primary Care Practice with Mental Health Care Manager
An Integrated Team-Based Approach – with a new Twist

IMPACT doubles effectiveness of care for depression
50% or greater improvement in depression at 12 months

IMPACT reduces health care costs
ROI: $6.5 saved / $1 invested

MHIP: P4P-based quality improvement
cuts median time to depression treatment response in half.
What about SMI patients who:
1. Get the majority of their services in a CMHC?
2. Have much more complicated service teams?

Integrated Primary Care Team vs. Integrated Community BH Care Team

Health Promotion: Improving Fitness and Reducing Obesity: What Works

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Report Weight Loss of BMI</th>
<th>Report Clinically Significant Findings</th>
<th>Report Weight Loss and Health</th>
<th>Key Findings</th>
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<td>In SIMPLER</td>
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<td>ACHIEVE</td>
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<td>RENEW</td>
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<td>✔</td>
<td>6.4 lbs weight loss</td>
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<td>0.3–1.8 lbs weight loss</td>
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<td>Lifestyle Interventions</td>
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<tr>
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<td>DART</td>
<td>✔</td>
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<td>5 lbs weight loss</td>
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<td>Behavioral Therapy (BT)</td>
<td>✔</td>
<td></td>
<td>27% with 10 weight loss</td>
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<td></td>
<td></td>
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<td>41% who completed BT with 10 weight loss</td>
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</table>

Key Findings:
- Increased Preventive Care (58% versus 21%)
- Treatment for CV illness (34% versus 28%)
- Primary Care Linkage (71% versus 52%)
- Increase in self-rated health

Create a Table to follow…

<table>
<thead>
<tr>
<th>Topic</th>
<th>Tool</th>
<th>Frequency</th>
<th>Target</th>
<th>Goal</th>
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<td>Blood Pressure</td>
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<td>SBP&lt;140 and DBP&lt;90</td>
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<td>Tobacco/Nicotine</td>
<td>Smoking status</td>
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<td>5%</td>
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<tr>
<td>Depression</td>
<td>PHQ</td>
<td>Monthly</td>
<td>5 point reduction or score &lt;10</td>
<td>10%</td>
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<tr>
<td>Anxiety</td>
<td>GAD</td>
<td>Monthly</td>
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<td>10%</td>
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<tr>
<td>Obesity</td>
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<td>Quarterly</td>
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<td>45%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>HBA1c</td>
<td>Annually</td>
<td>&lt;7.5</td>
<td>25%</td>
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<tr>
<td>Cholesterol / Lipids</td>
<td>LDL-C</td>
<td>Annually</td>
<td>LDL-C&gt;40 HDL-C&lt;130</td>
<td>50%</td>
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<tr>
<td>Alcohol</td>
<td>AUDIT (modified)</td>
<td>Quarterly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug Use</td>
<td>DAST (modified)</td>
<td>Quarterly</td>
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SAMSHA-HSA Primary and Behavioral Health Care Integration (PBHCI) Program

Grantees

<table>
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<th>Grantee</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
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<td>13</td>
<td>9</td>
<td>34</td>
<td>8</td>
<td>30</td>
<td>9</td>
</tr>
</tbody>
</table>

Study Questions:
1. Is PCBHCI Possible?
2. Does it improve outcomes?
3. What components work best?
Models:
1. Coordinated Care
2. Co-located Care
3. Integrated Care
   • Partner with primary care organization
   • Hire primary care team


THANK YOU!

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http://uwaims.org/index.html

Practical Experience with Facilitating Population Based Care

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Associate Director
CA Institute for Behavioral Health Solutions
Jennifer Clancy, MSW

DISCLOSURES

Employment:
Associate Director, California Behavioral Health Solutions

Grant funding (current & recent)
None

Contracts (current & recent)
CA Department of Health Care Services

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Topics

1. Overview Of The Organizations That Are Vital for the SMI Population

2. The Role of Convening Organizations in SMI Population Health

3. Historical Barriers to Creating Coordinated Care Systems for SMI Population

3. Solutions: Examples of Convening Organizations Coordinated Care to Address Population Health Needs

The Organizations Shaping the SMI Population Health- As Is

Where Are We Going?
Coordinated System Offering Integrated Care

Various Funding Sources Organized by Population Health and Triple Aim Principles
Convening Organizations

1. **What Can The “Convening Organization” Do?**
   - Assumes accountability for a population
   - Convenes all provider organizations necessary to support the whole health of the population
   - Builds a vision and shared understanding of the potential benefits of a coordinated system
   - Supports the development of the organizational relationships and agreements/MOUs

2. **Which Organizations Can Serve as “Convening Organizations” for SMI population?**
   - Medi-Cal Managed Care Plans
   - County Mental Health Plan

Convening Organizations

1. **What Are The Barriers each Faces in serving as the “Convening Organization” for SMI population?**
   - Medi-Cal Managed Care Plans (MCPs):
     - Historically not responsible for mental health care
     - Subcontracts to Managed Behavioral Health Organizations
     - MCPs need to develop knowledge—build a provider network and a delivery system SMI population
   - County Mental Health Plans (MHPs):
     - Historically isolated from agencies they must partner with
     - Organizational isolation consequence of: stigma; carved out funding; traditional split of mind/body care
     - Limited experience using health information technology

Solutions for Coordinated Care Partnerships for Population Health

**Fresno County Care Coordination Partnership:**
(County Mental Health Plan as Convener)

**FRESNO COUNTY CCC PARTNERSHIP TEAM**

- Clinica Sierra Vista: FQHC, integrated mental health & primary care clinic serving Medi-Cal, Medi-Care & uninsured individuals
- Fresno County Dept. of Behavioral Health: County MHP, convening organization and client care coordinator
- Ambulatory Care Center: High-fidelity IMPACT model of integrating mental health services into primary care clinic. Serves clients with mild/moderate mental illness
- CalViva: A local Public Health Plan created by the Regional Health Authority to serve Medi-Cal members in the counties of Fresno, Kings & Madera.
The Fresno County Care Coordination Partnership Team will make changes to improve the whole health status of adult individuals by coordinating services for the clients with the most serious mental illness and substance use disorders.

Behavioral Health and physical health care’s coordination has, thus far, been driven by individual providers rather than system change. Long-term change must be driven by the systems rather than pushed forward by a few practitioners.

**HISTORY OF & KEY CATALYSTS FOR CARE COORDINATION**

**Overall Theme Across All Agency Partners**
- Recognize the importance of physical and mental health care to overall well-being of an individual
- Shared goal and all agency partners benefit!

**Agency Catalysts for Care Coordination/Population Health:**
- Mental Health (Medical Director)
- CalViva Health Plan
- Primary Care

**CHANGES TO PROMOTE CARE COORDINATION AND POPULATION HEALTH**

**Key changes the Team has been working on**
- Multidisciplinary Clinical Care Conferences (routine & ad hoc)
- Develop routine SUD screening
- Support of client self-management
- Ensuring and monitoring routine medication reconciliation
- Ensuring and monitoring authorizations for sharing client PHI
- Referral process between MHP and PCP
- Sharing of patient physical exams, test & lab results
DATA COLLECTION

CC measures data collection process
- Excel spreadsheet (tracks key health indicators, ROIs, etc.)
- MHP’s EHR system (Avatar) - Data reports created specifically for CCC & embedded into EHR for ease of generating data

Who is responsible for collection?
- PCPs and MCPs collect data for their respective measures.
- MHP data analyst responsible for MH data collection, synthesis of data from MCP & PCPs, and reporting out to CiBHS

SUSTAINING SYSTEM CHANGES THAT PROMOTE POPULATION HEALTH

- Maintain key personnel from partner agencies
- Buy-in from executive leadership
- Right People at the Table with the Right Personalities:
  - Client centered and dedicated providers
  - Providers who follow through and are accountable
  - Providers who are real learners. “Care coordination and population health is so different from what has been done before- given the learning curve, the team members must be learners”.
  - Providers who are honest, transparent, and “leave their egos at the door”

Solutions for Coordinated Care Partnerships for Autism Population Health

Autism Assessment Center of Excellence
(Medi-Cal Managed Care Health Plan as Convener)

The Problem:
Late Diagnosis = Late Intervention = Diminished Quality of Life & Higher Life-Long Care Cost
**Inland Empire (IE) ASD Collaborative**

**Vision:**

“Every child in the Inland Empire will have access to a collaborative, organized, integrated and Trans-Disciplinary Assessment/treatment resource for Autism.”

**Mission:**

“To meet the autism community’s needs through shared responsibility for a comprehensive and Trans-Disciplinary assessment, Treatment Recommendations, Referrals and Resources in order to maximize the quality of life for children in the Inland Empire with Autism and their families.”

**The Solution:**

Formation of the Inland Empire ASD Collaborative

**AACE Center:**

Integrated & Child-Centric

- **Inter-agency collaboration**
  - Improves referrals and aligns providers and educators

- **Comprehensive assessment**
  - Eliminates wasted time & duplicative assessments

- **“One Stop Shop”**
  - Reduces parent’s burden of having to advocate and coordinate across multiple agencies

- **Early Intervention**
  - Access to treatment at an earlier age leads to a higher Quality of Life & functioning

**Scarc Resources**
- Lack of clinical criteria
- Lack of essential medical personnel

**Fragmented System**
- Treatment is not well understood or coordinated
- Decisions based on cost rather than clinical criteria

**Quality of Life**
- Delay in diagnosis = Lost early intervention = Diminished life-long functioning

**Lack of clinical criteria**
- Lack of essential medical personnel

**Kids with Autism Deserve an Answer!**
The AACE Center Opens 2014 and Promises to:

- Be recognized by medical treatment providers, school districts and social service programs as a trusted and credible assessment provider
- Provide families and providers with useful, appropriate and actionable treatment recommendations, referrals and resources
- Be financially self-sustaining 2 years after start-up
- Create a model that can be replicated in other communities.

Creating Population Health

- When a Solution Depends on Shared Responsibility, there Must Still Be a “Convening Organization”
- Collaboration takes Longer to Implement
- Bringing Everyone Along takes Shared Vision and Mission which must be centered on the Target Population - not any single Agency
- When Commitment and Perseverance Prevail a Collaborative Strategy often yields The Best Result for Population Health as it is a:

“Community Solution”